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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 II**

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the Inn at Loretto, 211 Old Santa Fe Trail, Santa Fe, New Mexico, on October 15 and 16, 2002.

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October 16, 2002\_\_\_\_\_

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

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

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

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

17 The last bullet here is that environmental  
18 data must be used in all cases that have a likely  
19 probability of causation of less than 50 percent.  
20 We need to keep pulling the string, as we say, on  
21 that dose the person would receive. So if their  
22 internal dose and their external dose was less than  
23 50, we need to look at the environmental dose to see  
24 if that would put them over the top as far as  
25 compensation would be concerned.

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

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

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

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

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

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

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

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

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

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

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

25 This is a snapshot as of -- I think last

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

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

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

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

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

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



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

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

6 **DR. NETON:** Yes.

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

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

1           trick is getting time.

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

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

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

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

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

19                 **DR. NETON:** Just the badge reads, the TLD  
20          reads.

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

24                 **DR. NETON:** Yes. Right, yeah.

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

1 things --

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

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

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

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

12                   **DR. ANDERSON:** Yeah. How do you determine  
13          completeness?

14                   **DR. NETON:** Again, it's a rough number, and  
15          these are relative terms, but I wouldn't say that  
16          we're 95 percent complete with the profile. This is  
17          -- the DOE has sent us 95 percent of the -- we have  
18          95 percent of the operating history of the plant  
19          covered for a profile with regards to the badge  
20          type, the lower limit of detection, the frequency of  
21          exchange, that sort of stuff. So we have a pretty  
22          good idea for 95 percent of the operating history of  
23          the site what those were.

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

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

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

6                        **DR. ANDERSON:** Qualitatively --

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

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

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

15                      **DR. NETON:** Yes.

16                      **DR. ZIEMER:** -- as bioassay?

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

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

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

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

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

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

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

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



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

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

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

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

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

22 **DR. ZIEMER:** Presumably you have that then.

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

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

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

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

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

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

13 **DR. ZIEMER:** As if it were --

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

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

20 **DR. NETON:** Yeah, yeah.

21 **DR. ZIEMER:** You are? Good.

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

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

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

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

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

23 **DR. NETON:** That would probably --

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

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

4           **DR. ZIEMER:** Jim?

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

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

25           **DR. MELIUS:** You're getting close to

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

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

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

1 to 40-year period.

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

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

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

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

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

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

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

11 **DR. MELIUS:** -- my concern and, you know,  
12 again, at the same time it could be an overwhelming  
13 --

14 **DR. NETON:** Right.

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

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

1 about.

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

16 **DR. NETON:** Yeah.

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

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

25 **DR. NETON:** Good point. That has not been



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

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

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

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

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

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

16          **DR. NETON:** I just coined a new one.

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

1 profile data. Maybe that's too strongly stated.

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

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

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

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

23 **DR. NETON:** Right.

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

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

5 **DR. NETON:** That's okay.

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

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

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

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

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

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

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

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

18 **MR. GRIFFON:** -- be worthwhile to look into.  
19 Yeah.

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

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

5 **MR. GRIFFON:** Exactly.

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

15 **DR. ZIEMER:** Additional questions?  
16 Comments?

17 (No responses)

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

20 **BOARD MEMBERS DEALING WITH THE PUBLIC**

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

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

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

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



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

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

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

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

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

1           you would see that this is really the only one where  
2           there's a number eight. But 5 C.F.R.  
3           2635.101(b)(8), employees shall act impartially and  
4           not give preferential treatment to any private  
5           organization or individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

25           Another possible question, I heard you

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

10 **MS. MUNN:** No.

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

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

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

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

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

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

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

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

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

25           **DR. ROESSLER:** I certainly avoid the press

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

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

25                 **DR. ROESSLER:** And I think what you put on

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

3 **MR. NAIMON:** Thank you.

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

6 (No responses)

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

10 **MR. NAIMON:** Thank you very much.

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

25 (Whereupon, a recess was taken.)

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**IREP UPDATES**

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

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

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

(Pause)

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 radiation hazard.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

6           **UNIDENTIFIED:** (Inaudible)

7           **MR. HENSHAW:** I'm sorry?

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

10          **MR. GRIFFON:** Yeah.

11          **MR. HENSHAW:** The current model?

12          **DR. ZIEMER:** Yes.

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

16          **MR. GRIFFON:** Okay.

17          **MR. HENSHAW:** -- for the current model.

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

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

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

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

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

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

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

11 **MR. ELLIOTT:** Yes.

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

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

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

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

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

10          **MR. HENSHAW:** Yes.

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

12          **MR. HENSHAW:** And at zero.

13          **DR. ZIEMER:** And at zero.

14          **MR. HENSHAW:** Yes, sir.

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

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

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

3 Any questions on this graph?

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

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

10 Question?

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

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

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

18 **MR. HENSHAW:** That's right.

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

25 **MR. HENSHAW:** You're exactly correct.

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

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

7                     **MR. HENSHAW:** Yes.

8                     **DR. ANDERSON:** -- using the same  
9           characteristics in the --

10                    **MR. HENSHAW:** That's right.

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

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

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

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

21                    **DR. ANDERSON:** Right.

22                    **MR. HENSHAW:** -- inputs.

23                    **DR. ZIEMER:** I think Gen Roessler has a  
24           question.

25                    **DR. ROESSLER:** Russ, you're talking about

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

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

8 **DR. ROESSLER:** So it wouldn't change.

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

12 This is a rather busy slide. Without  
13 belaboring it too much, it's -- this is a  
14 hypothetical example of the probability of causation  
15 results comparing the current model to the proposed  
16 model. And the inputs are fixed -- male, born in  
17 1930, diagnosed in 1980, exposed to 50 rem. Look at  
18 the table, the left-hand column is the year of  
19 exposure, this is the corresponding time since  
20 exposure. The current model results -- and that's  
21 the one that determines compensation, the 99th  
22 percentile, and the proposed model.

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

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

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

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

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

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

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



1 but only two percent higher than the proposed model.

2 Any questions on that? Okay.

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

20 Any questions? Okay.

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

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

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

1 questions or comments on the issue?

2 **DR. ZIEMER:** I think Wanda has a question.

3 **MR. HENSHAW:** Yes, ma'am?

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

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

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

7           **MR. HENSHAW:** That's correct.

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

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

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

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

12 **MR. HENSHAW:** I'm sorry?

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

15 **MR. HENSHAW:** Yes.

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

18 **MR. HENSHAW:** Correct.

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

1 significant portion of --

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

3 **MS. MUNN:** -- workers.

4 **MR. HENSHAW:** -- absolutely right.

5 **MS. MUNN:** Yeah.

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

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

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

24 **DR. ZIEMER:** Larry has a comment here.

25 **MR. ELLIOTT:** And for the Board's further

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

25 **MR. HENSHAW:** I might also mention, by the

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

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



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

17                   **UNIDENTIFIED:** (Inaudible)

18                   **DR. ZIEMER:** Or two, sure.

19                   **UNIDENTIFIED:** (Inaudible)

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

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

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

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

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

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

24 **DR. ZIEMER:** And Jim.

25 **DR. ANDERSON:** Yeah, I would almost back up

1 a bit that the issue of latency is, as you say, time  
2 since exposure and it's typically time since first  
3 exposure. So the latency here -- and I believe the  
4 data that they have is if your only exposure is  
5 within two years, what's your risk of developing  
6 disease, as opposed to what you're trying to do here  
7 is does more recent -- how much to the cumulative  
8 exposure does more recent exposure contribute. And  
9 the data on that is basically non-existent. So I  
10 think talking about it as latency for an individual  
11 who had -- if you were to say here's this man's  
12 exposure history and ask me -- occupational health  
13 epidemiologist, and you said he was first exposed in  
14 1942, I would say his latency is since 1942. And  
15 now you have to address, you know, when did the  
16 malignancy actually occur. And if it's already  
17 there, then subsequent exposure to the -- when it  
18 was there isn't going to have contributed. So you  
19 get into the mix of are you going to use years of --  
20 you know, rem years so that earlier you weight  
21 earlier exposure versus later exposure because the  
22 damage is done and now, over time, that begins to  
23 express itself, even if you haven't had subsequent  
24 exposure. So I would be more comfortable with  
25 adopting the new one. If you had somebody whose

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

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

9                     **MR. HENSHAW:** Yeah, just for clarifi-- yeah  
10          --

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

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

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

9 **DR. ANDERSON:** As an independent effect.

10 **MR. HENSHAW:** Right.

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

13 **MR. HENSHAW:** Right, that's correct.

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

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

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

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

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

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

16 **MR. HENSHAW:** Yeah, just out of curiosity,  
17 though, I was running models -- I was varying the  
18 dose for that one acute exposure. And as it turns  
19 out -- I think at 26 rem, if I recall correctly --  
20 using those inputs from that slide I put up earlier,  
21 the hypothetical claim, one acute dose of 26 rem  
22 using that type of radiation -- which I think was  
23 gamma photons greater than 250, I think we used --  
24 results in a probability of causation of 50 -- 50 or  
25 51 percent. So that's an issue where this latency

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

6                   **DR. ZIEMER:** Jim.

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

12                   **UNIDENTIFIED:** Substantial.

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

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

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



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

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

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

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

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

19 **DR. ZIEMER:** Any further questions or  
20 comments?

21 **MR. HENSHAW:** Can we go to the public?

22 **MR. SILVER:** May I?

23 **DR. ZIEMER:** Yes, please.

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

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

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

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

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

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

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

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

12 **MR. HENSHAW:** Yes.

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

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

16 **MR. SILVER:** Yes.

17 **MR. HENSHAW:** Yes.

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

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

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

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

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

16 **MR. SILVER:** Thank you.

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

1 continue to do.

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

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

13 **UNIDENTIFIED:** One quick question.

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

20 **REVIEW AND APPROVAL OF DRAFT MINUTES**

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

1 you can submit individually in a marked-up copy.

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

5 Yes, Mike.

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

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

13 **UNIDENTIFIED:** The seventh meeting, page  
14 two.

15 **UNIDENTIFIED:** The August 27th meeting.

16 **DR. ZIEMER:** We're still on the August 14th  
17 --

18 **MR. GIBSON:** Oh, I'm sorry.

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

22 (No responses)

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

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

3 **DR. ANDERSON:** Yeah.

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

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

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

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

22 **DR. ZIEMER:** Any objections to that change?

23 **UNIDENTIFIED:** No.

24 **DR. ZIEMER:** Other changes?

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



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

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

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

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

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

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

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

14 **MR. GRIFFON:** -- raw case --

15 **DR. ZIEMER:** -- file --

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

18 **DR. ZIEMER:** Is that agreeable?

19 **UNIDENTIFIED:** That's agreeable.

20 **DR. ZIEMER:** Other changes?

21 **MR. OWENS:** Dr. Ziemer?

22 **DR. ZIEMER:** Yes, Leon.

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

1           **DR. ZIEMER:** Yes.

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

5           **DR. ZIEMER:** Mr. Lawson now works --

6           **MR. OWENS:** Yes, sir.

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

9                           (No responses)

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

14           **DR. ANDERSON:** I'll make that.

15           **MR. GRIFFON:** Second.

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

18                           (Affirmative responses)

19           **DR. ZIEMER:** All opposed, no?

20                           (No responses)

21           **DR. ZIEMER:** Abstentions?

22                           (No responses)

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

1 or corrections to the minutes of the conference  
2 call?

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

10 **DR. ZIEMER:** Is that agreeable then?

11 **UNIDENTIFIED:** Yes.

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

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

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

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

25 **DR. ANDERSON:** Yeah.

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

4           **DR. ANDERSON:** You can see the mustard  
5 stains.

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

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

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

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

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

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

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

1 form.

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

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

7 **UNIDENTIFIED:** Yeah, that would be --

8 **UNIDENTIFIED:** -- a good idea.

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

13 **UNIDENTIFIED:** Yes.

14 **UNIDENTIFIED:** Yes.

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

17 **UNIDENTIFIED:** I didn't think so.

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

21 **MR. GRIFFON:** Attachment three?

22 **MR. ELLIOTT:** There are only two  
23 attachments.

24 **DR. MELIUS:** We never got an attachment  
25 three.

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

3           **UNIDENTIFIED:** It was the menu from the  
4 restaurant.

5           **DR. ZIEMER:** I have something called report  
6 attachment three.

7           **UNIDENTIFIED:** Attachment three is the --

8           **DR. ZIEMER:** Report attachment three, rule  
9 comment attachments.

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

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

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

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

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

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

20          **MS. MUNN:** Yes.

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

23          **MS. MUNN:** Report attachment number three.

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

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

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

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

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

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

13          **DR. ANDERSON:** Oh, okay.

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

16          **DR. ANDERSON:** I got it, okay.

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

21          **UNIDENTIFIED:** Yes.

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

1                   Okay. Are there any other corrections?

2                                   (No responses)

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

6                   **DR. MELIUS:** I so move.

7                   **UNIDENTIFIED:** And second.

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

10                                   (No responses)

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

13                                   (Affirmative responses)

14                   **DR. ZIEMER:** Opposed say no.

15                                   (No negative responses)

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

18                                   (No responses)

19                   **DR. ZIEMER:** No abstentions.

20                   **BOARD DISCUSSION/WORKING SESSION**

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

25                   **MR. GRIFFON:** I think that should go first,



1           anyway.

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

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

15                   (Whereupon, a recess was taken.)

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

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

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

1           **DR. ZIEMER:** And also before you begin,  
2 might I ask, is Richard Toohey still here? Rich,  
3 could you sort of be on deck in case there was  
4 specific questions concerning ORAU that we might  
5 need to ask you about, too. Is that agreeable with  
6 --

7           **DR. MELIUS:** Yeah, yeah, yeah.

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

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

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

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

14 **DR. MELIUS:** Right.

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

17 **DR. MELIUS:** And actually --

18 **DR. ZIEMER:** -- voice any concerns.

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

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

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

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

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

1 and correct me if I'm wrong.

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

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

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

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

3 **DR. ZIEMER:** At the front end?

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

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

20 **DR. MELIUS:** Suggestion, yeah.

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

24 **DR. MELIUS:** Correct, yeah.

25 **DR. ZIEMER:** -- members. Do you generally

1 agree with this kind of an approach?

2 DR. MELIUS: Uh-huh.

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

5 DR. MELIUS: Yeah.

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

11 DR. MELIUS: Correct.

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

14 DR. MELIUS: Correct, yes.

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

16 DR. MELIUS: That was it.

17 DR. ZIEMER: That was it.

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

20 DR. ZIEMER: Have concerns --

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

22 DR. ZIEMER: -- (inaudible) -- yeah. Okay.

23 Now just react to that, pro or con.

24 DR. ANDERSON: Yeah, I would support that.

25 I think it's much better as part of a kind of an

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

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

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

18 **MR. PRESLEY:** A one-pager.

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

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

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



1           **MS. MUNN:** No, no --

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

4           **MS. MUNN:** But the reason --

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

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

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

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

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

18 **DR. NETON:** I think that's --

19 **DR. ZIEMER:** -- and not every job or every  
20 degree or every --

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

1           **DR. ZIEMER:** Yes.

2           **DR. NETON:** -- in these cases.

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

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

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

20           **MS. MUNN:** No.

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

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

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

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

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

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

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

22                 **DR. ANDERSON:** Yeah.

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

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

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

3 **DR. ZIEMER:** Any other comments?

4 **MR. OWENS:** Dr. Ziemer?

5 **DR. ZIEMER:** Yes?

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

14 **DR. ZIEMER:** Yes, Richard.

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

20 **DR. ZIEMER:** Thank you. Mike, comment?

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

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

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

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

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

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

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

1 the dose recon of --

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

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

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

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

20 **DR. NETON:** Right.

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

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



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

5           **MR. ELLIOTT:** And then there would be --

6           **DR. NETON:** -- discussed that.

7           **MR. ELLIOTT:** -- a third reviewer that would  
8           be a --

9           **DR. NETON:** The NIOSH staff.

10          **MR. ELLIOTT:** -- NIOSH person to -- you  
11          know.

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

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

25          **DR. NETON:** I suppose for transparency

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

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

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

19 **DR. ZIEMER:** Any other comments? Roy?

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

23 **DR. ZIEMER:** Yeah.

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

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

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

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

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

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

4           **DR. ZIEMER:** Mark?

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

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

10          **UNIDENTIFIED:** Which Richard?

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

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

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

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

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

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

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

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

16 **DR. ZIEMER:** Thank you for that input. **DR.**

17 **DEHART:** Could I respond?

18 **DR. ZIEMER:** Roy?

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

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

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

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

21 **DR. ZIEMER:** Other comments? Gen? Thank  
22 you.

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



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

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

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

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

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

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

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

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

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

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

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

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

8           **UNIDENTIFIED:** That's what Roy's proposing.

9           **DR. ZIEMER:** I'm going --

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

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

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

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

5 **PUBLIC COMMENT PERIOD**

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

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

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

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

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

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

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

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

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

1 have this experience. Thank you.

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

6 (No responses)

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

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

13 (Whereupon, a luncheon recess was taken.)

14 **BOARD DISCUSSION/WORKING SESSION**

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



1 the same name as you used yesterday.

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

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

12 **DR. DEHART:** (Inaudible)

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

16 **DR. TOOHEY:** Right here.

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

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

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

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

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

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

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

1 are.

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

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

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

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

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

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

20           **DR. ANDRADE:** Great.

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

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

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

25                   **DR. ZIEMER:** Thank you for that information.

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

6 **DR. ANDRADE:** I do agree.

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

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

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

13 **DR. NETON:** Point of clarification.

14 **DR. ZIEMER:** Thank you. Okay.

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

22 **DR. ZIEMER:** I think the intent is --

23 **DR. MELIUS:** The intent is -- yeah.

24 **DR. NETON:** Okay. Thank you.

25 **DR. ZIEMER:** It's the letter.

1           **DR. MELIUS:** Yeah.

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

4           **DR. MELIUS:** Why don't I second it and that  
5 --

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

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

12          **DR. ZIEMER:** The recorder has the wording --

13          **DR. ANDRADE:** Right.

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

23          **MR. OWENS:** Dr. Ziemer, I have a comment.

24 If I understood Tony initially, his motion was to --  
25 for the Board to make a motion in support of the

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

3 **UNIDENTIFIED:** No.

4 **UNIDENTIFIED:** Well, it was (inaudible) --

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

8 **DR. ANDRADE:** It was.

9 **MR. OWENS:** Okay.

10 **DR. ZIEMER:** But that was never seconded  
11 and --

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

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

17 **DR. ZIEMER:** Is that the case?

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



1 dose reconstruction process.

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

8 **DR. MELIUS:** It varies.

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

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

16 **DR. ZIEMER:** Leon has a question.

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

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

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

1 Dr. Melius' wording, given that --

2 **DR. ZIEMER:** As the official motion.

3 **DR. ANDRADE:** As the official motion.

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

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

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

1           **DR. MELIUS:** Correct.

2           **DR. ZIEMER:** -- correct? Wanda.

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

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

9           **DR. ZIEMER:** Thank you. Other comments?

10                           (No responses)

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

14                           (Affirmative responses)

15           **DR. ZIEMER:** Any opposed, say no.

16                           (No negative responses)

17           **DR. ZIEMER:** Any abstentions?

18                           (No responses)

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

22           **DR. MELIUS:** Yeah. Let me start general  
23 and --

24           **DR. ZIEMER:** Not issue, but the other  
25 comment.

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

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

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

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

19           **DR. MELIUS:** Yeah.

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

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

25           **DR. ZIEMER:** Okay. So you so move his

1 words.

2 **MR. ESPINOSA:** Uh-huh.

3 **DR. ZIEMER:** Is there a second?

4 **DR. DEHART:** I second.

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

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

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

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

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

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

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

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

25 **UNIDENTIFIED:** Correct, yeah.

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

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

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

10          **DR. ZIEMER:** They can request it.

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

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

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

20          **DR. ZIEMER:** Other comments?

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

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

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

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

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

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

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



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

21 **DR. MELIUS:** Can I make one other --

22 **DR. ZIEMER:** Jim, please.

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

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

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

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

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

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

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

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

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

1 the risk coefficients.

2 **DR. ZIEMER:** Okay, thank you.

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

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

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

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

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

25 **DR. ZIEMER:** Thank you. I think Dr.

1           Roessler has a question.

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

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

14                                   (No responses)

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

18                                   (Affirmative responses)

19                   **DR. ZIEMER:** All opposed, no.

20                                   (No negative responses)

21                   **DR. ZIEMER:** Abstentions?

22                                   (No responses)

23                   **DR. ZIEMER:** Motion carries. Thank you.

24 Now I think we may be ready to hear from the working  
25 group on dose reconstruction. Mark?

1           **MR. GRIFFON:** Sure.

2           **DR. ZIEMER:** You want a break first?

3           **MR. GRIFFON:** You want to take a break?

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

5 **DR. ZIEMER:** Right, so I'm suggesting that  
6 wherever we've said something like that, it is in  
7 the sense that the contractor will assist the Board  
8 --

9 **MR. GRIFFON:** Right.

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

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

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

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

22 **MR. GRIFFON:** Okay, but not -- not to -- I  
23 mean there -- there's some things, not to use words  
24 I've heard before, but case by case basis. I think  
25 2 through 6, there are certain things there where

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

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

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

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

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

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

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

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

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

10 **MR. GRIFFON:** Right.

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

14 **MR. GRIFFON:** Right.

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

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

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

4           **DR. ZIEMER:** Right.

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

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

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

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

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



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

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

23 **MR. GRIFFON:** Right.

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

1                   **MR. GRIFFON:** Right.

2                   **MR. ELLIOTT:** And I understand that. That  
3 helps.

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

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

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

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

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

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

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

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

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

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

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

3 **DR. ZIEMER:** Jim?

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

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

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

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

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

10                    **MR. ELLIOTT:** Raw case file data.

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

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

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

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

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

6 **DR. ZIEMER:** Comments on I guess E.1, 2 or  
7 3?

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

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

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

15 **DR. ANDRADE:** Well --

16 **DR. ZIEMER:** Tony.

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

1           I really believe that if we start with E.1  
2           as a separate piece, what we're going to be doing is  
3           educating a contractor -- I'll slice that -- to the  
4           degree that we have been educated about the process,  
5           and perhaps even further so to the degree that the  
6           OCAS health physicists are in performing or in going  
7           through this process, and I'd say this is -- to me,  
8           this scope of what would be involved in carrying out  
9           1 by itself is a tremendous scope. It's a huge  
10          scope to try and go back and understand everything  
11          that goes into all the health physics, all of the  
12          assumptions, all of the claimant-friendly decisions  
13          or methods in which decisions are made, all of those  
14          things. I think that comprises just a huge work  
15          scope. And I think rather than trying to educate a  
16          contractor for us to do that sort of thing, it would  
17          be perhaps more efficient if we were to, in your  
18          words, choose some cases wisely and then use those  
19          cases for them to independently go out and make  
20          determinations on the adequacy of the methodologies  
21          that are being used.

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



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

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

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

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

19 **DR. ZIEMER:** Well, those are --

20 **MR. GRIFFON:** That sets certain parameters  
21 for --

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

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

1           certainly not the intent.

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

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

13                   **DR. NETON:** Yes.

14                   **DR. ZIEMER:** -- the nature of the  
15          deliverable?

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

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

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

11 **DR. ZIEMER:** Jim?

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

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

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

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

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

22 **MR. GRIFFON:** Are you saying the ORAU team?

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

1 thing. They're doing a lot of that.

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

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

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

20 **DR. ZIEMER:** Yeah.

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

23 **DR. ZIEMER:** Right.

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

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

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

6           **DR. ZIEMER:** Yeah.

7           **MR. GRIFFON:** -- to these interview groups.

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

10          **MR. GRIFFON:** Right.

11          **DR. ZIEMER:** Right. Other comments? Okay,  
12 Roy.

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

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

8                     **DR. ZIEMER:** Okay. Wanda?

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

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

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

25                    **DR. ZIEMER:** Then it could be tasked --



1           **MR. GRIFFON:** Right.

2           **DR. ZIEMER:** -- at some appropriate point.

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

10          **DR. ZIEMER:** It would be a similar --

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

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

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

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

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

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

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

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

15 **DR. ZIEMER:** Wanda, is there --

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

18 **DR. ZIEMER:** Wanda, you have a comment?

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

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

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

9                   **MR. ELLIOTT:** Go ahead.

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

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

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

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

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

9 **MR. ELLIOTT:** This is --

10 **MR. GRIFFON:** -- an open discussion.

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

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

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

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

11 **MR. GRIFFON:** Right.

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

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

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

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

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

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

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

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

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

10 **DR. MELIUS:** -- applying.

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

14 **UNIDENTIFIED:** (Inaudible)

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



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

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

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

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

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

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

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

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

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

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

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

23 **MR. GRIFFON:** Worked for.

24 **DR. ZIEMER:** Worked for.

25 **MR. GRIFFON:** Right. That's a more

1 restrictive provision and I'm asking if that's --  
2 we'll certainly circulate the language that we come  
3 up with, but is that a reasonable criteria to  
4 include within the evaluation plan?

5 **DR. ZIEMER:** One of the ways you do this --  
6 as I understand the evaluation plan, you can score  
7 them. Suppose that everybody that comes in is --  
8 it's been four years, not five, and you don't have  
9 -- are you going to throw all the proposals out or  
10 do you say if it's -- if it's been -- if it's been  
11 more than five years, they'll score higher. But if  
12 there aren't any of those animals, we'll go to the  
13 four-year one and maybe they're better off than the  
14 threes and the twos. Wanda?

15 **MS. MUNN:** That gives you the rationale to  
16 propose Canadian personnel to do that.

17 **DR. ZIEMER:** There are no qualified people  
18 available.

19 **MR. GRIFFON:** Yeah, and I think that -- yes,  
20 I agree with you there, so okay.

21 **DR. ZIEMER:** So it doesn't become -- it  
22 becomes a kind of guide or sliding scale where you  
23 can score it, and those who --

24 **MR. GRIFFON:** Depending on how recently --  
25 what kind of work --

1           **DR. ZIEMER:** Yeah.

2           **DR. NETON:** I would --

3           **MR. GRIFFON:** This is all -- we're still  
4 going to look at attachment A, actually, so --

5           **DR. NETON:** I would propose that there's a  
6 balancing criteria, though, for the expertise, as  
7 well, so they have to offset each other. I mean a  
8 conflict of interest balanced by a set of work  
9 experience criteria that are really great, I mean  
10 you have to score both of those and strike a  
11 balance.

12           **DR. ZIEMER:** Right, there would be other  
13 criteria that get scored. Roy had a comment.

14           **DR. DEHART:** That bullet we were talking  
15 about before lunch was not exclusionary. It simply  
16 was information that was to go into a database.  
17 Let's not get confused thinking that those people  
18 would not have been hired.

19           **DR. MELIUS:** Well, I can't remember the  
20 exact bullet, but -- to determine whether -- some  
21 were informational, some were -- would be criteria  
22 that were considered in terms of assignment. They  
23 were allowed to be part of the contract, but not be  
24 assigned to certain -- certain cases within that  
25 contract.

1                   Back to sort of Mark's question, I think if  
2                   the, you know, working group then came up with a set  
3                   of balanced, you know -- and evaluation plan that  
4                   incorporates these and really you have to sit down  
5                   and sort of work out what the scoring should be and  
6                   so forth, I think we could probably come to pretty  
7                   easy agreement on that, based on our discussions  
8                   here so far.

9                   **MR. GRIFFON:** Yeah, I agree with that.  
10                  Okay? And I don't think there's much to -- the big  
11                  discussion for the technical evaluation criteria  
12                  would have -- would have been these same items,  
13                  which is section F, which is left out right now.

14                  **DR. ZIEMER:** So the real issue then that  
15                  comes before us at this point is that, given that  
16                  this is roughly what you -- what we need -- I say  
17                  roughly because there may be some polishing to do --  
18                  how does it get implemented in terms of the process?  
19                  Is that correct? And it's not clear to me at this  
20                  point if the working group now was proposing this as  
21                  a draft version of a procurement document --

22                  **MR. GRIFFON:** Well, I don't -- I think this  
23                  is more of a discussion document at this point --

24                  **DR. ZIEMER:** Yeah.

25                  **MR. GRIFFON:** -- because I think we -- we

1 have to reconsider -- if it's a task order proposal  
2 then it wouldn't include this scope information and  
3 we just would outline technical qualifications, et  
4 cetera, so...

5 **MR. ELLIOTT:** I agree with Mark. I think  
6 this has been a discussion document. I don't think  
7 it's in the shape and form ready for us to put  
8 before a procurement officer to put out an RFP. I  
9 would think that the working group probably needs to  
10 have another meeting or two, you know, with Jim's --  
11 Jim Neton's involvement and perhaps Martha DiMuzio,  
12 as you've had her engaged before, to discuss  
13 procurement options and process.

14 I want to make sure that we -- on the record  
15 it's noted as an advisory caution that all of this  
16 is preliminary. And for the audience's benefit and  
17 for those who read the transcripts, this is in fact  
18 preliminary and it's not -- it's pre-decisional and  
19 no one should start preparing a proposal against  
20 this.

21 Additionally, I think we need to make sure  
22 that you understand that the business aspect of this  
23 proposal, the budget and the independent government  
24 cost estimate that has to be created that goes along  
25 with this, still has yet to be discussed by the

1 Board and it's -- because this was a discussion  
2 document, it's premature to do that and we couldn't  
3 do that today or yesterday because we had not  
4 announced it in the *Federal Register* notice for this  
5 meeting. You need to understand it'll take us 60  
6 days, at a minimum, to put such in place for you to  
7 have a executive session meeting of that sort. So  
8 you've got that much time to pull this together, as  
9 well as the business part of the plan. But we would  
10 need to know perhaps today, if that's your pleasure,  
11 that you want -- the full Board wants to have an  
12 executive session.

13 **MR. GRIFFON:** And that executive session,  
14 can that be via conference call or what -- what...

15 **MR. ELLIOTT:** No, it needs to be face-to-  
16 face, because we cannot verify by telephone that  
17 there -- that the participation is limited to the  
18 Board.

19 **DR. ZIEMER:** And if we use that 60-day as a  
20 starting point and use today's date, that means, at  
21 the earliest, December 16. That is theoretically.

22 **MR. GRIFFON:** Let me ask just one more thing  
23 for the working group's benefit. If we're going to  
24 go down this path of discussing the business aspects  
25 of this, including person hours, et cetera, for the

1 task order, can we do that via conference call with  
2 the working group?

3 **MR. ELLIOTT:** I think you have already done  
4 that, and so by precedent, yes --

5 **MR. GRIFFON:** Thank you for saying yes.

6 **MR. ELLIOTT:** -- you can. You have done  
7 that. We're concerned about that, though, and if  
8 you prefer to have a face-to-face, we will  
9 accommodate that. But we want to look at how the  
10 phone -- such a phone conversation meeting is set up  
11 with you all. We're going to look into that and see  
12 if there's a way we can do that so that we verify  
13 that only the parties on the line are those that  
14 need to be on the line.

15 **DR. ZIEMER:** You're talking about working  
16 group then.

17 **MR. ELLIOTT:** Working group, yeah.

18 **MR. GRIFFON:** 'Cause my -- my --

19 **MR. ELLIOTT:** The working group meeting has  
20 not been a public meeting. It's -- working groups  
21 don't have to be announced in the *Federal Register*.  
22 They don't have to be a public venue, and that's the  
23 way this has been going up to this point. It's all  
24 been work in progress and pre-decisional, and so you  
25 could continue along that line.



1                   **MR. GRIFFON:** As long as we -- you know, I  
2 think my feeling is that, you know, the 60-day  
3 limit, I think we need to make that decision now is  
4 my --

5                   **DR. ZIEMER:** The decision that needs to be  
6 made is whether the Board wishes to have an  
7 executive session at the appropriate time, which in  
8 essence would probably be our next meeting. And  
9 what I was getting at is the earliest we could do  
10 that would be December 16th. Now I know from  
11 talking -- and incidentally, if you had some  
12 November dates blocked off on your calendar for this  
13 Board, you may recall that those were back-up dates  
14 in case we couldn't meet today, so those you can --  
15 you can delete those from your calendars.

16                   I've talked to some of the Board members and  
17 I didn't detect a great deal of enthusiasm about  
18 meeting between December 16th and New Year's, which  
19 suggests that we're into January before the full  
20 Board could meet. We will, in fact, after our  
21 break, talk about a specific meeting date. And the  
22 issue then would be do you wish, during that  
23 meeting, to have an executive session to address the  
24 budgetary aspects of such a proposal. If we want to  
25 do that, it would be useful for the Board to go on

1 record to request NIOSH to go through whatever steps  
2 are necessary, including the *Federal Register* notice  
3 and other requirements, 'cause there are some other  
4 requirements within the government. If you're going  
5 to have an executive session, the topic has to be  
6 know, the attendees have to be known, it does have  
7 to have a court reporter, so there are some very  
8 specific requirements that have to be set up if we  
9 are to have an executive session.

10 Roy and then Jim.

11 **DR. DEHART:** My question would be is it  
12 necessary for the Board to participate in the  
13 business plan of this proposal? In other words, do  
14 we need to participate in the budget and those kinds  
15 of issues?

16 **DR. ZIEMER:** Let me -- let me partially  
17 answer that is that the working group was set up to  
18 bring recommendations to this Board. They are not  
19 authorized to act on behalf of the Board  
20 unilaterally. In the normal course of things,  
21 whether or not this included the budget, whatever  
22 recommendation comes, the protocol is for the  
23 working group to make a recommendation to the Board.  
24 At that point we have to take action. And insofar  
25 as there is -- there are these issues, including the

1 budgetary issues, an executive session would be  
2 called for. Jim?

3 **DR. MELIUS:** What if -- Roy asked my  
4 question, so I'll elaborate as another possibility.  
5 What if the Board approved what's been presented to  
6 us today, you know, with whatever, you know, changes  
7 and so forth --

8 **MR. ELLIOTT:** Conceptually.

9 **DR. MELIUS:** -- conceptually and so forth --

10 **MR. ELLIOTT:** (Inaudible) scope of work and  
11 the evaluation plan?

12 **DR. MELIUS:** Correct. And then, you know,  
13 authorize the working group to work with NIOSH to,  
14 you know, implement this.

15 **DR. ZIEMER:** You're saying to authorize the  
16 working group to reach the final decision.

17 **DR. MELIUS:** Yeah, that we've done a -- you  
18 know, done the major part of the work.

19 **MR. GRIFFON:** I think he's saying he doesn't  
20 want to meet.

21 **DR. MELIUS:** Well, I'm --

22 **DR. ZIEMER:** We're going to meet anyway.

23 **DR. MELIUS:** Well, the question is would  
24 this expedite the -- the process? I think -- I  
25 think a lot of us would like to see this in place

1           sooner rather than later and I think it would make  
2           the whole process work -- work better, and if it's  
3           not necessary to delay it an extra 30 days or  
4           whatever it's going to take, given the gains -- I  
5           mean given the amount that would be gained from  
6           having executive session. I just don't see  
7           necessarily a lot of gain from an executive session  
8           that has to be done in person due to -- to do this.

9                       **MR. ELLIOTT:** You certainly could do it that  
10          way. You could task the working group with the  
11          responsibility of coming up with the business  
12          portion of the plan, of the proposal. We at NIOSH  
13          don't want to do that. But yet at -- I'm required  
14          to manage the budget and the resources, so I'm very  
15          much interested in this piece. You certainly could  
16          approve the two pieces that you've looked at today,  
17          once the working group has put those back together  
18          and fleshed them out better and taken into  
19          consideration the thoughts and the comments that  
20          you've offered today, and that would obviate the  
21          need for executive session at your next meeting.  
22          And if you felt you needed to have a teleconference  
23          to approve the working group's scope of work and  
24          evaluation plan before the next face-to-face Board  
25          meeting, then you could do that. You could have

1 that, and we could attend to this business plan just  
2 between staff and the working group.

3 **DR. ZIEMER:** But your comment was NIOSH does  
4 not want to do that? Or what was that?

5 **MR. ELLIOTT:** NIOSH -- we could come up with  
6 the business part of this plan and develop the  
7 independent government instrument, but I don't think  
8 you want us doing that. We don't want to do that.  
9 We have to monitor it and I'm responsible for  
10 managing all of this, but I don't want the  
11 perception out there that NIOSH is hiring the  
12 contractor, is controlling the amount of funds that  
13 are going to be placed before this effort. That's  
14 the problem. So I think it's important that you all  
15 work through that.

16 **DR. MELIUS:** But can I just -- it is a task  
17 order contract.

18 **MR. ELLIOTT:** Yes.

19 **DR. MELIUS:** And so the tasks are going to  
20 change over time and would be subject to review by  
21 the Board over time so that it's not as if we're  
22 making it -- recommendation or a decision -- the  
23 Board is not making a recommendation or decision at  
24 this point as to what would be the financial scope  
25 of this overall --

1                   **MR. ELLIOTT:** Yes, you do. You really do.  
2                   You have -- there has to be a business part of this  
3                   plan that gives an independent government estimate  
4                   of the funds needed to conduct the scope of work.  
5                   And under task order contract, you're able -- we're  
6                   able then to put more funds into it if we exceed the  
7                   funds that were awarded. Okay? So if you don't  
8                   expend all of the funds that were awarded in the  
9                   first year, they carry over into the second year of  
10                  the contract. If you expend all of the funds that  
11                  were awarded in the first year, we put more funds  
12                  back -- back into the contract. But we have to have  
13                  this -- what's called an independent government  
14                  estimate that is used to -- for me to sign the  
15                  funding document that says funds are committed for  
16                  this procurement. Now that's not releasable to any  
17                  RFP. The proposers don't know what the independent  
18                  government estimate is. They don't have that level  
19                  of knowledge, but it has to be put in place before  
20                  we can effect this procurement.

21                  The other thing that Jim's kindly reminded  
22                  me of is for this Board's sense of the time line  
23                  here, once the scope of work has been approved and  
24                  the procurement process is complete to the point we  
25                  issue the RFP, request for proposals, and that would

1 appear in *Business Daily*, that will take 45 days as  
2 a minimum, 15 days for the announcement and 30 days  
3 for proposals to be submitted, so you need to factor  
4 that into your time line for your considerations.  
5 So whenever the scope of -- the draft RFP that  
6 includes all these different elements is prepared,  
7 there's that 45 days, plus there's a processing time  
8 that we never can predict at NIOSH through  
9 procurement. We've worked -- as Mark knows already  
10 with the procurement folks, they know this is coming  
11 down the pipeline, they know this is urgent. It has  
12 the Office of the Secretary's sense of urgency about  
13 it so I'm sure that it's going to get expedited.  
14 But there's probably 30 days for the procurement  
15 office to do whatever magic they have to do to turn  
16 this thing into an RFP, and then 45 days, at a  
17 minimum, if that's what you want. If you wanted  
18 more time to try to capture more proposers, you  
19 would just need to add that.

20 **DR. ZIEMER:** I'm going to have us recess  
21 briefly. You can cogitate on this information and  
22 then we'll be prepared immediately after that, so  
23 we'll take a 15-minute break here.

24 (Whereupon, a recess was taken.)

25 **DR. ZIEMER:** We're trying to ascertain what

1 legal issues there might be involved with  
2 authorizing the working group to act on behalf of  
3 the full Board. It's not -- it's not completely  
4 clear that they can do that. We don't know the  
5 answer to that legally at this point, I don't think.

6 There is also some possible perception  
7 issues on taking that route that it could look to a  
8 casual observer that this was a method whereby the  
9 Board decided to circumvent the process of taking  
10 our action through the regular meeting. Even though  
11 it would be an executive session, but it still would  
12 be an announced meeting with an announced topic and  
13 so on. It could look like an end run to the FACA  
14 process if we weren't cognizant of that. So there  
15 are some concerns that at least have been expressed  
16 about that approach. It's not clear whether that's  
17 something we should do.

18 In any event, it is clear that we want to  
19 move ahead. And it seems to me -- and I think other  
20 Board members would concur -- that it's obvious the  
21 working group needs to proceed -- and even meet in  
22 person, if they need to, but by phone if that's  
23 better -- to put the -- these documents in final  
24 form. It's not quite clear how much time that would  
25 take, but even -- even if it were -- if it's



1           determined that they could legally have the  
2           authority to act on our behalf on the business plan,  
3           it's not clear that that would necessarily speed  
4           things up very much, if you look at all the  
5           different parts of this issue in terms of what's  
6           required in procurement and so on.

7                         I have the feeling that we would be well-  
8           served to plan on an executive session at our next  
9           meeting, and in the meantime have the working group  
10          move ahead on preparing the documents, get them  
11          ready. We could have a Board -- we could have a  
12          Board conference call, without the business plan, as  
13          soon as that's ready to bless the scope and so on.  
14          And we would have a little better feel for where we  
15          were timetable-wise. But it would seem to me that  
16          it might be appropriate to plan, because if we're  
17          going to have an executive session, we need to start  
18          that process right now. And it would almost be  
19          better to start that process and then decide we  
20          don't need it than to not do it and then find out  
21          that we do need it.

22                         So let me ask if anyone would object to us  
23          proceeding in that way. The work -- it's sort of a  
24          tandem process. Wanda, I am going to let you speak,  
25          but --

1           **MS. MUNN:** No, no.

2           **DR. ZIEMER:** -- it's sort of a tandem  
3 process where we would proceed under the assumption  
4 that at some point this Board has to bless the final  
5 business plan. That would require an executive  
6 session. But in the meantime the working group  
7 would proceed to work on the final development of  
8 the scope and so on, and at some point between now  
9 and our next meeting, we would probably need to have  
10 a conference call meeting -- again, publicly  
11 announced and available for the public -- to review  
12 and make a final blessing of the scope. We're  
13 assuming that you might be able to get that all done  
14 sometime before the year's end.

15           So let me ask for reaction to that. This is  
16 just sort of the sense of what I got in talking to  
17 various people during break. Mark, if you would.

18           **MR. GRIFFON:** I mean I guess I was going to  
19 ask that we -- you know, whether the Board would  
20 agree that if we don't need that executive session,  
21 if we can do it prior to that, is the Board  
22 comfortable with having the working group do the  
23 business side of that?

24           **DR. ZIEMER:** If it can be done legally and  
25 if there aren't any ramifications. And I might also

1 add that if -- it seems to me, and I have no way of  
2 knowing one way or the other, it might be possible  
3 to do it legally and you would still have the  
4 perception issues that it's legal but it's an end  
5 run on the process.

6 **MR. GRIFFON:** Perception issues from --

7 **DR. ZIEMER:** The public.

8 **MR. GRIFFON:** Even though these executive  
9 meetings are not open to the public.

10 **DR. MELIUS:** Can I --

11 **DR. ZIEMER:** The executive meetings are not  
12 open to the public, but they are announced in terms  
13 of the content of the meeting. There is an official  
14 record kept. This is not true of the working group.  
15 So they are closed to the public, but the knowledge  
16 of what is going on, that -- this is a -- this is a  
17 very specific topic that's being addressed, who is  
18 there doing it, when it's occurring, and the record  
19 is kept.

20 **MR. GRIFFON:** And the record, yeah,  
21 that's --

22 **DR. ZIEMER:** And that meets the FOIA  
23 requirement, even though it's a closed session.  
24 Okay. Jim, Wanda -- Wanda, you had a comment first  
25 or -- no. Yes?

1                   **MS. MUNN:** I don't believe there's any  
2                   question that this Board has a job to do that has  
3                   both time constraints, ethical restraints and legal  
4                   restraints that none of us are pleased with. We all  
5                   would like this to be able to be done sooner,  
6                   quicker, easier with the smallest possible amount of  
7                   effort by everyone involved. But I don't see any  
8                   way that that's going to happen. I am prepared to  
9                   move, when the Chair would like such a motion, that  
10                  we ask the task group to move forward with  
11                  completion of the scope of work that's before us and  
12                  with developing the budgetary items that are  
13                  necessary to complete the recommendations for an  
14                  RFP, that we immediately make notice of the need for  
15                  an administrative session at our next meeting, and  
16                  that we plan to spend a significant amount of time  
17                  at that meeting -- my guess would be, given the  
18                  amount of deliberation we usually have to go  
19                  through, I can't imagine that we would do that in  
20                  less than a day -- at which time the working group  
21                  would bring to us their draft of the proposed  
22                  business plan that we would then be constrained to  
23                  act upon.

24                  **DR. ZIEMER:** And Jim, do you have a comment?

25                  **DR. MELIUS:** Yeah, and I'd like to get some

1 clarification from Larry and whoever else he needs  
2 to ask, to the extent that he can clarify it, 'cause  
3 -- on some of these issues. If I'm correct in my  
4 understanding that the business plan we're talking  
5 about is for a task order contract is simply some  
6 estimate of the number of hours of work involved in  
7 that?

8 **MR. ELLIOTT:** It's skill levels and hours  
9 associated with those skill levels. There's  
10 different rates for different skills.

11 **DR. MELIUS:** Okay. Number two, I'm confused  
12 from some of the prior statements, but is there any  
13 reason that NIOSH is unable to do that under  
14 procurement rules, or is your concern only the  
15 perception if NIOSH makes those determinations?

16 **MR. ELLIOTT:** Yes, it is -- we could do  
17 this. My technical staff could do this, come up  
18 with the business plan. But a part of the role we  
19 have of managing and controlling perception of  
20 conflict of interest includes OCAS staff, as well.  
21 And so that's the issue -- perception here that  
22 we're driving this in the direction, perhaps. And  
23 I've tried to be very cooperative and collaborative  
24 and having staff be the same with the working group,  
25 trying to do our level best to work through the

1 procurement issues to get the Board involved in  
2 various ways, the Board members integrated in this  
3 process so that you have ownership as much as  
4 possible in the RFP, even to the point of -- as we  
5 learned yesterday, the resolution that a Board  
6 member could serve on the technical review panel  
7 gives ownership in the selection of the final award.

8 **DR. MELIUS:** Yeah. The other -- I guess  
9 this is a comment to the Board is that the other  
10 perception that we have to be concerned about is  
11 that if this contract is inordinately delayed, to  
12 remember that there will be a lot of claimants out  
13 there who may have concerns about their dose  
14 reconstructions, that the Board will not be in  
15 position to review those dose reconstructions  
16 because there -- we will not have a contract in  
17 place for doing that and that depending on how  
18 quickly ORAU gears up and so forth and so on -- I'm  
19 not quite sure what the schedule will be, but we're  
20 talking about that where a 30-day delay or a 60-day  
21 delay would mean that there would be, you know,  
22 literally hundreds of people that will have gotten  
23 their final dose reconstructions and that we will  
24 not have a process in place or not be able to  
25 respond to concerns about the review of those. So I

1 think that perception or potential problem has to be  
2 weighed against the perception of NIOSH controlling  
3 or -- you know, over-controlling or whatever you  
4 want to call it, being biased in their -- in their  
5 involvement in different parts of this process. And  
6 I think it's very hard for us to make some of these  
7 judgments because we also know that, despite all the  
8 best efforts on the part of NIOSH, that this  
9 proposal could get buried down in contracting for  
10 six months and all sort of other things can delay it  
11 that are beyond everyone's control. And we -- also  
12 having problems really figuring out what this  
13 schedule will be that -- and maybe the -- one of the  
14 ways to think about this is to work backwards from  
15 what's -- when will our next meeting be.  
16 Realistically, what can -- how close will we be to  
17 getting -- having a scope of work and these other  
18 parts figured out. I mean if this -- having an  
19 executive session is going to mean a difference of a  
20 week or two weeks or something, that's very  
21 different than if we're talking about a delay of 90  
22 days or something like that. And I think if we work  
23 backwards, maybe we can come up with sort of a  
24 practical solution to this rather than trying to  
25 figure out all the legal things and balance some of

1 this out.

2 **DR. ZIEMER:** Other comments? Roy.

3 **DR. DEHART:** In listening to Wanda's  
4 comments, following it through up to the last  
5 comment that she made, I was in essentially full  
6 agreement. What I would like to see happen is not  
7 have the Board review a draft when we next meet, but  
8 have the Board, having already reviewed a draft,  
9 that it would be forward to them with the completion  
10 of the working group, and make comments by  
11 teleconference. And if necessary, a second  
12 teleconference to finalize that, certainly before  
13 the holidays, so that when we come to our next  
14 meeting, that has been done and all that needs to be  
15 done then is the -- the final business plan.

16 **DR. ZIEMER:** Roy, that is what I had  
17 proposed. It's only the business plan that requires  
18 the executive session, and certainly a full Board  
19 review before the end of the year is conceivable, in  
20 my mind, if the working group is able to finish  
21 their work.

22 I sort of had in my mind that we would  
23 probably, in any event, want to meet in January.  
24 But we do need to look at some dates here shortly,  
25 but -- and maybe you would want to do that first,



1 following -- before we have a formal motion  
2 following Jim's idea to sort of see when we're going  
3 to meet next and then what implications does that  
4 have on this particular process.

5 And let me add one thing, Jim, and you made  
6 a comment -- I hope that there's not a perception  
7 that our review of the system will hold up the  
8 awarding of -- we do not review decisions before  
9 they are finalized. In fact, the audit process is  
10 like a bank audit. It's always after the fact. The  
11 rules do not require completed dose reconstructions  
12 to be approved by this Board before awards are made.  
13 I hope you weren't implying --

14 **DR. MELIUS:** I was not implying that. I  
15 just -- and that's why I guess I was using some of  
16 the numbers there. I think there -- people with  
17 concerns about the process or about their own dose  
18 -- because there will be so many in process, both  
19 completed and in process, that people will -- that  
20 the overall process will be better served if people  
21 know that there's a --

22 **DR. ZIEMER:** Right --

23 **DR. MELIUS:** -- review --

24 **DR. ZIEMER:** -- and it's that that we're  
25 concerned about, that if there is a glitch, we don't

1 want the process to be going on for a long time  
2 before it's corrected.

3 **DR. MELIUS:** A glitch or just that -- I  
4 think it'll -- that our review will be very  
5 supportive of the overall effort on the part of  
6 NIOSH and the credibility of this effort.

7 **MR. GRIFFON:** Just as another option, and  
8 before -- before I said it, I'll say I might not  
9 even vote for this option, but as another option,  
10 could NIOSH -- just -- just in the -- 'cause this is  
11 60 days potentially, or maybe not 60 days but some  
12 amount of time that we're adding onto the front end  
13 just to have an executive session. If we have some  
14 agreement on the broad tasks, the four tasks ordered  
15 -- the four tasks in the task order, my  
16 understanding is that a task order is the -- is the  
17 way these would be written, they can be expanded in  
18 the future, so there could be a possibility that  
19 NIOSH could come up with the initial business plan  
20 for the four tasks. And like I said, I'm not sure  
21 I'd want to vote on this myself, but NIOSH could  
22 come up with the initial one just to get it out  
23 there with the -- if the Board -- if there was an  
24 agreement on this Board that the -- we could have  
25 future executive sessions to discuss the expansion

1 or -- if need be, the expansion of the -- of that  
2 business plan. I don't know if that's an option.

3 **DR. ZIEMER:** But again, I think the cautions  
4 -- Larry's already told us that NIOSH can come up  
5 with a business plan, and the issue really boils  
6 down to is that really what you want to do,  
7 particularly in terms of perceptions.

8 **MR. GRIFFON:** But I guess one way I was  
9 thinking that this could avoid the perception  
10 problem is that, you know, we would make it very  
11 clear as the Board that we can review these business  
12 plans in the future and expand them if necessary,  
13 depending on --

14 **MR. ELLIOTT:** No. There could be no  
15 expansion of the business plan. Okay? Nor the  
16 scope of work. If you expand the scope of work or  
17 you expand -- if you say that oh, hey, you know, we  
18 -- within the scope of work, we can add money, once  
19 the money that had been allocated originally has  
20 been expended and the work remains to be done, you  
21 have tasks yet to be done. Okay? Under that scope  
22 of work. But you can't expand the scope of work  
23 because that's a new RFP, has to be recompeted. In  
24 a new RFP, we would require a new business plan. So  
25 I'm lost on expansion.

1           **DR. MELIUS:** Well, I think expansion refers  
2 to expansion of tasks or the amount of funding  
3 available for tasks that would fit into the scope of  
4 work, and I --

5           **MR. ELLIOTT:** As long as the task is  
6 encompassed in the scope of work, we're okay. And  
7 we can add -- we can add funds as we proceed. It's  
8 going to be an open-ended task order, but original  
9 amount of funds has to be allocated, and will have  
10 to have some criteria that the proposers can develop  
11 their proposals against. Okay? And that's where  
12 the independent government estimate comes into play.

13           **MR. GRIFFON:** You mean -- criteria, you mean  
14 more specificity in the task items. Is that --

15           **MR. ELLIOTT:** No.

16           **MR. GRIFFON:** No.

17           **MR. ELLIOTT:** No, the type of skills needed  
18 and the hours needed to conduct those skills in a  
19 given year. That's what's going to be place out  
20 there in the RFP. Okay? The type of skills that  
21 are necessary to complete this -- this -- the tasks  
22 under this technical consultation. Okay?

23           **DR. ZIEMER:** In the sort of parallel path  
24 that I described earlier, after the working group  
25 completes its recommendations and we do as Roy

1 described and bless them in a conference meeting,  
2 before an RFP is released -- which is the business  
3 plan part and the scope of work -- I think there are  
4 some internal NIOSH things that have to occur. And  
5 let me ask. Are there some steps after -- after --  
6 here's what I'm getting at. Suppose a preliminary  
7 business plan was developed by the working group.  
8 We have not yet blessed it, but they have developed  
9 it. Are there some internal steps before an RFP is  
10 issued that have to occur at NIOSH where that part  
11 of it could start, awaiting the final blessing of  
12 the Board on -- the full Board on the business plan  
13 so that when our blessing occurred the RFP can go  
14 out right away? Do you see what I'm getting at? An  
15 RFP is not going to go out the day after we say --  
16 after the working group says we have a business  
17 plan, even if we -- if we could legally and agreed  
18 to authorize them to do it, it's not going to go out  
19 the next day after that occurs. Right? There's  
20 something that happens internally, surely.

21 **MR. ELLIOTT:** Yes, there is a lot that  
22 happens internally.

23 **DR. ZIEMER:** And that in a parallel fashion  
24 --

25 **MR. ELLIOTT:** And the ans--

1           **DR. ZIEMER:** -- in anticipation of Board  
2           action.

3           **MR. ELLIOTT:** The answer is yes, up to a  
4           certain point. And I don't -- I'd have to get with  
5           procurement to find out what the point -- what's the  
6           drop-dead point here where they could not process  
7           the procurement any further without knowing that the  
8           Board supports not only the scope of work but the  
9           business plan.

10          **DR. ZIEMER:** Again looking for some  
11          efficiencies in these processes.

12          **MR. ELLIOTT:** And I'm sure there's this  
13          point, there's this control point where they would  
14          not move any further -- move the procurement any  
15          further until they understood that the Board had  
16          approved the whole -- the whole RFP, whole scope of  
17          work, everything.

18          **DR. ZIEMER:** Comment, Wanda? Okay.  
19          Suspending all that for the moment, can we look at  
20          -- can we look at -- it's my sense in terms of --  
21          even though this is mid-October, we know that the  
22          staff is going to really be busy in the next few  
23          months as the contractor gets up to speed. It's  
24          unlikely that any of us want to meet in December.

25          **MR. GRIFFON:** Is that ruled out?

1                   **DR. ZIEMER:** No, I'm -- I don't want to rule  
2                   it out. I haven't -- I haven't talked to anybody  
3                   who's very enthusiastic about it.

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

5                   **ADMINISTRATIVE HOUSEKEEPING AND BOARD WORK SCHEDULE**

6                   **MR. ELLIOTT:** If I could, behind your tab  
7                   under housekeeping, there's a calendar if you don't  
8                   have a calendar. And I know Cori would like to have  
9                   this anyway. She'd like to know what your -- we'd  
10                  like to know what your availability is. This is a  
11                  housekeeping item. So your availability beyond --  
12                  you know, if we're talking January, think about  
13                  that, as well. You might want to use this calendar  
14                  and turn it in to her. Okay?

15                  And yes, we are going to be very busy.  
16                  December is always a bad month for holidays, and if  
17                  you know anything about the government service at  
18                  all, those who are fortunate enough to have use or  
19                  lose leave are forced to use it in that month,  
20                  December, unless there's very good circumstances of  
21                  why they cannot, and then they're granted a reprieve  
22                  from that. They don't lose it. You know, there's  
23                  things like this that we have to take into  
24                  consideration.

25                  **MR. GRIFFON:** So the week of December 16th

1 to 20th would probably not be a good candidate, huh?

2 **DR. MELIUS:** Well, and I think another way  
3 of looking at that is that nothing would probably  
4 get done between the next -- the next two weeks,  
5 anyway, so you know -- till after the 1st, so --  
6 there's lots of meetings usually that week, but not  
7 much work after that week.

8 **DR. ZIEMER:** Cori?

9 **MS. HOMER:** The week of the 18th is out for  
10 me. I'll be in the Caribbean.

11 **DR. ZIEMER:** Okay. And I don't suppose  
12 we're allowed to meet there, either. Right?

13 Could I ask you to look at January calendars  
14 and let's find out -- who has -- who's not available  
15 the week of January 1st?

16 **MR. PRESLEY:** (Inaudible) the week of the  
17 6th?

18 **DR. ZIEMER:** I'm looking at the wrong year.

19 **DR. MELIUS:** Are we going forwards or  
20 backwards?

21 **DR. ZIEMER:** Here we are, yeah. The week of  
22 January 6th.

23 **MS. MUNN:** I have a minor conflict on the  
24 9th. I could change it.

25 **DR. ZIEMER:** On what?



1           **MS. MUNN:** On the 9th, but --

2           **DR. ZIEMER:** But not serious?

3           **MS. MUNN:** No, I could -- you know, I can  
4 move --

5           **DR. ZIEMER:** Anyone else that week that's  
6 particularly bad?

7           **MR. ELLIOTT:** Henry's okay that week.

8           **DR. ZIEMER:** Week of the 14th?

9           **MR. ELLIOTT:** Henry's not available --  
10 that's actually the 13th, isn't it?

11           **DR. ZIEMER:** Well, 13th is a Sunday, 13th  
12 is --

13           **MR. ELLIOTT:** Henry's not available on  
14 Tuesday the 14th. He won't be available --

15           **MS. MUNN:** No, Monday the 14th.

16           **DR. ZIEMER:** Any others that week? How  
17 about the week of the 21st?

18           **MR. ELLIOTT:** Henry's not available Thursday  
19 the 23rd.

20           **DR. ZIEMER:** That's Wednesday.

21           **MR. ELLIOTT:** I'm sorry?

22           **DR. ZIEMER:** You know what, I'm still  
23 looking at 2002.

24           **MR. ELLIOTT:** 2003.

25           **DR. ZIEMER:** Cori, you gave us 2002.

1           **MS. HOMER:** No, there should be --

2           **MR. ELLIOTT:** And I'm just reminded that  
3           January 20th is a Federal holiday.

4           **MR. PRESLEY:** That's what I was going to  
5           say --

6           **DR. ZIEMER:** That'd be a good day to travel  
7           on, wouldn't it?

8           **MR. PRESLEY:** I'm not going to be available  
9           that week.

10          **DR. ZIEMER:** You're not available that week  
11          at all, Robert? Okay.

12          **MS. MUNN:** Why don't we just go back up to  
13          the first week? I was the only one who had any --

14          **DR. ZIEMER:** I was just trying to get an  
15          overview of everything. You want to try for early  
16          in January?

17          **MS. MUNN:** Yeah.

18          **DR. ZIEMER:** First week of January, the week  
19          of the 5th?

20          **MR. PRESLEY:** Sixth.

21          **DR. ZIEMER:** Or 6th. The 6th is Monday.  
22          What days, Tuesday/Wednesday?

23          **MR. PRESLEY:** That's fine.

24          **MS. MUNN:** Depends on how long --

25          **MR. ESPINOSA:** Where are we going to be

1 meeting at? That's...

2 **DR. ZIEMER:** We can -- we certainly can meet  
3 in Washington. Oak Ridge is a site we talked about  
4 meeting. There are other sites like Hanford that  
5 are interested in having us visit, keeping in mind  
6 that a portion of this is going to be executive  
7 session so that makes it less convenient for members  
8 of the public, but --

9 **MS. MUNN:** D.C. is probably the best bet.

10 **MR. PRESLEY:** I'd like to have you come to  
11 Oak Ridge in the spring.

12 **MR. ESPINOSA:** What about the Pan-Tex area?

13 **DR. ZIEMER:** Texas?

14 **MR. ESPINOSA:** Yeah.

15 **DR. ZIEMER:** Pan-Tex itself is a little hard  
16 to get to, but we could go to Texas, San Antonio.  
17 Is Pan-Tex the nearest?

18 **MR. ESPINOSA:** Amarillo. Amarillo or  
19 Lubbock would be --

20 **MR. ELLIOTT:** I'm sorry, our recorder cannot  
21 capture everybody's conversation at once. I would  
22 ask -- including myself.

23 **MR. GRIFFON:** Do we want -- I don't know if  
24 we want to go to one of the sites where we expect a  
25 lot of public participation when we're going to open

1 up with an executive session for --

2 **DR. ZIEMER:** Well, that was the point I was  
3 making. It's less --

4 **MR. GRIFFON:** You know, I would rather go to  
5 those sites at another time when we had a --

6 **DR. ZIEMER:** Yeah, when we had a full  
7 meeting. You just want to -- shall we go to  
8 Washington then?

9 **DR. ROESSLER:** How about Cincinnati?

10 **MR. PRESLEY:** Cincinnati's fine.

11 **MR. ESPINOSA:** Cincinnati's great. I think  
12 that's great.

13 **MS. HOMER:** Let me know then. Washington  
14 can be very difficult to get on short notice.

15 **DR. ZIEMER:** Okay.

16 **UNIDENTIFIED:** Washington's not a real safe  
17 place to be right now, folks.

18 **DR. ZIEMER:** You want to go back to  
19 Cincinnati?

20 **MS. MUNN:** What do you mean Washington's not  
21 a --

22 **DR. ZIEMER:** Robert was suggesting we come  
23 to Oak Ridge in the spring and it's -- if we went to  
24 Seattle or somewhere in the Washington area, it  
25 would be for the benefit of the Hanford folks.

1 Again, I think, Mark, your comment is pertinent  
2 again. Do we want to go there when the chance to  
3 interact is abbreviated.

4 **MR. GRIFFON:** Especially Hanford. I mean  
5 I'd be concerned about locking off into a six-hour  
6 executive session when you have people --

7 **DR. ZIEMER:** Robert.

8 **MR. PRESLEY:** It looks like the working  
9 group's going to be working with Cincinnati pretty  
10 close. It might be that we need to go into  
11 Cincinnati in January. That way Larry's got all his  
12 experts and staff and things like that up there if  
13 -- when we meet with this executive group, as an  
14 executive group.

15 **DR. ZIEMER:** Richard?

16 **MR. ESPINOSA:** Is the working group going to  
17 meet face-to-face or are we going to meet in  
18 conference call? How do you plan on doing that,  
19 Mark?

20 **MR. GRIFFON:** I don't know that we've  
21 resolved that, but for scope and for the evaluation  
22 part of it, I'm assuming conference call. To draft  
23 budget, I don't know if we have an option of a  
24 conference call for that. Yeah. Okay. So  
25 conference call would be the preferred method and

1 most likely.

2 **DR. ZIEMER:** Shall we plan on Cincinnati for  
3 January?

4 **MR. PRESLEY:** That's fine with me.

5 **DR. ZIEMER:** It appears to be okay.

6 **MR. ELLIOTT:** Was that January 7th and 8th?

7 **DR. ZIEMER:** 7 and 8, January 7 and 8 in  
8 Cincinnati.

9 **DR. MELIUS:** Otherwise known as the big  
10 blizzard of 2003.

11 **DR. ZIEMER:** Right.

12 **MR. ELLIOTT:** I would wonder if it would be  
13 the Board's pleasure to consider a secondary date in  
14 January --not as an option, not as another -- an  
15 option before this one, but as an option for another  
16 meeting, a second meeting in that same month to take  
17 up perhaps the SEC rule incase we're not ready by  
18 the early part of January, and because this 6th and  
19 7th -- or 7th and 8th date is pretty much -- seems  
20 to me to be wrapped up trying to get this -- get  
21 through this working group and this statement of  
22 work. So I'm just throwing that out. I mean we're  
23 not sure where we're going to be at at that point in  
24 time on the SEC rule.

25 **DR. MELIUS:** Can I just make sure I

1 understand this right, but my sense would be that  
2 the executive committee portion of this is a half-  
3 day or something. I mean 'cause the scope and most  
4 of the work on the contract's done and it's not --

5 **DR. MELIUS:** Resolved ahead of time, and  
6 that I would -- certainly would like to limit the  
7 executive committee as much as we can, simply if  
8 we're having -- for public availability and those  
9 sort of issues, so if that's a half a day, that  
10 still would give us a day and a half or whatever for  
11 that. And then I guess my question, Larry, is that  
12 -- I don't know if you can answer this; you usually  
13 can't, but I have to ask it anyway -- is what is  
14 your expectation of the Board's involvement in  
15 what's happening with the SEC rule?

16 **MR. ELLIOTT:** I'd like Ted to answer that.  
17 Obviously I didn't have the answer.

18 **DR. ZIEMER:** We haven't heard much from Ted.

19 **MR. KATZ:** No, I've been happily quiet. I  
20 mean this is all sort of contingent and depends on  
21 how things work out, but if we have -- if we come  
22 out in January with something that requires -- that  
23 opens up public comment again, then as before, we  
24 would want the Board's advice, as well. So that's  
25 -- that's what would happen. And as to the time

1 line, that's hard to predict, but the very beginning  
2 of January, given what Larry told you about how the  
3 Federal departments work in December and so on, it's  
4 just pretty -- I think that's really a high risk to  
5 make it in the beginning of January for that, if it  
6 is to come out in January, so -- I think it'd be  
7 good to at least hold open some dates on that  
8 possibility later in the month, but...

9 **DR. MELIUS:** Or in early February?

10 **MR. KATZ:** Or in early February.

11 **DR. MELIUS:** What's the -- the comment  
12 period would be, if there is a comment period?

13 **MR. KATZ:** I mean again, that's all sort of  
14 unknown at this point, but I'm assuming if we're  
15 going to have a comment period, we're going to try  
16 to condense things, make things happen quickly, so  
17 -- so that's why it really would be good to have the  
18 Board meeting right around the time we'd have  
19 something available for the Board.

20 **MR. GRIFFON:** Do you know what the  
21 minimum --

22 **MR. KATZ:** Well, the minimum -- I think the  
23 minimum we'd consider -- I mean I think there may be  
24 special provisions to do less, but I don't think  
25 we'd even consider something less than 30 days for



1 public comment.

2 **DR. ZIEMER:** Larry, are you simply asking  
3 that we get some dates set aside and we would decide  
4 later whether we would actually need to use them,  
5 but get them cleared on people's calendars? Let's  
6 see if that's doable.

7 The week of January 26th, are there any  
8 major conflicts the week of January 26th?

9 **MR. OWENS:** Dr. Ziemer, that's not -- that's  
10 not good for me.

11 **DR. ZIEMER:** Not good. That whole week is  
12 bad. Okay. How about the first week of February?  
13 Any --

14 **DR. ROESSLER:** When is the health physics  
15 meeting, the mid-year?

16 **DR. TOOHEY:** It's the week of the 27th, Gen.

17 **DR. ROESSLER:** Of what month?

18 **DR. TOOHEY:** January.

19 **DR. ROESSLER:** Oh, really?

20 **DR. ZIEMER:** Yeah, the health physics --  
21 health physics mid-year is 26th through 29th. It's  
22 in San Antonio -- sounds like a good time to meet in  
23 San Antonio.

24 The first week of February, is that bad for  
25 anyone?

1           **DR. MELIUS:** Monday's bad for me, but  
2 otherwise --

3           **DR. ZIEMER:** Otherwise?

4           **DR. MELIUS:** Yeah.

5           **DR. ZIEMER:** Would it be better to meet like  
6 on a Wednesday and Thursday? How would  
7 Wednesday/Thursday of that week as a set-aside date?

8           **DR. MELIUS:** From Tuesday on is fine for me,  
9 so...

10          **DR. ZIEMER:** Yeah, shall we do that?

11          **MR. ESPINOSA:** The first week of February?

12          **DR. ZIEMER:** Yeah.

13          **MS. HOMER:** What dates?

14          **DR. ZIEMER:** It would be 5 and 6 for the  
15 meeting dates. Any conflicts there? Is Henry okay  
16 on that?

17          **MR. ELLIOTT:** Henry's okay on that.

18          **MS. HOMER:** Location?

19          **UNIDENTIFIED:** Hanford.

20          **DR. ZIEMER:** Hanford in February.

21          **DR. MELIUS:** I really would like to -- I  
22 think we should get out to a site -- a site we  
23 haven't been to for that meeting, particularly --  
24 the SEC comments are --

25          **UNIDENTIFIED:** You could go to --

1           **MR. ESPINOSA:** You can catch direct flights  
2 from almost anywhere to the Bay area. I think  
3 Lawrence -- near Lawrence Livermore would be ideal,  
4 too.

5           **DR. ZIEMER:** Or Savannah River area.

6           **MR. ELLIOTT:** We have more claims from  
7 Hanford, Savannah River, Oak Ridge than we do from  
8 Lawrence Livermore/Lawrence Berkeley combined. So I  
9 just offer that for your consideration. And  
10 certainly I know that around the Savannah River site  
11 there have been advisory board meetings of other  
12 advisory bodies, the health effects subcommittee and  
13 the ACERER has met at Charleston, Savannah, Augusta,  
14 Aiken, Hilton Head, so -- which are south at that  
15 time of year.

16           **DR. ZIEMER:** Well, just as a practical  
17 matter for the snowstorm of 2003 or whatever it is,  
18 a southern location may be preferable. Wanda, how's  
19 -- how's Hanford that time of year?

20           **MS. MUNN:** Hanford that time of year can be  
21 very nice, as a matter of fact. I warn you again,  
22 don't try to fly into Seattle and then think you're  
23 going to drive and get to Hanford easily. If you're  
24 going to go there, you must fly into Pasco and --  
25 but my rule of thumb is I keep my studded tires on

1           until the 15th of February, so -- so you're on the  
2           cusp. It will be -- it will be sunny, and it will  
3           probably be cold, but as long as you're flying into  
4           Pasco rather than flying into Seattle, you'll be  
5           fine.

6                   **MS. HOMER:** What about Spokane?

7                   **MS. MUNN:** You don't want to drive down from  
8           Spokane that time of year.

9                   There's a possibility you're not going to  
10          get much public from Hanford up there, but you can  
11          do it.

12                   **DR. ZIEMER:** Shall we focus on Savannah  
13          River area? Okay, and you can pick out a nearby  
14          town that's -- you've got to see what facilities are  
15          available.

16                   Okay. So that -- and that's still going to  
17          be kind of tentative 'cause it's going to depend on  
18          where we are on the rule.

19                   **MS. HOMER:** When will you know for sure?

20                   **DR. ZIEMER:** That's what we -- that's what  
21          the Board is asking the staff.

22                   **MS. HOMER:** (Inaudible) and if I have to  
23          cancel after the contract is signed, we pay  
24          penalties.

25                   **DR. ZIEMER:** Sure.



1           **DR. ZIEMER:** Right, and --

2           **MR. GRIFFON:** -- conference call meeting?

3           **DR. ZIEMER:** Keep in mind that Cori needs --  
4 how much advance notice do we need for *Federal*  
5 *Register* for a conference call of the Board?

6           **MS. HOMER:** Well, I'm supposed to have 30  
7 days, but if there's less time, there's less time.

8           **DR. ZIEMER:** But it's not going to be let's  
9 -- you know, we're done, let's have a Board call the  
10 next day. Cori's got to have a reasonable amount of  
11 time to get the notice in the *Federal Register* and  
12 get the conference call set up, so... Okay?

13           **MR. GRIFFON:** Should we ask for dates on  
14 that, considering that you need 30-day notice?  
15 Should we ask for dates -- potential dates?

16           **DR. ZIEMER:** This is to have a conference  
17 call of the full Board to review their  
18 recommendations --

19           **MR. ELLIOTT:** Scope of work and language --

20           **MR. GRIFFON:** Right. And I'm assuming we're  
21 looking at dates at least 30 days from now, or 30  
22 days from --

23           **DR. ZIEMER:** Yeah, I think we're getting --  
24 we're getting into late November or early December,  
25 probably. November/December time frame probably.

1 Right?

2 **MR. GRIFFON:** Right.

3 **DR. ZIEMER:** Okay, so --

4 **MR. ELLIOTT:** So I understand this, the  
5 expectation would be to have the Board review the  
6 scope of work and the evaluation plan. The working  
7 group's developing -- or has developed at that point  
8 in time the business plan and you're anticipating  
9 that then the whole package could be submitted to  
10 procurement until you have the opportunity to meet  
11 in executive session to review and approve the  
12 business plan, the RFP would not go further than  
13 necessary through procurement. And it's the --

14 **DR. ZIEMER:** Full Board would not have seen  
15 the business plan.

16 **MR. ELLIOTT:** Full Board would not have seen  
17 the business plan and the full Board would, in  
18 effect, review and approve that at the first  
19 opportunity -- this Board meeting in January -- in  
20 an executive session. What I need to find out is  
21 what's that control point internally for when it  
22 wouldn't move any farther. And it may be right at  
23 the start -- at the front door. Okay?

24 **DR. ZIEMER:** And if that's the case, that's  
25 how it'll have to be.

1           **MR. ELLIOTT:** That's how it'll have to be,  
2           so they may not take any action on it at all. I'm  
3           working on trying to figure that out.

4           **MR. PRESLEY:** Can --

5           **DR. ZIEMER:** Robert.

6           **MR. PRESLEY:** Can we go ahead and set a  
7           conference call date up now, sometime the first week  
8           in December?

9           **MR. GRIFFON:** Yeah, what I -- yeah, what  
10          I --

11          **MR. PRESLEY:** Let's go ahead and do that,  
12          and that way it'll help Cori, and we've got  
13          everybody here, almost, that can tell us what their  
14          schedules are, and let's go ahead --

15          **DR. ZIEMER:** Set aside two hours or more?

16          **MR. GRIFFON:** No, it's a lot of detail,  
17          probably, so maybe three hours.

18          **MR. ELLIOTT:** Is it your intention to submit  
19          -- the working group to submit the -- your final  
20          document in advance of this conference call so that  
21          they can review it and have been prepared with their  
22          questions? That'll cut down the time.

23          **MR. GRIFFON:** Yeah. We'll circulate it --  
24          we'll try to circulate it a week in advance.

25          **MR. ELLIOTT:** We would want to put that on



1 the web site, as well, because it's a public meeting  
2 and so the discussion documents that would be used  
3 in that need to be available to the public.

4 **MR. GRIFFON:** Do they have to be available  
5 30 days prior to the...

6 **MR. ELLIOTT:** The discussion documents -- I  
7 don't believe.

8 **MR. GRIFFON:** Of course, yeah, yeah.

9 **MR. PRESLEY:** Larry, how long does it take  
10 you to put something like that on the web?

11 **MR. ELLIOTT:** A matter of half a day.

12 **MR. PRESLEY:** Okay.

13 **MR. GRIFFON:** That's fine, so let's look for  
14 dates the first week in December.

15 **MR. ELLIOTT:** Henry can't meet on the 3rd or  
16 the 5th or the 6th. He's available the 2nd and the  
17 4th, and anytime during the week of the 9th.

18 **DR. ZIEMER:** The only day I have open that  
19 week is the 2nd.

20 **UNIDENTIFIED:** Let's do it --

21 **DR. ZIEMER:** The 2nd?

22 **DR. DEHART:** I'm out.

23 **DR. ZIEMER:** You're out on the 2nd. How  
24 about November 30? Is that too early?

25 **MR. PRESLEY:** 2nd of December's a Sunday.

1 No, wait a minute, I'm sorry. I'm looking at the  
2 wrong one.

3 **MR. GRIFFON:** The 29th, is that Thanksgiving  
4 Day weekend?

5 **DR. ZIEMER:** Yeah, okay, so let's -- how  
6 about the 9th of December?

7 **DR. ROESSLER:** I'm out.

8 **DR. ZIEMER:** 10th?

9 **DR. ROESSLER:** Out.

10 **DR. ZIEMER:** 11th?

11 **DR. ROESSLER:** Out.

12 **DR. ZIEMER:** 12?

13 **DR. ROESSLER:** Yeah.

14 **DR. ZIEMER:** How's 12? You're okay with  
15 that?

16 **MR. ESPINOSA:** What was wrong with the 4th?

17 **DR. ZIEMER:** Several of us were out on the  
18 4th.

19 **UNIDENTIFIED:** Roy's out.

20 **DR. ZIEMER:** Roy's out, I'm out. 12? Is it  
21 the 12th?

22 **MR. GRIFFON:** December 12th at 1:00 p.m.  
23 eastern time -- or are we talking eastern time?

24 **DR. ZIEMER:** 1:00 p.m. eastern standard  
25 time.

1           **MS. HOMER:** Two hours?

2           **DR. ZIEMER:** Okay. Everybody has that then  
3 on their calendar.

4           **DR. MELIUS:** Would someone repeat for me the  
5 contingency date for February?

6           **UNIDENTIFIED:** February 5th and 6th.

7           **DR. MELIUS:** 5th and 6th, thank you. The  
8 contingency of the follow-- second meeting, whatever  
9 we're calling it. I shouldn't have called it  
10 contingency.

11           **MR. GRIFFON:** And do we need an agenda for  
12 that conference call to put in the public record?

13           **DR. ZIEMER:** Yes.

14           **MR. GRIFFON:** I guess it would be --

15           **DR. ZIEMER:** Agenda item -- it's going to be  
16 a one-item agenda.

17           **MR. GRIFFON:** Well, two items, I guess, the  
18 techni-- or...

19           **DR. ZIEMER:** Well, it's one item with two  
20 parts.

21           **MR. GRIFFON:** Right.

22           **MR. ELLIOTT:** To discuss the RFP.

23           **DR. ZIEMER:** Yeah, that's it.

24           **MR. GRIFFON:** That's fine. I just wanted  
25 (inaudible).

1           **DR. ZIEMER:** You can give her the agenda  
2 today. Thank you.

3           Now, having done that, I think we need to --  
4 we do have some other housekeeping items, but in  
5 fairness to members of the public who asked to be --  
6 well, actually I haven't received -- are there any  
7 requests for this afternoon? The public comment  
8 period was scheduled for 3:45 and we appreciate the  
9 -- those who have been willing to delay briefly.

10                           **PUBLIC COMMENT PERIOD**

11           Okay, I'll take these in order. I think  
12 Phil Scofield we heard from this morning. I think  
13 this was on the morning list, so Mike Schaeffer,  
14 you're up, I think.

15           **MR. SCHAEFFER:** I just have some brief  
16 comments, kind of postscript to being here for two  
17 days. One is on the consideration for the task to  
18 review -- independently review dose reconstructions.  
19 One of the key tasks of course was task four, to  
20 look at the SEC petition profile. And the question  
21 I have is, would that also include some means to  
22 review the NIOSH decision as to whether or not dose  
23 reconstructions could be performed or not?

24           **DR. ZIEMER:** One of the group want to answer  
25 that?

1           **MR. GRIFFON:** No. I don't know that we can  
2 answer that. I mean you've mentioned this earlier  
3 to me. I think we should consider it. We haven't  
4 seen -- seen the final SEC rule, so --

5           **MR. SCHAEFFER:** Yeah, we realize that I'm  
6 asking this question in anticipation of what your  
7 final 42 CFR part 83 rule is going to look like, but  
8 if there is some means of deciding when dose  
9 reconstructions can or cannot be performed, at least  
10 if that is a item that goes into the 42 CFR part 18  
11 final rule that also is part of the checkout of the  
12 -- the independent checkout of the dose  
13 reconstructions, that that, too, be a provision.

14           **DR. ZIEMER:** It's certainly been an item of  
15 discussion, Mike, so we appreciate your comment on  
16 that.

17           **MR. SCHAEFFER:** Next one is, I wanted to  
18 recognize that the VA, of course, Department of  
19 Veterans Affairs, initiated and funded the task to  
20 update the radioepidemiological tables from 1986  
21 that resulted of course in the IREP product that you  
22 all are using with some modifications. Likewise,  
23 the Department of Veterans Affairs has an advisory  
24 committee much like yourselves that oversee the  
25 application of such things as the IREP table.

1           Should there not be some means between say this  
2           committee and the committee that the VA has to at  
3           least open up some line of communications concerning  
4           the implementation of IREP and the changes that are  
5           going to of course come along? Obviously the VA has  
6           had some concerns in how just to implement IREP, and  
7           they're going to be reconvening their particular  
8           advisory board in December. My recommendation would  
9           be that both of the advisory boards provide at least  
10          some observer to each other in terms of sharing some  
11          of the concerns of implementing changes to IREP.

12                   **DR. ZIEMER:** Mike, could you be sure to make  
13          available to us the schedule of that group so that  
14          we can at least --

15                   **MR. SCHAEFFER:** I most certainly will.

16                   **DR. ZIEMER:** Appreciate that.

17                   **MR. SCHAEFFER:** The last item really owes  
18          from -- goes back to the fact that we also have an  
19          independent process on our dose reconstruction being  
20          performed by the National Academy of Sciences. And  
21          of course they've boiled down the task to two very,  
22          very key issues, is one, are the dose  
23          reconstructions we perform correct, are they right;  
24          and second of all, are they fair.

25                   It looks like in your consideration for an

1 independent review process that you've done a very,  
2 very good job in considering how to evaluate and  
3 assess whether the dose reconstructions are right.  
4 We think it would also be useful to -- at least for  
5 the general public who is going to be having claims  
6 heard through your process, that there be some means  
7 of evaluating that there's some degree of customer  
8 satisfaction and fairness through the process. We  
9 think that's also a very, very key item, even though  
10 it's a non-technical item, that I think is very,  
11 very important to assess the well-being of the  
12 program.

13 **DR. ZIEMER:** Thank you very much. Next  
14 we'll hear from Alex Smith. Alex.

15 **MR. SMITH:** I'm from New Mexico, just south  
16 of here about 30 miles. I worked for LANL for 35  
17 years and retired in 1982, from 1947 to 1982. And  
18 this morning I kept hearing the year 1952, and as a  
19 claimant, I am concerned about the period prior to  
20 1952. I'm talking about the years 1947 to 1952 when  
21 I became contaminated with mercury and asbestos and  
22 perhaps radiation. Is research and investigation  
23 going to reach back that far when working -- when  
24 working conditions at LANL were sub-standard and  
25 compared to today's standards would be considered

1 quite hazardous, or are we talking 1952 until the  
2 present?

3 **DR. ZIEMER:** I think we can get an answer to  
4 that right away and Jim here --

5 **DR. NETON:** Yeah, I think I can answer the  
6 question. The 1952 I believe that you saw on the  
7 site profile chart that I showed was what we  
8 actually had received from the site itself, and I  
9 think if you noticed, that bar was not 100 percent,  
10 so they're missing -- there's missing information,  
11 and that would include that 1947 to '52 period. And  
12 I would say even today, as we speak, there are  
13 people up at Los Alamos that work for NIOSH looking  
14 at records in that specific time frame and we're  
15 going to capture as many of those records as we can,  
16 so they're certainly going to be looked at.

17 **MR. SMITH:** There's not too many of us left,  
18 you know.

19 **DR. NETON:** I understand. But there are log  
20 books, my understanding, that outline the dosimetry  
21 results for people in that time frame, and other  
22 records that we're pursuing.

23 **MR. SMITH:** Thank you very much.

24 **DR. NETON:** You're welcome.

25 **DR. ZIEMER:** Next we'll hear from Bob Tabor.



1 Bob?

2 **MR. TABOR:** (Inaudible)

3 **DR. ZIEMER:** Well, Bob, you signed up. We  
4 didn't twist your arm.

5 **MR. TABOR:** Yeah. Well, I'm not going to go  
6 through that long rendition of who I am. I've been  
7 here quite often. I want to chime in on something  
8 that I believe Phillip chimed in on earlier today  
9 that deals with the IREP model. And I guess the way  
10 I look at this is I'm not a scientist and so I like  
11 to put it in terms of more from what I would just  
12 call kind of a common sense perspective.

13 I look at it somewhat like apples and  
14 oranges, and I guess my -- my concerns deal with  
15 more so the process, maybe the philosophy, the  
16 strategy, the dynamics by which, you know, the model  
17 might have been developed. And as I said, I look at  
18 it somewhat as apples and oranges.

19 The nuclear worker, he wasn't at Hiroshima  
20 and Nagasaki when the A-bombs was dropped. The  
21 nuclear worker, he was not the larger part of the  
22 national public. Therefore I would say that the NCI  
23 studies and that particular type of model is not  
24 probably the most representative and applicable  
25 model for the nuclear worker's issues.

1                   Now you've got on one hand over here -- let  
2 me just say -- let's call it Bob's best book on  
3 fruit farming, and you're in the apple growing  
4 business. And over here you've got Bob's best book  
5 on how to grow apples. My common sense says that  
6 what's most applicable is that of what deals with  
7 how to grow apples.

8                   Okay. My point is simply this, folks. I  
9 find that the IREP model was lacking. Where is the  
10 worker epidemiological studies? You know, there's  
11 -- apples and oranges are fruit, but there's a  
12 difference between apples and oranges. And I think  
13 you probably get my point on that, so that's all I  
14 got to say to that.

15                  Yesterday I touched on a comment -- I  
16 touched on the issue of credibility. I would just  
17 like to remind us that that, in my mind, is a -- is  
18 a very serious issue. And if we have issues  
19 relative to conflict of interest, which we've  
20 discussed a lot here in the last two days, and have  
21 heard a lot of new things. And issues on disclosure  
22 and maybe transparency issues and those type of  
23 things, all's I would urge us to do is to be sure  
24 that we really look at the root cause of things if  
25 we have those issues and not to do a band-aid effect

1 but to really find the -- you know, a good solution  
2 to those things. And I guess that basically ends my  
3 comment, and I learned a lot, so thanks.

4 **DR. ZIEMER:** Bob. Oh, I didn't give the  
5 Board opportunity to ask questions of Bob, Mike or  
6 Alex. Any questions?

7 (No responses)

8 **DR. ZIEMER:** Okay, we'll continue then.  
9 Let's see is it Paul -- is it Montoya? I have a  
10 little trouble reading everybody's handwriting.  
11 Paul is a former LANL employee from Espanola, New  
12 Mexico. If you'd use the mike, please, Paul.

13 **MR. MONTOYA:** Yes, thank you for giving me  
14 the opportunity to make a comment out here. I went  
15 to work at the Laboratory -- for Los Alamos National  
16 Laboratory in 1962 in the powder\* metallurgy group  
17 and also in the fabrication group, also -- or rather  
18 in the casting or foundry, and I worked all my 31  
19 years -- I retired in 1993, November, 1993 and so  
20 that was a total of 31 years. And throughout all  
21 that time I worked with beryllium. My first 15  
22 years I worked in the powder form beryllium and the  
23 second 15 years I worked in the metal form and it  
24 was all casting, a little bit of assembly work. And  
25 also I worked with plutonium A-239\*, a little bit of

1           238. And also -- I also worked with U-235 my whole  
2 years.

3                   And the reason that I'm out here today, I do  
4 have a -- I was diagnosed at the National Jewish  
5 Hospital in Denver as having -- and also with John  
6 (sic) Hopkins University as having beryllium  
7 sensitivity. I do have also a body burden -- what  
8 they call a body burden of -- and I do have like  
9 five molecules of americium 240 in my lungs.

10                   However, the Department of Energy rules that  
11 that's -- that's not sufficient, but in the eyes of  
12 the attorney -- of an attorney, that's more than  
13 enough. As I quoted it to -- one time in -- I had a  
14 meeting with an associate director of the National  
15 Laboratory and that's how much they care. He told  
16 me that -- what's wrong with a body burden? And I  
17 told him, how would you like to have one?

18                   So -- but anyway -- and I went up there for  
19 a ten-minute meeting. He said you're interrupting  
20 two days. It ended up a meeting of two days. And  
21 you know, a lot of these people, they're  
22 disrespectful and that's why the Laboratory really  
23 -- they're having problems. I could be over here --  
24 and that's why a lot of things went bad.

25                   And so that's the reason -- okay, I retired

1 in 1993. In 1994, in February, 1994, myself and two  
2 co-workers that worked with me -- Harold Archuleta  
3 and Lepio\* Garcia -- we went around out there. We  
4 hand-delivered a letter to Bill Richardson, the  
5 Congressman, and we asked him to come up with a  
6 compensation bill, which he did, but then he moved  
7 on to -- so then he turned the whole thing over to  
8 Jeff Bingaman.

9 Jeff Bingaman has been very good to us. He  
10 came up with a compensation bill and it went on and  
11 on and now -- now -- he went ahead and -- and also  
12 came up with the -- in which is last -- sometime  
13 last week where it will cover me. Also if I have  
14 beryllium sensitivity.

15 And right now what -- and the reason that I  
16 am out here is because all this -- all this  
17 compensation bill that is intended to help us  
18 people, the workers, it's not working. And the  
19 reason it's not working because the bureaucrats got  
20 involved in it. They appropriated \$226 million for  
21 this compensation. Now everybody's got their hands  
22 in the cookie jar, and that's -- that's very true.  
23 And the reason --

24 Okay, so when this bill came up, the way the  
25 language was written up, it said okay, we will go

1 ahead and pay off these claims with the Department  
2 of Labor. However, okay, the Department of Labor,  
3 okay. (Inaudible) appeal (inaudible) the appeal  
4 (inaudible) that is going to deny your claim was  
5 going to hear the appeal.

6 Okay, so the whole (inaudible) idea. I  
7 hired an attorney. I signed a letter of  
8 representation. Today if I call the Department of  
9 Labor in Denver or wherever, I can't even get the  
10 time of day. And the reason is because I signed --  
11 they told me that I signed a legal representation  
12 and the reason that I signed a legal representation  
13 was on -- upon advice of the attorney, my attorney.  
14 And my attorney said okay, in other words, the  
15 reason -- well, what -- if these people over there  
16 at the office in Espanola, if they fill out the  
17 form, are they going to (inaudible) will have to go  
18 out there under an appeal.

19 Okay, so I went through the whole process.  
20 I was denied. Okay? So when I (inaudible) my  
21 attorney and my attorney said there's nothing to  
22 appeal. It says the same person, you stand a chance  
23 like a snowball in Hell, you know, so the same  
24 person at the Department of Labor denied your appeal  
25 -- I mean denied your claim, they're going to be

1 hearing -- so we're wasting our time.

2 So what we would like to do, like I told  
3 Jeff Bingaman, we want to make this thing work.  
4 Okay? And that's exactly what we need and so we  
5 would -- what we would like to do is compensate all  
6 these people that -- that have -- they deserve --  
7 half -- or maybe -- mostly all my co-workers,  
8 they're gone. They're gone. And nobody likes to  
9 hear the word AIDS. Okay? But in comparison -- the  
10 way -- the way a doctor described it to me at the  
11 National Jewish Hospital is if you have beryllium  
12 sensitivity, that's -- that's compared -- compared  
13 to HIV, which would be -- so in other words, it's a  
14 -- in other words, it's a foot in the grave. How  
15 long -- it's not a matter of if, it's a matter of  
16 when, you know. It's -- in other words --

17 So I would like to ask you that -- to please  
18 get this bill going. And like Jeff Bingaman, I have  
19 a lot of faith in God and I know that Jeff Bingaman  
20 -- and he promised me and he said that it would be  
21 covered and my -- he said you -- you will get your  
22 compensation. And there's no matter what -- nobody  
23 can tell me how sick I am or whether I have the  
24 potential of dying through this illness and so  
25 forth.

1           You know, so in other words, it's a -- it's  
2           a -- it's a -- the burden of proof. In other words,  
3           right now the burden of proof is on us right now,  
4           and what -- we would like to have the burden of  
5           proof on these people (inaudible) making claims. I  
6           feel that this -- that by having the Department of  
7           Labor -- and as a matter of fact, I recommended that  
8           to Congressman Udall and also to Jeff Bingaman. I  
9           told them that the Department of Labor shouldn't be  
10          involved in this. They should give it to an  
11          accounting firm and that'd be -- that would be about  
12          the right way 'cause it doesn't matter how --  
13          they're going to try to beat you out of something  
14          that you have coming, so I -- I -- giving -- thing  
15          -- I'm sorry that I took a little bit of time -- of  
16          your time, but I sure thank you for giving me the  
17          opportunity, so thank you.

18                 **DR. ZIEMER:** Thank you very much. We  
19                 certainly appreciate the frustration you feel. It  
20                 sounds like you've enlisted some pretty strong help  
21                 with the Congressional people to -- so maybe they  
22                 will be successful in addressing this issue in your  
23                 behalf.

24                 Let's see, I have next -- oh, are there  
25                 questions from any of the Board members?



1 (No responses)

2 **DR. ZIEMER:** I think Ken Silver is next on  
3 the list. Ken.

4 **MR. SILVER:** I'm sure it's okay with you if  
5 I allow B. Jo\* Baer to speak.

6 **DR. ZIEMER:** Oh, yes, I have her on the  
7 list, and she's certainly welcome to go -- I just  
8 was taking them in the order they were handed.  
9 You're welcome to go next. And it's B. Jo --

10 **MS. BAER:** B. Jo Baer, and my husband was a  
11 nuclear physicist at the Los Alamos National Lab in  
12 the seventies to the -- to 1991 when he died. He  
13 died of lung cancer and had never smoked a cigarette  
14 in his life and was a very healthy man with healthy  
15 habits. I'm a claimant, and I have a question that  
16 is very personal and I don't -- I hope I'm not  
17 taking time asking my personal question, but it has  
18 to do with record-keeping and it has to do with  
19 credibility and it has to do with my unfortunate  
20 lack of total confidence in this government process.

21 I filled out my application and it's very  
22 large and I was lucky to get records that other  
23 people weren't able to get, so I know how difficult  
24 it is to get records and I know that when I read the  
25 law, it said that when -- that the decision would be

1           made depending -- if a person's cancer or illness  
2           was at least as likely to have been caused by work  
3           at the Lab. And then I don't understand what dose  
4           -- how you do dose reconstructions, but then -- but  
5           I do understand it's becoming harder -- it seems to  
6           be becoming harder and harder to provide the  
7           information that you -- that is needed in order to  
8           do a credible dose reconstruction because I don't  
9           have -- myself, as a claimant -- access to all the  
10          information that's needed.

11                        However, several, several months ago I  
12          received a telephone call -- or a letter that things  
13          were moving along and that I might be on the list of  
14          people to be interviewed, or maybe I had a letter  
15          and I didn't -- wasn't -- it wasn't (inaudible) to  
16          me. I made a telephone call to Denver and I was  
17          told that some records had come from DOE that was  
18          going -- that would be used for the dose  
19          reconstruction, and I asked for a copy of those  
20          records because I would like to have in my  
21          possession the same information that -- that the  
22          people who were doing dose reconstruction have -- I  
23          mean if it's possible. And then I -- that's a --  
24          that's a fair question -- fair request. And I --  
25          thank you.

1           So -- but I was told that what I had to do  
2           was fill out a form and go through DOE and apply for  
3           public -- you know, what is it, Freedom of  
4           Information Act. And I said I don't want to do  
5           that. I want to know what you have. I want to know  
6           what they gave you. And that sounds like that's  
7           okay? I don't have -- okay. So --

8           **DR. ZIEMER:** And we probably won't want to  
9           discuss the details of your --

10          **MS. BAER:** No.

11          **DR. ZIEMER:** -- case here in --

12          **MS. BAER:** No, absolutely not.

13          **DR. ZIEMER:** -- this sort of forum, but in  
14          terms of gathering information -- and maybe Jim or  
15          Larry can address that -- but in fact the burden is  
16          not on you to come up with the records. We do like  
17          to obtain records that survivors may have.  
18          Sometimes they know some things that maybe are a  
19          little difficult to learn otherwise. But the burden  
20          is on NIOSH to -- and DOE to come up with those  
21          records.

22                 Could we ask either Larry Elliott or Jim to  
23                 -- on the NIOSH staff to address those questions.  
24                 Jim?

25          **DR. NETON:** Dr. Ziemer's correct. It is

1 NIOSH's responsibility to obtain the records, not  
2 the claimant's, as I think I indicated yesterday.  
3 The claimant's certainly -- it's acceptable for a  
4 claimant to obtain the records and to review them.  
5 That's their right, but it is really our burden to  
6 request the information from the Department of  
7 Energy.

8 I'm somewhat confused regarding the way  
9 things occurred in this particular case. I believe  
10 you indicated that the Department of Labor informed  
11 you that they had the Department of Energy records  
12 that they'd just received. That is not the usual  
13 means by which we obtain records. The Department of  
14 Labor would forward a claim to us, at which point we  
15 would issue a request to the Department of Energy  
16 for your exposure -- or your father -- or husband's  
17 exposure records.

18 **MS. BAER:** Well, I meant to say that the  
19 Department of Energy had given the -- had provided  
20 the information that was needed. But when I asked  
21 for a copy of the information, I was told I would  
22 have to go through some Freedom of Information Act  
23 procedure.

24 **DR. NETON:** Well -- right, I understand what  
25 you're saying. But it's unusual for the Department

1 of Energy to send exposure records directly to the  
2 Department of Labor. That is not the normal  
3 mechanism.

4 **MS. BAER:** Oh.

5 **DR. NETON:** The Department of Labor merely  
6 establishes an employment at the covered facility  
7 and the diagnosis of a cancer.

8 **MS. BAER:** Maybe it was from the Lab that  
9 they got them.

10 **DR. NETON:** Well, they shouldn't have. I  
11 mean not -- sometimes mistakes do happen or maybe  
12 records were sent to the wrong location, but the  
13 normal mechanism is that we would request -- NIOSH  
14 -- the exposure records for your --

15 **MS. BAER:** Husband.

16 **DR. NETON:** -- your husband. And then once  
17 we receive those records, call to schedule an  
18 interview with the claimant.

19 **MS. BAER:** Well, the -- if I -- excuse me.  
20 My understanding was you called whoever you were  
21 supposed to call and you got the record, and I then  
22 asked for a copy of the records, and I was told --  
23 and that's really -- that's really my question.

24 **DR. NETON:** If you did call the Department  
25 -- if you did call NIOSH and we had the records, we

1 -- certainly it's not our policy to instruct you to  
2 go to the Department of Energy to obtain copies of  
3 those records. We would provide them to you, given  
4 the appropriate paperwork were filled out in our  
5 organization.

6 **MS. BAER:** Well, I have on my answering  
7 machine a recording of the woman who called and told  
8 me she'd tell me how to go through the Freedom of  
9 Information Act, so I have her name and her  
10 telephone number.

11 **DR. NETON:** Well, perhaps after the meeting  
12 we could talk and you could give me that information  
13 and I'll exchange my phone number with you and we  
14 could discuss it.

15 **MS. BAER:** Okay. So what I'm understanding  
16 is that I -- it is okay for me to have that  
17 information that you're using to make your decision.

18 **DR. NETON:** Absolutely.

19 **MS. BAER:** That's what I --

20 **MR. ELLIOTT:** Just to add to that, of course  
21 you're allowed to have that information and it will  
22 be provided to you. It will also be available in  
23 the administrative record that goes with our  
24 determination of the dose reconstruction to the  
25 Department of Labor for the final decision, and so

1           you'd have access to that, as well. And as we  
2           talked in Cincinnati before we boarded the plane to  
3           come out here, we're -- we'll check on this issue  
4           about the interview and we'll get back to you.  
5           You'll get a call later from me or Jim.

6                     **MS. BAER:** Thank you very much.

7                     **DR. ZIEMER:** Okay. And then Ken, you still  
8           wish to address the group. Thank you.

9                     **MR. SILVER:** We're always very impressed  
10          when members of a public body like this stay until  
11          the late afternoon to hear public comment, so thank  
12          you all.

13                    A few quick points. I was mentioned that  
14                    someone yesterday referred to ORISE or ORAU as a  
15                    major DOE contractor. We're well aware that it  
16                    never has been and is not now an M&O contractor.  
17                    But in the world of health physics and epidemiologic  
18                    studies, which is why we're all here, of course it's  
19                    a major contractor to DOE.

20                    One simple example, a DOE contractor with  
21                    history associates some years back to compile  
22                    finding aids to epidemiologically relevant record  
23                    series. Hanford filled several volumes, Savannah  
24                    River, Los Alamos, a big three-ring binder, and they  
25                    took their time to do a separate binder for ORISE

1           because it has had a central role in health studies  
2           in DOE facilities for many years. There's a lot of  
3           expertise there, but we need to balance that with  
4           public concerns about conflict of interest.

5                        There are other stakeholders in this program  
6           and in fact the stakeholders who made this program a  
7           reality, the folks you've heard from, PACE\* Union,  
8           the building trades. And they have some very good,  
9           innovative ideas for how to build public confidence  
10          in dose reconstruction. PACE has pioneered public  
11          worker participation in exposure assessment,  
12          methodologies, and it's really time for a fresh look  
13          at some of these old DOE sites. And if we put all  
14          our reliance on ORISE, we wouldn't get that.

15                       Secondly, you've heard how important it is  
16          to not take documents that you get from LANL at face  
17          value. I would argue you need to take workers at  
18          face value and to just dig and dig and dig in the  
19          course of trying to document people's exposures.

20                       I wasn't in the room when Alex Smith began  
21          his talk, but at a public meeting like this in March  
22          of 2000 he described a mercury poisoning incident  
23          occurring in the late 1940's. The Lab, throughout  
24          his subsequent career, denied it had ever occurred.  
25          And some of us took the time to dig into DOE records



1 and lo and behold found extensive documentation from  
2 Harriet Hardy\* in one year that she spent at Los  
3 Alamos in 1948 of that very contamination incident.

4 Another example of why it's important to dig  
5 and dig at Los Alamos, we had a spike in thyroid  
6 cancer in Los Alamos County in the late 1980's or  
7 early 1990's, so serious public and scientific  
8 concern focused on the research reactors located in  
9 the middle of town. Omega west reactor was five  
10 megawatts when built, increased to eight megawatts  
11 in the late 1960's under a national security  
12 exemption. The stack was 200 feet tall, but since  
13 the reactor was down in the canyon, that meant it  
14 vented essentially at ground level.

15 We're not aware of any fuel failures at  
16 Omega west, but ran across a memo in 1971 where a  
17 bunch of people from H-1, the radiologic health  
18 group arrived at the reactor to find that the surge  
19 tank valve was open. And we found that -- and the  
20 entire rest of the sentence is blacked out on the  
21 best available copy.

22 So this is a plea to NIOSH and your  
23 contractors to not be satisfied with this kind of  
24 thing, but to dig and dig and dig, and listen to  
25 what the workers have to tell you. Like Alex Smith,

1 the documentation may not be in hand, but the story  
2 was very, very real.

3 Another example, in the late 1960's DP\* west  
4 was the Lab's major plutonium facility. A major  
5 production push was on throughout the complex in  
6 1969. And if you were satisfied with the official  
7 emissions inventory in the community reading room,  
8 you might believe that room 401, the hot cell, was  
9 not in use in 1969.

10 But if you dig a little deeper, use the  
11 Freedom of Information Act, in fact there was a  
12 major increase in plutonium counts in the room air  
13 of room 401 and possible fission products, as well.  
14 In a column of two and three-digit numbers, there is  
15 some seven, eight and nine-digit numbers on these  
16 monitoring reports, with a little notation that says  
17 these figures should not be recorded in annual  
18 report.

19 And we're still at a loss to figure out what  
20 happened in room 401 at DP west in July of 1969.  
21 We're hoping that some of the workers will now talk  
22 to us and some of the monitors will open up about  
23 why these figures should not be recorded in annual  
24 report.

25 Los Alamos is particularly problematic when

1 it comes to access to historical documents, so we're  
2 going to be watching you very, very carefully on  
3 that phase of the dose reconstruction.

4 I also wanted to mention the frustration the  
5 families feel in interpreting some of the  
6 documentation. A sheet metal worker whose family  
7 spoke very passionately yesterday, 1950 he's  
8 documented to have had moderate exposure to some  
9 hazard in 11 of 12 months of the calendar year.

10 What is the hazard? Well, it's something  
11 with a code number 49. We're pretty sure it's not  
12 his technical area. Among the other hazards that he  
13 was not exposed to are polonium, tube alloy\*, TNT.  
14 We know what all those are. But what in the world  
15 was hazard 49? And why in the world are there no  
16 dosimetry readings in his personal report for the  
17 year 1950?

18 So this is a plea for some serious  
19 independent technical assistance in helping families  
20 understand what this is all about. Thank you.

21 **DR. ZIEMER:** Thank you very much for that  
22 input. Again I'll ask if any of the Board members  
23 have questions?

24 (No responses)

25 **DR. ZIEMER:** Okay. We thank all those who

1 did stay to participate and provide their comments,  
2 and those again will all be on the record, as well.

3 **UNIDENTIFIED:** Excuse me, we've just been  
4 notified that Congressman Udall's office has a brief  
5 statement.

6 **DR. ZIEMER:** Oh, okay. Yes, I hadn't been  
7 informed of that. We'd be pleased to hear from  
8 representatives of the Congressman's office. And  
9 you'll need to give us your name for the record.

10 **MR. VASQUEZ:** My name's Robert Vasquez and I  
11 work for Congressman Tom Udall. And this is just a  
12 brief statement from his office.

13 Congressman Tom Udall, who represents  
14 northern New Mexico in Congress, and many of the  
15 constituents who work -- worked and work for Los  
16 Alamos National Labs has been closely monitoring the  
17 legislation and how the program is being carried  
18 out. Congressman Udall is one of the original co-  
19 sponsors of the EEOICA (sic). The Congressman is  
20 co-sponsoring the Strickland Bill to some of the  
21 flaws in the Act -- to address some of the flaws in  
22 the Act, I'm sorry.

23 There are many compelling arguments to  
24 support why LANL or LANL groups should be designated  
25 as a special cohort. We understand that the

1 catalyst to the process will really be the release  
2 of the regulations in January, 2003. However, we'd  
3 like to say that Congressman Udall will be  
4 investigating ways to allow LANL to be so designated  
5 as a Special Exposure Cohort. Thank you.

6 **DR. ZIEMER:** Thank you very much, and please  
7 note that the Board does appreciate the ongoing  
8 interest of his office in this process.

9 **ADMINISTRATIVE HOUSEKEEPING**

10 I want us to return now to the housekeeping  
11 issues. Cori, could you -- and/or Jim, help us with  
12 what other things we need to do. I think -- I know  
13 that you all need to provide Larry with your hours  
14 -- preparation hours and other time spent beyond the  
15 meeting times. Right?

16 Be sure to include your name. If you're not  
17 sure of your name, just put it under mine.

18 (Pause)

19 **DR. ZIEMER:** There is a section called  
20 housekeeping, and --

21 **MS. HOMER:** There should be an action item  
22 which I believe you've already seen. And I'll try  
23 to make this really quick.

24 **DR. ZIEMER:** I think we're looking at the  
25 table --

1           **MS. HOMER:** How's that?

2           **DR. ZIEMER:** The table. Right? Under  
3 action --

4           **MS. HOMER:** Yes.

5           **DR. ZIEMER:** -- items, you see the table  
6 where we have the running list of action items and  
7 their status.

8           **MS. HOMER:** And you can tell that there's  
9 been a little bit of a structural change to it.  
10 What we are hoping to do is to be able to define  
11 things a little better for everybody with the action  
12 items listing. Wanted to be very specific about the  
13 items and the status, and identify whether it was  
14 the Board's action item or agenda item, or whether  
15 it was NIOSH's item to deal with. And we have --  
16 as soon as it -- let me see if I can get this up.  
17 Where is it?

18           **UNIDENTIFIED:** What?

19           **MS. HOMER:** The action items listing. It's  
20 not here.

21           **UNIDENTIFIED:** I don't have it.

22           **MS. HOMER:** You don't have it? I gave it to  
23 Chris. Oh, well, I guess I'm winging it, folks.

24           **UNIDENTIFIED:** There's a hard copy.

25           **MS. HOMER:** There is a hard copy in your

1 book. As you can see, we've divided it by meeting,  
2 by date and status. In order to keep this less --  
3 at least somewhat simple, as each item has been  
4 completed and identified as completed, it will show  
5 up on the next meeting's action items listing, then  
6 it will disappear. Well, not exactly disappear.  
7 What we're going to do is move it to a completed  
8 action items listing, so we will be able to keep  
9 track of everything that's been done, the day it was  
10 completed, et cetera. But if we were to bring a  
11 running action items list to the Board every time,  
12 it would become unmanageable very quickly.

13 Each action item on this listing is  
14 something that the Board has provided consensus on.  
15 The action items are not for individual --  
16 individuals requests. It has to be brought to the  
17 attention of the Board and discussed and voted on  
18 for it to make it to the action items listing.

19 **MR. ELLIOTT:** Or maybe not voted on, but at  
20 least there's a sense of the Board that it's --

21 **MS. HOMER:** Well, yeah, sense of the Board,  
22 provided that -- you know, most folks really want  
23 this on there.

24 We have decided that NIOSH is going to  
25 manage this action items listing and provide it to

1 be attached to the minutes so that it's still  
2 provided prior to the meeting. What we're going to  
3 do is, with the assistance of the writer/editor and  
4 the court reporter, as well as NIOSH staff and the  
5 Board, we're going to try and cover everything from  
6 every meeting to make sure that everything that --  
7 we have a sense of the Board -- that it makes it to  
8 the action items listing. We just want to make sure  
9 that that's everything that has been requested is  
10 covered.

11 I think that's about all I have, Larry.

12 **DR. MELIUS:** Can I just -- a question to  
13 make sure I understood you, but if you look at the  
14 first page there, it's under meeting four --

15 **MS. HOMER:** Uh-huh.

16 **DR. MELIUS:** -- item number two, or let's  
17 take an even quicker on. Number four, e-member --  
18 e-mail members about web site. That I don't think  
19 needs to stay on the list. It's something -- you've  
20 instituted a policy of -- procedure for doing that  
21 now. We are now getting those.

22 **MS. HOMER:** Okay.

23 **DR. MELIUS:** To me, that would be something  
24 that I'd just take off 'cause it's a procedural  
25 change and I think it just clutters up, and if we



1 forget to --

2 **DR. ZIEMER:** Some of those ongoing things  
3 are probably in that category.

4 **MS. HOMER:** Well, we'd also planned on  
5 providing this information to you in a house --  
6 under the housekeeping section of the agenda at  
7 every meeting so that we all have an opportunity to  
8 comment on what can be taken off, what should be  
9 left on. There may be some items that are ongoing  
10 that you want kept in front of the Board and the  
11 public and -- on a consistent basis.

12 **DR. MELIUS:** Yeah. And the other thing I'd  
13 suggest we -- I mentioned earlier today is I think  
14 it would be helpful with some of these -- we have  
15 some things like further information on IREP and,  
16 you know, some was -- Dr. Land presenting and so  
17 forth, but there are a number of issues that had  
18 been brought up and suggested that we haven't gotten  
19 to, and I think if we did -- a working group would  
20 help us sort of consolidate those issues, work with  
21 you in terms of scheduling if there are appropriate  
22 outside speakers or something to come to Board  
23 meetings and so forth, and maybe that's a better way  
24 of dealing with that issue than -- rather than  
25 keeping this as an ongoing thing. And since Henry

1 did leave, we certainly will volun-- I will  
2 volunteer him for that committee.

3 **DR. ZIEMER:** Is it also possible to cross-  
4 sort the -- and this is helpful, they're sort of  
5 sequentially here, but maybe this is partially what  
6 you're -- have in mind, but for example, a table  
7 that had the IREP items is pulled out of this. In  
8 other words, a topical table as a quick cross-  
9 sorter, a crosswalk\* of these. So if you said well,  
10 what open items do we have in IREP, it would be  
11 there, what other items do we have --

12 **MS. HOMER:** Okay, we can do that. That's  
13 should be -- that should be very easy.

14 **DR. ZIEMER:** That's something you could do.  
15 That would help address what your concern is, Jim.

16 Jim, it wasn't clear to me at this point,  
17 though. Were you making a formal motion on an  
18 action on IREP or --

19 **DR. MELIUS:** I was -- a formal motion or  
20 sense of the Board or whatever you want to do, but I  
21 guess I'm suggesting that we set up a working group  
22 on dealing with some of the IREP and scientific  
23 issues to try to work to I guess prepare the Board  
24 for dealing with some of these issues as they come  
25 up to -- to review -- we deal with some of the

1 scientific information that is ongoing, and actually  
2 some of our public comments today about how do we  
3 coordinate what our activities and what our -- what  
4 NIOSH and what -- how we handle IREP with what some  
5 of the other groups are, the VA and so forth in  
6 dealing with it. I think that working group could  
7 work on some of those issues, also, and I think it  
8 would be helpful.

9 **MS. HOMER:** There's a difference between a  
10 working group and a subcommittee, and it sounds to  
11 me like what you're proposing might be something of  
12 a subcommittee. Working group has one task and  
13 short term. A subcommittee is something a little  
14 bit longer term or very much longer term.

15 **DR. MELIUS:** Well, let's charge a working  
16 group with coming up by the next meeting with a  
17 proposal for whether this needs to be dealt with  
18 through a subcommittee or what's the right best  
19 procedure for doing -- for handling some of these  
20 issues.

21 **DR. ZIEMER:** On an ongoing basis.

22 **DR. MELIUS:** On an ongoing basis.

23 **DR. ZIEMER:** So you're looking at a work  
24 group to simply come up with a more solid proposal.

25 **DR. MELIUS:** Right. And then if it needs to

1 be a subcommittee, we can decide and some issues  
2 with that, yeah.

3 **DR. ZIEMER:** It would be appropriate for you  
4 to make a motion to that effect, and the content of  
5 the motion would become basically the charge to the  
6 committee, I think. So if you want to give us a  
7 formal motion.

8 **DR. MELIUS:** Yeah, I would move that the --  
9 we establish a working group to come up with  
10 recommendations to the Board at its next -- at our  
11 next meeting -- next full meeting, personal meeting  
12 rather than the conference call meeting, regarding a  
13 number of issues related to IREP, as well as our  
14 coordination of IREP issues with some of the other  
15 government groups that are dealing with the IREP  
16 model.

17 **DR. ZIEMER:** Is there a second?

18 **MR. ESPINOSA:** I'll second.

19 **DR. ZIEMER:** Seconded. Is there discussion  
20 on this motion? Tony.

21 **DR. ANDRADE:** I question even the necessity  
22 for having any group deal with -- have to deal with  
23 IREP issues from this particular Board when we have  
24 NIOSH staff that deals directly with SENES and  
25 provides us with very timely updates, I believe,

1 with respect to models in IREP, how they are  
2 implemented, and the effects that those  
3 implementations may have on POC. Hence, I'm not too  
4 terribly enthusiastic about spreading ourselves even  
5 thinner in either a working group or subcommittee.

6 **DR. MELIUS:** Can I respond to that?

7 **DR. ZIEMER:** Yes.

8 **DR. MELIUS:** Yeah, I was not proposing to  
9 replace any of the activities of the NIOSH staff or  
10 -- nor to provide any sense of an ongoing update  
11 regarding IREP issues. However, there have been a  
12 number of issues that we've been brought up several  
13 times at these meetings that we have requested  
14 clarification on and briefing on. I thought we had  
15 all agreed to at meetings -- issues regarding -- and  
16 have come up -- some of them have been brought up  
17 today by the general public, the how do we deal with  
18 occupational studies in relationship to IREP, how do  
19 we deal with toxic exposures in relationship to  
20 radiation exposures in IREP, how do we deal with  
21 some of the scientific issues -- age at exposure,  
22 for example, things like that. And I would just  
23 like -- think it would be helpful -- I think helpful  
24 both to NIOSH staff and to the Board to have some  
25 sort of a plan for what extent we -- how do we get

1           briefed on some of those issues, how do we deal with  
2           those issues. Do we just let them go and let --  
3           wait until the NIOSH staff updates us on them, or  
4           are there some that we want to take a more active  
5           involvement at this point and lay out a plan. So --  
6           proposing is a short term committee, working group,  
7           that would report back to the Board. And we can  
8           decide, is it -- you know, the scope of that  
9           appropriate and is the -- what should be the task,  
10          does it need to be ongoing or not.

11                   **DR. ZIEMER:** Let's have other comments?  
12          Tony, you want to respond and then Wanda, will  
13          you --

14                   **MS. MUNN:** I was going to say something.

15                   **DR. ZIEMER:** Tony and then Wanda.

16                   **DR. ANDRADE:** The issues that come about  
17          usually come about as a result of questions that are  
18          brought up by the public and/or this Board. And --  
19          for example, the whole issue of whether we are  
20          relying solely on Japanese atomic bomb survivors  
21          data to do -- as data that is used in dose  
22          reconstructions or to model behavior of the human  
23          body with respect to radiation. That, since it was  
24          brought up today, could be -- we could easily  
25          solicit a briefing on that very topic for this --

1 for our upcoming meeting.

2 I just don't know if there's going to be a  
3 competent enough, qualified enough subsection of  
4 this working -- of this Advisory Board that's going  
5 to go out and, on its own, fish out, quote, issues  
6 with IREP. But you know, I know that Jim Neton  
7 could give us a very complete briefing on all of the  
8 data that is used in all of our models and could  
9 give the public a really good understanding of  
10 what's used.

11 And so I -- again, I think that we can  
12 handle these issues one at a time.

13 **DR. ZIEMER:** Okay. Wanda is next.

14 **MS. MUNN:** I'm comfortable with the level of  
15 information that NIOSH staff has been giving us.  
16 Added to that, our own working group is in the  
17 process of putting together another independent body  
18 which will audit what's been said and done all over  
19 again, so I'm quite happy with where we are.

20 **DR. ZIEMER:** Does anyone else wish to speak  
21 pro or con? Yes, Mark?

22 **MR. GRIFFON:** Yeah, I stepped out of the  
23 room so I'm assuming this is the proposed working  
24 group that Henry was going to -- no. I guess I feel  
25 that we -- we -- we tabled these IREP is-- we -- we

1 -- I know many IREP issues and we've had  
2 presentations on many that -- not issues, I  
3 shouldn't say, but areas for future consideration I  
4 guess is the way they've sort of been spelled out.  
5 But -- and in looking at the probability of  
6 causation and rules, I think everyone on the Board  
7 -- I think the sort of agreement was that specific  
8 comments for IREP could be tabled at this point, but  
9 it wouldn't be off the scope of work for the Board.  
10 And I think -- I think to have a working group that  
11 concentrated on those issues and maybe looked at  
12 them one at a time and laid out -- researched them a  
13 little bit to the extent that they could report back  
14 to the whole Board on what is the status of  
15 knowledge in this area and is it a priority for --  
16 maybe the Board needs to talk about, or are certain  
17 things priorities for inclusion within the IREP  
18 model, are certain things longer term. I mean I  
19 think there's some stuff that a working group could  
20 have quite a bit of input on.

21 **DR. ZIEMER:** Mark, let me clarify. The  
22 motion that's before us is actually not a group that  
23 would do what you just described, but a group that  
24 would recommend whether we should have a group.

25 **MR. GRIFFON:** Oh.



1           **DR. MELIUS:** Would lay out -- let's lay out  
2 options for how we could address those, I think is a  
3 better --

4           **DR. ZIEMER:** Yeah, not that this would be  
5 the group to do it, but that it might, as one  
6 option, do what you just described.

7           Okay, who else had -- Larry.

8           **MR. ELLIOTT:** I'm not here to speak to how  
9 you wish to go about doing this, but I would like to  
10 share my interest in how you go about doing this.

11           It's been a dilemma for me in trying to set  
12 the agenda for your meetings with Dr. Ziemer, having  
13 this long list here that we've got before you of  
14 action items. And I'd just call -- maybe it's -- in  
15 my opinion, it's not just IREP. It's research-  
16 related issues that feed into IREP or don't feed  
17 into IREP. Some of these research interests feed  
18 into dose reconstruction methodology. So if you  
19 look at the action item list, you look at the -- on  
20 the first page, starting on the first page, you look  
21 at item number five, item number eight, you go to  
22 the second page you look at nine, you look at 14.

23           Those are what I'm having some difficulty in  
24 in trying to determine how soon do you need -- do  
25 you need presentations, how -- where is your feeling

1 at on prioritization of these things. We've got two  
2 meetings -- two face-to-face, two-day meetings  
3 scheduled now for the month of January and February,  
4 and I'm going to be looking forward to knowing  
5 what's the Board's interest and pleasure in filling  
6 those four days out, besides what we've already  
7 talked about with the SEC rule and this RFP.

8 So that's where I -- my perspective on this  
9 and where I'm coming from. I appreciate your help  
10 and I'm certainly -- will support whatever approach  
11 or process you decide.

12 **DR. ZIEMER:** Any others speaking pro or con?  
13 Yes, Wanda.

14 **MS. MUNN:** With respect to what Larry just  
15 brought to us, it appears to me that, given the new  
16 process for the action items and what Cori's going  
17 to be presenting to us, that perhaps one of the  
18 standard housekeeping items of this group could be  
19 at the end of our session, at this time, we could  
20 look at the current action items and suggest to  
21 Larry which of them we wanted on the agenda next.  
22 That would seem to be the most simple and direct way  
23 to address it.

24 **DR. ZIEMER:** Thank you. And speaking to the  
25 motion, are you ready to vote for the motion?



1           **DR. ZIEMER:** One abstention. Okay. I  
2 believe the motion has passed by voice vote.

3           In addition to Jim and Henry -- Jim are you  
4 willing to chair --

5           **DR. MELIUS:** Yeah, I would.

6           **DR. ZIEMER:** Yeah, if you make the motion --

7           **DR. MELIUS:** I was -- yeah.

8           **DR. ZIEMER:** Are there others who want to  
9 volunteer to be on the work group? We need one or  
10 two additional people, I would say.

11          **MR. ELLIOTT:** I will serve as the staff  
12 liaison.

13          **DR. ZIEMER:** And Larry will serve as the  
14 staff liaison. Is there one or two other people?  
15 Just...

16          **MR. OWENS:** I'll volunteer.

17          **DR. ZIEMER:** Good, Leon. That's three plus  
18 Larry. If there's someone else and you just don't  
19 want to publicly admit how badly you want to serve  
20 on this group, we'll take volunteers later. But the  
21 working group now is Leon Owens -- it's Jim who will  
22 serve as chairman and Henry Anderson, Larry Elliott  
23 will serve as the staff liaison person. Thank you.

24                 Are there other items that need to come  
25 before the Board at this session today?

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(No responses)

**DR. ZIEMER:** Is there a motion to adjourn?

**DR. DEHART:** So move.

**DR. ZIEMER:** Is there a second?

**MR. PRESLEY:** Second.

**DR. ZIEMER:** All in favor say aye?

(Affirmative responses)

**DR. ZIEMER:** Motion carries, we are  
adjourned.

(Meeting adjourned at 4:45 p.m.)

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C E R T I F I C A T E

STATE OF GEORGIA :  
:  
COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 16th day of October, 2002; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 17th day of November, 2002.

\_\_\_\_\_  
STEVEN RAY GREEN,  
CERTIFIED MERIT COURT REPORTER  
CERTIFICATE NUMBER: A-2102