1 **DR. ZIEMER:** Okay. Thank you. Jim and Wanda?
2 **DR. MELIUS:** Just to follow up on that, the
3 evaluation plan -- not everybody has seen it --
4 it's very general. I'm not sure that at this
5 point in the process that we could expect a
6 more detailed evaluation plan. And some of the
7 genesis of this group was trying to -- would
8 our evaluation -- evaluation plan assist if we
9 were going to be confronted with a full
10 evaluation at this meeting. It turns out we're
11 not.
12 I think we may, as a next step, want to come
13 back and look at this issue after we've seen a
14 couple of evaluation plans, and we may have
15 some general recommendations at that point in
16 time as to what should be the content of the
17 evaluation plan. As well as NIOSH may -- as it
18 gains experience doing these evaluations, you
19 know, decide to organize them differently or --
20 or whatever, and --
21 **DR. ZIEMER:** So you concur with Bob's statement
22 that probably the working group doesn't need to
23 look at each of these evaluation plans as we go
24 forward, at least for now?
25 **DR. MELIUS:** At least for now, correct, yeah.

1 **DR. ZIEMER:** Thank you. Wanda?
2 **MS. MUNN:** I guess I have a slightly different
3 perspective. It appears to me that even though
4 the general template may be the same for most
5 of the reviews that we can anticipate, it's
6 also very obvious to me that every petition is
7 going to have some uniqueness to it. And until
8 we have a few of them under our belt, it would
9 seem wise to me that we have a working group
10 that does in fact try to evaluate how large
11 those differences in approach might need to be,
12 given the unique nature of each of the
13 petitions that we get. I think in the long
14 term I probably will agree with Bob. But at
15 this juncture, this is too fresh, too new, in
16 my view, for us to make that step quite so
17 completely.
18 **DR. ZIEMER:** Let me raise, though, in that
19 connection, a practical matter. And maybe the
20 working group can help us with this. Let's
21 take, for example, the Mallinckrodt plan, which
22 is the next one in line, and the work group has
23 that plan. Now if you were -- if the work
24 group were to meet and do what you did on this
25 one and come back to the Board and the Board

1 have to approve that before NIOSH proceeds, it
2 seems to me we have a very practical problem
3 because we're looking toward having the
4 Mallinckrodt evaluation at our next meeting.
5 And unless this Board wishes to meet again,
6 either by conference call or in person, to act
7 on that individual item, then we have a
8 practical issue as to what to do -- unless the
9 Board wishes to authorize the working group to
10 review it and to pass their comments along.
11 Anyway -- yeah, so could you respond and --
12 **MS. MUNN:** Yes, that latter suggestion was what
13 I had in mind, that the Board review -- report
14 to all the members of the Board essentially the
15 -- what we just saw, that that go to the Board
16 as soon as possible after the working group has
17 looked at it, just our -- our statement that
18 we've looked at it and this is --
19 **DR. ZIEMER:** But the Board cannot act on that
20 unless we formally meet. That's my point.
21 Jim, you had a comment.
22 **DR. MELIUS:** Yeah, that was just what I was
23 going to reiterate, also. And I guess I would
24 see more utility to -- if I'm -- I'm sort of
25 guessing at the number of evaluations we're

1 going to be seeing and how soon we're going to
2 be meeting again, but that -- that we may again
3 want to empower another working group, after
4 we've seen a couple of evaluations, to sort of
5 review what ought to be the content of the
6 evaluations and make recommendations at that
7 point in time, rather than -- I think that
8 might be more useful than an ongoing process to
9 review each evaluation plan.
10 **DR. ZIEMER:** Is there any reason, however, that
11 the plan, such as this plan, the plan for the
12 next -- the Mallinckrodt petition can be made
13 available and Board members individually
14 comment, or are you able to use that if they
15 don't represent any kind of consensus? I'm not
16 sure --
17 **MR. ELLIOTT:** No, first of all, we didn't give
18 you this for approval. We're moving forward.
19 Okay? And anything you give us is going to be
20 considered in our effort to research and
21 evaluate the petitions.
22 **DR. ZIEMER:** Yeah, but I'm asking -- you don't
23 necessarily need consensus --
24 **MR. ELLIOTT:** No, no, I do not.
25 **DR. ZIEMER:** -- comments. You can utilize

1 individual comments.

2 **MR. ELLIOTT:** I can utilize -- we can -- OCAS

3 can utilize individual comment on these

4 evaluation plans if that's your pleasure.

5 **DR. ZIEMER:** Okay. We'll take that up in a

6 moment then, in terms of what the Board wishes

7 to do. Let's take action -- the recommendation

8 from the working group represents, in itself, a

9 motion. It doesn't require a second. It's

10 those three recommendations that Bob

11 enumerated. Is there any further discussion on

12 the recommendations of the work group?

13 (No responses)

14 **DR. ZIEMER:** If there are not, are you ready to

15 vote on accepting those recommendations? All

16 in favor, say aye?

17 (Affirmative responses)

18 **DR. ZIEMER:** Are there any opposed?

19 (No responses)

20 **DR. ZIEMER:** Are there any abstentions?

21 (No responses)

22 **DR. ZIEMER:** Then those become our

23 recommendations and we thank the work group for

24 taking that issue and preparing this

25 recommendation for us.

1 Now do you wish to discuss the issue any
2 further on providing input on the Mallinckrodt
3 -- Larry's already indicated that the -- the
4 plan -- the review -- what's the proper name?
5 The petition review -- petition evaluation plan
6 for Mallinckrodt will be provided to all Board
7 members. He has indicated that they will be
8 glad to have individual comments. Does the
9 Board wish to proceed in that fashion? It
10 doesn't necessarily take a motion, but I'd like
11 to get some feel -- if this is how you wish to
12 proceed.
13 In the absence of any action to the contrary,
14 that's basically what will happen, because you
15 will get the document and you're welcome, of
16 course, to provide individual comments. So
17 unless we have a motion to act in some other
18 manner on this next one, that's basically kind
19 of the default position. Does that seem to be
20 agreeable?
21 Well, one or -- one or two are agreeable, I --
22 **MR. PRESLEY:** Well, we'll go -- we'll go do
23 them, but --
24 **DR. ZIEMER:** The rest are still numb. Okay, I
25 think -- I think we're going to proceed on that

1 basis.

2 **MR. PRESLEY:** Thank you.

3 **DR. ZIEMER:** Thank you.

4 **MR. ELLIOTT:** So has the working group
5 concluded its effort?

6 **DR. ZIEMER:** The working group has concluded --
7 and keep in mind, working groups, in a sense,
8 are ad hoc. They have -- they have carried out
9 the mission that --

10 **DR. MELIUS:** The working group has expired.

11 **DR. ZIEMER:** They have carried out the
12 responsibilities that -- for which they were
13 appointed. I think they can be reactivated
14 later, but they -- they cease to exist, I
15 believe.

16 **MR. ELLIOTT:** Yes. So I'll make sure that we
17 get the other Board members who weren't on the
18 working group a copy of what the working group
19 got. And if you individually have comments,
20 you can send those by e-mail or however you
21 wish to us and we'll carefully consider those.

22 **DR. ZIEMER:** Okay. Thank you very much.

23 **BOARD WORKING SESSION**

24 I'd like to outline for the Board very
25 quickly items that we have to address

1 during our working session -- or
2 sessions -- so that we can kind of judge
3 time and so on. And I believe -- Henry,
4 you're leaving at noon?
5 **DR. ANDERSON:** Yeah.
6 **DR. ZIEMER:** So we need to select those issues
7 that we want to address -- those things we want
8 to do once Henry leaves.
9 **DR. MELIUS:** Form a new working group.
10 **DR. ZIEMER:** I have on my list the following
11 items. I want to make sure that the charge to
12 the new working group that's going to monitor
13 the -- the final dose reconstruction report,
14 that the charge to them is clear. I have it
15 written out before me, based on our minutes --
16 or our comments yesterday and I want to make
17 sure that's clear.
18 We need to address the handling of future site
19 profile drafts. I believe that's the one that
20 we wanted to address while Henry was still
21 here, actually.
22 We need to talk about future meeting times and
23 places.
24 I actually have on my notes that we still need
25 to act -- take final action on SCA's quality

1 assurance and conflict of interest plans. You
2 may recall at our last meeting there were some
3 primarily editorial changes, but there were a
4 large number of changes that SCA wished to make
5 -- just some wording things, mainly. There
6 were no substantive changes, but we deferred
7 final action on those till we got the clean
8 copy. That clean copy -- I'm not sure it's in
9 the book. Maybe it is, I haven't looked, but I
10 know it was distributed by e-mail earlier.
11 **MR. ELLIOTT:** It is in the book and you were --
12 it was submitted to each member by e-mail.
13 **DR. ZIEMER:** So we also need to take action on
14 that. I don't anticipate that that will be
15 long or prolonged, but just to outline those
16 items that have to be taken care of, and then
17 there may be some additional housekeeping
18 issues that Cori wishes to take care of, as
19 well.
20 **DR. MELIUS:** I have one --
21 **DR. ZIEMER:** Are there some other items that
22 I've overlooked in terms of this working
23 session?
24 **DR. MELIUS:** I have one, and I may have missed
25 it 'cause I didn't attend the subcommittee

1 meeting the other day. But I believe that SC&A
2 had raised some issues about access to -- site
3 access about Q-clearance issues and about
4 getting some information, I believe from NIOSH,
5 I can't recall specifically --
6 **DR. ZIEMER:** Well, I don't think that was part
7 of that session, but those -- those issues were
8 raised, I think in some separate letters that -
9 -
10 **DR. MELIUS:** Right, and my question is that do
11 they need to be discussed or have they been
12 resolved or -- I guess I'd like some feedback
13 on them and --
14 **DR. ZIEMER:** Yeah, let's --
15 **DR. MELIUS:** -- at some point that could be --
16 **DR. ZIEMER:** -- have that as an item, the
17 status -- I'm just going to call that status of
18 SCA access. That's -- I think basically has to
19 do with -- it's more in the Q-clearance issues.
20 I'm looking for John -- it's the Q -- the Q-
21 clearance issues, is it not, John?
22 **DR. MAURO:** Yes.
23 **DR. ZIEMER:** So we'll put that on the agenda,
24 as well. And -- other items? Mark, did --
25 **MR. GRIFFON:** Yeah, just -- I think we need

1 more discussion on the function of the dose
2 reconstruction subcommittee.
3 **DR. ZIEMER:** Okay, yes.
4 **MR. GRIFFON:** We've done one item out of eight
5 scope items, at this point. We're down to case
6 selection is all we really have been doing --
7 **DR. ZIEMER:** Yes.
8 **MR. GRIFFON:** -- and I want -- you know, going
9 forward, how --
10 **DR. ZIEMER:** Okay, thank you. Let's start with
11 going forward on this site profile drafts
12 issue. That's one that Henry wanted to be
13 present for. Let me begin that discussion by
14 outlining what I think are the issues, and then
15 the rest of you can help clarify it.
16 Perhaps the overriding issue has to do with the
17 status of the contractor's report to the Board
18 in the interim period from when the report is
19 completed to the time of the open meeting where
20 the report is discussed. The report is
21 identified -- at least has been identified, I
22 believe from kind of a legal point of view and
23 from the Department's point of view, as a work
24 product that is subject to certain kinds of
25 constraints. One of the issues, as I

1 understand from the discussion that arose, was
2 the extent to which those legal aspects
3 completely bind us to a certain kind of action,
4 or is the Board in fact in a position -- if it
5 wishes -- to allow the document to be viewed
6 sort of in the open market prior to the Board's
7 having discussed it or indicated any kind of
8 position on it and that sort of thing. Is that
9 -- that's the nature of the issue, I believe,
10 is it not? Right.
11 **DR. MELIUS:** My understanding of the issue was
12 that it is a HHS policy, and so I think the
13 nature of any action we would take would be a
14 recommendation I guess to the Secretary that
15 that policy --
16 **DR. ZIEMER:** If we -- if we wished to somehow -
17 -
18 **DR. MELIUS:** -- if we wished to do -- yeah,
19 there's a conditional -- maybe Liz can --
20 **DR. ZIEMER:** Liz, can you -- can you speak
21 further to that maybe?
22 **MS. HOMOKI-TITUS:** No, actually I can't.
23 That's what I was going to say is the
24 Department doesn't have a policy on that right
25 now.

1 **DR. ZIEMER:** Does not have a --
2 **MS. HOMOKI-TITUS:** There's a legal
3 determination that has to be made and the
4 Department's going to have to take it up --
5 well above NIOSH. But Dr. Melius is absolutely
6 correct, if you all have a position on that and
7 want to make a recommendation to the Secretary,
8 you're welcome, but we can't give you guidance
9 on that right now.
10 **DR. ZIEMER:** Okay. Do -- we don't know whether
11 or not there is a policy or...
12 **MS. HOMOKI-TITUS:** I'm not sure that they have
13 -- as far as these documents go, I'm not sure
14 that they've established a policy. But I can
15 assure you that we don't have a legal position
16 on them yet.
17 **DR. ZIEMER:** Yeah, I understand then. Okay.
18 **DR. MELIUS:** But -- but you did take an action
19 on these, so --
20 **MS. HOMOKI-TITUS:** We --
21 **DR. MELIUS:** Yeah.
22 **MS. HOMOKI-TITUS:** We did take an action on
23 this first set of documents, but you know, this
24 is a learning process for everyone and the
25 Department now realizes that this is an issue

1 and it's something that we need to legally
2 consider, as well as determine what our
3 policy's going to be, and that hasn't been done
4 yet. But you act as an advisory board and if
5 you want to advise the Secretary on it, we
6 would --
7 **DR. ZIEMER:** Sure.
8 **MS. HOMOKI-TITUS:** -- obviously welcome your
9 input.
10 **DR. ZIEMER:** Right. Thank you. Okay. So that
11 -- that's sort of the framework, and before
12 maybe even getting a motion before us, maybe we
13 can have some general discussion and kind of
14 learn where people are coming from on this.
15 Henry and then Jim.
16 **DR. ANDERSON:** I guess my issue was one of
17 there were public comments, critiques,
18 rebuttals by Department of Labor and NIOSH to a
19 document that, you know, others had not seen so
20 that you have basically a critique by -- a
21 public critique without the public having an
22 ability to review what are they actually
23 critiqueing and are those critiques -- do they
24 make sense. I think that -- to me, that was
25 one of the issues. It's sort of like having a

1 medical journal write a negative editorial
2 about a manuscript that hasn't been published
3 yet. It isn't out there in the public yet.
4 Now if the NIOSH comments and other comments
5 were similarly not going to be anything but
6 communication to the Board, then I see it a
7 little differently, but it just seemed to me,
8 on a fairness issue, it's very hard to judge
9 the -- or assess the credibility of critiques
10 if you haven't had an opportunity to see what's
11 being critiqued.
12 **DR. ZIEMER:** Uh-huh, To-- no, let's see, we had
13 Jim and then Tony, okay.
14 **DR. MELIUS:** And just in follow-up to that, I
15 think there's that point. There's also -- I
16 think Tony made the point yesterday that -- I
17 think he used the term real world, I don't
18 recall specifically, but that we were not in
19 the real world, but we're -- part of the real
20 world we're in is a Federal advisory committee
21 that's supposed to operate in the public, that
22 -- I think we've operated in the sense -- and
23 NIOSH has -- that this -- given some of the
24 past issues with DOE and this kind of a program
25 that it was very important that we operate as

1 open as possible, that our processes and so
2 forth be as transparent as possible, and that
3 we try to maintain, you know, openness with the
4 public and with the people affected by this --
5 this program. And having a document labeled as
6 not being available to the public raises issues
7 and I'd just like to pass to the Board -- I'm
8 not sure everybody got a chance to see this,
9 and I believe there are copies in the back for
10 the public, also. I mean this issue on the
11 Bethlehem report made the -- an editorial on
12 the Buffalo news. I'm sure you've read it in
13 Wisconsin or --
14 **DR. ZIEMER:** It's one of those papers we all
15 read on a regular basis.
16 **DR. MELIUS:** -- you know, what's new in
17 Buffalo, but -- but I mean they raised I think
18 legitimate concerns, at least their perception
19 was that this is an issue that people should be
20 open about and so forth. We also had, you
21 know, a group come from Buffalo by train all
22 the way out here to listen to us review report
23 and -- that they hadn't seen yet, they hadn't
24 had an opportunity to see until they got to the
25 -- the meeting. It's a long enough report that

1 it took many of us some time to struggle --
2 struggle through it. And I just think in the
3 interest of the credibility of this program of
4 being open that we should, you know, in the
5 future let these reports be in the public
6 domain. I think we probably should indicate
7 that they are a draft report, indicate that the
8 Board has not accepted them yet or endorsed
9 them yet, however we want to view that process,
10 but that we would have a process where we would
11 make the reports available or -- through NIOSH.
12 Again, there may be privacy concerns, so there
13 could be a review for Privacy Act issues, make
14 those available. And as NIOSH completes its
15 review, that document would also be -- become
16 available. And then at the next meeting, you
17 know, we would discuss and take whatever
18 action's appropriate. But I think it would
19 improve the credibility of the process and make
20 the public less concerned about -- that there's
21 some secret information that we're withholding
22 from them or that is not going to be allowed to
23 be -- be available.
24 **DR. ZIEMER:** Tony?
25 **DR. ANDRADE:** I suppose I wouldn't be -- I

1 wouldn't be as concerned as I am currently
2 about making predecisional drafts available to
3 the public if -- if there was some sort of
4 very, very strong communications process at our
5 disposal that would ensure that everybody --
6 everybody, from the senators on down to the
7 worker at any of these facilities, or claimant
8 or whomever, public in general, knew darned
9 well that anything that is written in these
10 predecisional drafts is subject to being
11 completely erased, completely voted out, that
12 anything there is only the opinion of an
13 assessor. Okay? I don't like the fact that we
14 had to go into -- well, okay, that's a
15 different issue, and that's the fact that, you
16 know, we had to debate this -- at least the
17 site profile stuff publicly because that turned
18 into the sort of thing that you expect at a
19 closeout meeting after any assessment. And so
20 they even go -- even -- I think that even if
21 they had had the information available, I think
22 they would have walked out of here just as
23 confused and frustrated as -- as perhaps some
24 of us were.
25 So I still see that there is, without some sort

1 of proviso process -- okay? -- in place, the
2 potential for misinterpretation and for misuse
3 of data -- and frankly, I don't trust the
4 senators and I'm -- or let's say politicians in
5 general. I'm not going to point to anybody in
6 particular. There -- there could be, quote,
7 errors that have been pointed out in -- in a
8 predecisional draft by an assessment team,
9 which in-- which indeed turn out not to be
10 errors, and they're really only indications
11 that there need to be further clarifications
12 made in the way approaches are taken by NIOSH
13 in determining some aspects of a site profile.
14 Some of those data that are -- are brought to
15 light by the assessing team are norm-- are
16 normally, the first time out, taken by
17 newspapers and editorial and newspaper people
18 who are not technically qualified, taken to be
19 the final product and put out as though that is
20 going to potentially be the policy that is
21 adopted.
22 And then raw data and/or scientific -- new
23 scientific methods for looking at data, these -
24 - these really can be used to further the
25 political agenda by allowing politicians to use

1 these to make statements that are derogatory to
2 our work. And frankly, I am really, really hot
3 under the collar to hear that we're supposedly
4 an obstructive body -- okay? -- that we are not
5 doing our -- last night it was made clear to us
6 again that we're not doing our jobs -- not by
7 the senators, but by a member of the public.
8 In other words, the data is taken and twisted.
9 And so, again, I am not against completely --
10 or completely against hiding this stuff, but
11 there has got to be something that is put right
12 on the front cover that if you take this then -
13 - at face value and you think this is a final
14 product, you are really stupid. I mean it's
15 got to be just about that strong.
16 **DR. ZIEMER:** Okay. Leon?
17 **MR. OWENS:** Dr. Ziemer, I think everyone on
18 this Board knows that the members serve at the
19 pleasure of the President of the United States.
20 And for that reason and that reason alone, this
21 Board is political. I think that we hear the
22 word transparency used just about every
23 meeting, and I think it's incumbent upon the
24 members of the Board to ensure that the public
25 perception of this Board is maintained and --

1 and the credibility of the members of this
2 Board is maintained.
3 If a document is stamped "draft" and is
4 provided, each of us have no ability to change
5 the perception of individuals who read that,
6 but we are aware that it is a draft. And then
7 once a document is stamped "final," I think
8 that individuals are of the intelligence to
9 recognize that that means it's a final product.
10 So I'm hopeful that in the future documents of
11 this nature can be provided to the public for
12 their purview, along with the responsible
13 members of the Congressional delegation who
14 created and enacted this legislation that
15 allows us to have these type of debates.
16 **DR. ZIEMER:** Thank you. Wanda?
17 **MS. MUNN:** If we lived in a perfect world or
18 had no basis for making a judgment on issues of
19 this sort, I would have no qualms with what we
20 did with any predecisional document. We do not
21 live in a perfect world, and we have more than
22 adequate evidence of what happens when
23 predecisional documents are made public. Given
24 that background, it seems to me that the old
25 adage that those who do not recognize history

1 are doomed to repeat it is one that applies in
2 every respect to what we are deliberating here.
3 A predecisional document is a predecisional
4 document. Individuals who seek to identify any
5 single statement in any document that will
6 support a contention that they hold closely,
7 whether it is factual or not, will use that
8 information in every way that they can.
9 Predecisional documents should be treated as
10 predecisional documents and published at the
11 time that they have been fully vetted by the
12 organizations responsible to do so.
13 **DR. ZIEMER:** Okay. Thank you. Roy?
14 **DR. DEHART:** I don't think there's any other
15 way to word the audit report other than saying
16 it's quite negative to the NIOSH dose
17 reconstruction process. That's the way the
18 report is written and comes across, at least to
19 me. It will probably be misinterpreted or
20 interpreted as being a very negative slam to
21 NIOSH, and to anybody who has had a dose
22 reconstruction done, particularly if it is a
23 dose reconstruction that does not reach the
24 50th.
25 We can argue that we can clarify that, that we

1 can take care of some misinterpretations, that
2 we can bring intelligence and science to bear
3 that will soften that. But once it's in the
4 press, once it's in the mind of the worker that
5 they are being had by an unfair dose
6 reconstruction, you're not going to change
7 that. And I would hate to see us go forward to
8 publicly release that document until we've been
9 able to resolve the issues as best we can and
10 know exactly what that document is saying with
11 regard to the dose reconstruction that NIOSH
12 has been performing.
13 **DR. ZIEMER:** Okay. Thank you, Roy. I'm not
14 sure who was next.
15 **DR. MELIUS:** Mike was next.
16 **DR. ZIEMER:** Mike?
17 **MR. GIBSON:** Thank you. It appears to me that
18 based on most of the comments I hear from the
19 general public and constituents around my area
20 that they already think they're had. And I
21 think the more that we keep documents that
22 people know that may be in draft form and we
23 keep them behind a closed door, so to speak,
24 until we get them finished, I think that's
25 going to further the case to make them feel

1 whatever you want to put on this thing, and get
2 them out to the public.
3 I do think it's going to open up some
4 discussion down the road, and we as a Board
5 will probably have to defend some of the
6 actions in that, that people are not making the
7 right decisions and things like that. But as
8 long as we do these with the right caveats, I
9 have no problems with putting them out. But to
10 just open them up to the public the day they
11 come out, no.
12 **DR. ZIEMER:** Jim?
13 **DR. MELIUS:** Yeah. I guess I'd like to get
14 ready to offer a motion here if it's timely,
15 but let me sort of describe the process to make
16 sure that everyone's in agreement and that it
17 covers certain issues, is that I would be ready
18 to offer a motion that we do reco-- I guess
19 recommend to the Secretary that we release the
20 -- these draft reports to the public; that that
21 be done in a manner that includes on the cover
22 page a statement describing that this is a
23 draft report that has not been reviewed nor
24 accepted by the Board yet, nor -- and that
25 NIOSH has not had -- yet had the opportunity to

1 comment on factual or other information that's
2 in the report or -- in the report.
3 Then I think we have to modify our process for
4 these reports so that rather than having -- us
5 receiving them directly from the contractor,
6 that when a report is ready to be transmitted
7 to us, it would go to NIOSH; that there be an
8 opportunity for review of that report for any
9 Privacy Act or other proprietary information;
10 that then at that point it be transmitted to
11 the Board and at the same time that NIOSH make
12 it available on the web site. And I believe
13 the best place for that would be under the site
14 profile documents where you have a space for --
15 where you -- for -- for public comments on the
16 site profiles, where you sort of collect those.
17 Now you may have to -- probably should label it
18 some way, but I think that's the best place to
19 put it and would also link back to the -- to
20 the Board, Advisory Board part of the web site,
21 also.
22 So that would make it publicly available, would
23 have appropriate disclaimer on it, and I think
24 would satisfy a need for Privacy Act and other
25 -- other review. I guess I'm concerned that if

1 we receive a report from the -- our contractor
2 and -- directly and then it goes to NIOSH and
3 they find a Privacy Act issue, then we're going
4 to have two versions of the report and that's
5 just going to open ourselves to problems as to
6 -- you know, somebody asks us for a copy, we
7 give them the wrong copy or something like
8 that.
9 **DR. ZIEMER:** Could I ask, Liz, is -- is that,
10 the Privacy Act review issue, a -- is that a
11 required step or can the contractor agree to
12 have it waived?
13 **MS. HOMOKI-TITUS:** No, the contractor can't
14 waive the Privacy Act. That would have to go
15 through our privacy office to be cleared. They
16 -- I don't know why they --
17 **DR. ZIEMER:** That's to make sure that they're
18 not --
19 **MS. HOMOKI-TITUS:** Right, and they --
20 **DR. ZIEMER:** It's not their -- it's not
21 business confidential issues, it's --
22 **MS. HOMOKI-TITUS:** Yeah, if they --
23 **DR. ZIEMER:** -- issues that can -- I'm with you
24 now. Yeah, yeah, yeah. Yeah, Mark and then
25 Roy.

1 **MR. GRIFFON:** Just one more before he makes the
2 motion there. I -- I'm just reflecting a
3 little on Gen's comment, too, and I think, you
4 know, the really -- I -- I agree, by the way,
5 that I think we need to release this, and --
6 and two or three weeks staggered is not going
7 to make a difference and so forth, but I -- I
8 think of the -- this iterative process and I
9 think that Jim makes a good point that -- and I
10 think we -- we see it spelled out in this
11 Bethlehem Steel site profile process. The --
12 there was an iterative process before a report
13 came from the contractor to the -- to the
14 Board. In other words, NIOSH was involved in a
15 factual accuracy review meeting with SCA, I
16 believe --
17 **DR. ZIEMER:** That was separate, and I think
18 factual accuracy --
19 **MR. GRIFFON:** Right, right --
20 **DR. ZIEMER:** -- would still occur --
21 **MR. GRIFFON:** -- no -- no -- yeah, but --
22 -- yeah, the only -- the only point I wanted to
23 make was that there was no iterative process
24 where the Board was purviewed (sic) to those
25 discussions and I think maybe we -- sort of

1 like that iterative process that we just set up
2 with the dose reconstruction case reviews, we
3 might want to have some sort of Board role --
4 **DR. ZIEMER:** Actually, let me correct that.
5 The instruction before was that the Chair of
6 the Board would be informed of the issues,
7 which I was, that were raised by NIOSH. And I
8 was provided actually with that and a
9 transcript by SCA of the meeting with NIOSH, so
10 --
11 **MR. GRIFFON:** Oh, okay.
12 **DR. ZIEMER:** -- that information -- and that
13 was on the instructions of this Board to --
14 that the Chair be informed of the exchange, so
15 we had an independent paper trail of what --
16 what discussions went on between the contractor
17 and NIOSH so they're not just working off here
18 by themselves. So I was --
19 **MR. GRIFFON:** Okay, I guess --
20 **DR. ZIEMER:** -- provided with that.
21 **MR. GRIFFON:** I guess my -- my hope was that
22 maybe in the -- going forward we can alter,
23 strengthen that iterative process so that
24 hopefully we can have, at that level, some --
25 some comment -- some resolution to -- to the

1 first publicly-released report, and that may go
2 to -- what I'm trying to get at is Gen's
3 question of some -- you know, real dialogue
4 between -- over -- over differences in
5 findings, and it might happen easier prior to
6 two publicly-released positions that -- that
7 differ greatly, so I'm thinking, you know,
8 maybe there's a different iterative process
9 that can go on, but I think it's critical that
10 we have Board involvement in that somehow, but
11 it couldn't be subcommittee or full Board
12 because then it's a public meeting.
13 **DR. ZIEMER:** Right.
14 **MR. GRIFFON:** You know.
15 **DR. ZIEMER:** Right.
16 **MR. GRIFFON:** So the work group --
17 **DR. ZIEMER:** A comment from Jim here.
18 **DR. NETON:** I just wanted to comment on the --
19 the iterative process, which was really just a
20 factual accuracy review. And under the ground
21 rules laid out -- I think by the Board -- and
22 adhered to by SC&A, we -- we had very limited
23 opportunities. Factual accuracy was just that,
24 and we were not requested to comment on any
25 conclusions that were drawn or any assumptions

1 that were made in the document itself. So this
2 was really just a -- a calculational data type
3 review or a misinterpretation of the
4 regulation, and we had a very limited time -- I
5 believe it was five days or something like
6 that. I think we met it in seven, but you
7 know, to review an 80-page document in five or
8 six days is not reasonable.
9 And I would also comment that the day that it's
10 released as -- by the Board, I can guarantee
11 NIOSH is going to be asked for their comment on
12 a document that they have not had a chance to
13 look at the final version, and it's going to
14 put us in a very difficult position. But
15 that's just my opinion.
16 **DR. ZIEMER:** And it's even pos-- the iterative
17 process that you're talking about might include
18 a step which allows NIOSH to develop comments
19 so that they can be released together or
20 something like that. That's also a
21 possibility, which would -- which -- but does
22 that occur before the Board sees it? Because
23 at the point the Board sees it, we're talking
24 about that's presumably the release date that
25 we're talking about, the date that the document

1 comes to us.
2 **DR. MELIUS:** Can I just comment on that? Roy,
3 if you don't -- I just think we -- we also have
4 to remember we have to avoid a perception that
5 NIOSH is somehow involved in censoring the
6 report from SC&A and so forth. So I -- as much
7 as we would like to get resolution, I don't
8 think we can expect complete resolution without
9 running into other dangers.
10 I would also think the factual -- there's a --
11 attached to this report was a memo describing
12 the factual exchange and so forth, that when
13 NIOSH does have its comments prepared on the
14 document and it -- that those would also be
15 posted on the web site, and those don't
16 necessarily need to be a complete set of di--
17 and if you, you know, want to be split in parts
18 in order to be more timely on certain issues or
19 something that, you know, that NIOSH has
20 prerogative to do, I don't see a problem with
21 that. And I think if we keep them together
22 that once -- you know, we -- again, depending
23 on the timing of some of these issues, we may
24 get them two weeks, you know, before the Board
25 meeting, whatever, but at that point NIOSH

1 would -- they'd be there. They'd be in the
2 same place on the web site. People would be
3 able to read both of them.
4 **DR. ZIEMER:** Well, in fact the Board will be in
5 the same position, in principle, because that's
6 what happens. Reporters call and they -- they
7 want to know what the Board's position is on
8 this, you know, and I would have to say well,
9 the Board has not reviewed this yet. And you
10 would end up in the same position. I know,
11 it's -- it's tougher for the Feds.
12 **DR. NETON:** Right, I got the distinct
13 impression from the first round of this,
14 though, that what's going to happen is when the
15 Board receives the report they'll conduct a
16 meeting and forward a copy to us for review and
17 say please provide your comments. So I'm not
18 sure whether it's -- at that time it's
19 appropriate or just to pre-stage it and get
20 your comments at the same time. It's sort of -
21 - you know, if you get the copy and then
22 forward it to us and we comment, does it really
23 make a difference? I mean we're not editing
24 the document, we're just commenting on it. We
25 would not be allowed to do any revisions at

1 all, but just to prepare some comments so the
2 Board could get them in a more timely manner.
3 **DR. ZIEMER:** Uh-huh. Okay. Roy?
4 **DR. DEHART:** A point of clarification. We keep
5 referring to the SC&A audit of the Bethlehem
6 site as a draft. Was it a draft? Wasn't that
7 a final report to us?
8 **DR. ZIEMER:** I believe that was SCA's final
9 report.
10 **DR. DEHART:** Yes, so I think that's important
11 that we -- it's not a draft.
12 **DR. ZIEMER:** We're using it I think here in our
13 discussion -- the word draft in the context
14 that we're actually envisioning some kind of an
15 iterative process. But in fact the
16 contractor's report is the contractor's report.
17 Under our task, that's the deliverable, and
18 they deliver their report to us. And in fact,
19 at some point -- we've gone through a process
20 which we didn't envision at the front end, but
21 down the road, perhaps at the next meeting
22 after we have the exchanges that we've
23 described in our motion, this Board is going to
24 have to come to grips with specific items. We
25 cannot just say you guys go off and work this

1 out and let us know what you decided. We will
2 have NIOSH's view on those issues. We will
3 have the contractor's view. We -- we will then
4 have to say to the Secretary we agree with this
5 or we don't agree with that, or we would like
6 additional emphasis put on this or that. We
7 will have to specifically take a position of
8 some sort.
9 Now keep in mind that doesn't mandate that
10 NIOSH necessarily do anything. It's a -- it's
11 a recommendation to the Secretary. But we're
12 not off the hook by saying you guys get
13 together and work out these scientific issues.
14 If there -- there can be very valid, good
15 scientific disagreements. That's the nature of
16 science, and I -- I always take a little
17 exception to people who try to characterize
18 those as adversarial things. It's the nature
19 of science. It's a kind of collegial
20 adversarial relationship where we argue our
21 positions. I don't know who had said something
22 like that, but the point is that I don't think
23 we should expect that somehow all of these
24 things are going to go away by the groups
25 talking to each other. There are some valid

1 different points of view, which could very well
2 remain. That's the nature of the process.
3 Actually it's one of the reasons that the
4 audits are done is to bring in another possible
5 perspective that may or may not eventually
6 change the final product. Preach it, Brother.
7 Okay.
8 **MR. GRIFFON:** How about a motion?
9 **DR. MELIUS:** I'll make a mo-- okay. We're
10 ready. I move that the Board recommend to the
11 Secretary of Health and Human Services that the
12 contractor -- our -- SC&A -- our contractor's
13 reviews -- report on the review -- site profile
14 reviews be released as a public document at the
15 time that they are -- the final report is
16 conveyed to the Board; that that public release
17 include a statement advising the public that
18 this is a report that's not been accepted by
19 the Advisory Board and there's not been an
20 opportunity for full review by NIOSH of the
21 report; and that the Board will be reviewing
22 the report and may have findings and
23 recommendations relevant to the report at
24 future public meetings; that the process for
25 doing -- making the report public would also

1 include a Privacy Act and -- review of the
2 report before it be made available to the -- to
3 the public.
4 **MR. GRIFFON:** Is that it?
5 **DR. MELIUS:** That's it.
6 **DR. ZIEMER:** Is there a second?
7 **MR. GRIFFON:** Second.
8 **DR. ZIEMER:** Okay. Is there discussion? We've
9 had a lot already that, in essence, pertains.
10 Tony?
11 **DR. ANDRADE:** I'd like to offer an amendment.
12 Rather than include all of the wording with --
13 that detailed what -- what the provisos might
14 be, why don't we just say with appropriate
15 caveats, and between now and say our working
16 time this afternoon I'd be willing to work with
17 anybody here or I could do it myself in
18 developing a cover sheet that would have a list
19 of caveats.
20 **DR. ZIEMER:** Are you offering that as a
21 possible amendment right now?
22 **DR. ANDRADE:** The amendment would be to strike
23 the specific wording on what would go on the
24 cover sheet from -- from Jim's statement --
25 from Jim's motion.

1 **DR. MELIUS:** Can I offer --
2 **DR. ZIEMER:** Is that a friendly amendment, Jim,
3 or --
4 **DR. MELIUS:** It's a friendly amendment, but I
5 would just like a clarification. I was not
6 trying to specify the wording of the cover
7 sheet. I would expect it to be lengthier. I
8 was trying to describe in general the wording,
9 but not specify the wording, that it could very
10 well be longer and I have no objection to --
11 **DR. ZIEMER:** Here's a -- here's a way you could
12 include those, to include appropriate -- or
13 have appropriate caveats, including -- 'cause
14 you have two -- you at least want it to
15 indicate that it hasn't been accepted by the
16 Board, whatever words that takes, nor that it's
17 been reviewed by NIOSH. There may -- and
18 you're saying yes, and there may be some other
19 caveats.
20 **DR. ANDRADE:** Exactly.
21 **DR. ZIEMER:** So perhaps I'll interpret the
22 motion as -- as including the words
23 "appropriate caveats, including" those two that
24 you mentioned. Is that agreeable as a friendly
25 --

1 **DR. MELIUS:** As a friendly amendment, yes.
2 **DR. ANDRADE:** That's agreeable.
3 **DR. ZIEMER:** So that we're sure that at least
4 two topics are addressed in the list of
5 caveats. And it would be understood that the
6 exact wording of the appropriate caveats would
7 be worked out and would not necessarily be part
8 of the motion. Is that correct?
9 **DR. MELIUS:** Correct.
10 **DR. ZIEMER:** So the motion is that the Board
11 recommend to the Secretary of Health and Human
12 Services that future SCA site profile reviews -
13 - review reports be released to the public at
14 the same time as they are released to the
15 Board, with appropriate caveats, including a
16 statement indicating or advising that the
17 report has not yet been accepted by the
18 Advisory Board, nor has the report been
19 reviewed by NIOSH. Prior to the release a
20 Privacy Act review by NIOSH would also take
21 place.
22 Is that the motion?
23 **DR. MELIUS:** Yes.
24 **DR. ZIEMER:** Okay. Further discussion? And
25 this -- this, if it's passed, would become a

1 recommendation to the Secretary of Health and
2 Human Services as a policy -- as a policy for
3 the Board or for the agency, and it would --
4 basically we would be asking then that the
5 policy allow this, and the Secretary could say
6 yea or nay.
7 **DR. MELIUS:** Yeah.
8 **DR. ZIEMER:** That's understood then?
9 **DR. MELIUS:** And just another -- another
10 clarification is that I'd leave it up to NIOSH
11 to decide how to make it publicly available,
12 where on the web site and so forth. I don't
13 think we should specify that.
14 **DR. ZIEMER:** At this time.
15 **DR. MELIUS:** At this time. Let -- they may
16 want to think about it.
17 **DR. ZIEMER:** That's a mechanical thing that can
18 be -- and this doesn't address other process
19 issues, such as the one that -- as this stands
20 now, Jim, I think this says it's going to be
21 out there before you have a chance to do
22 anything about it.
23 Let me ask also this question. Is there now an
24 acting person who could actually do something
25 about this before -- is confirmation going to

1 come pretty fast? This is almost off the
2 record. We don't know, but I guess
3 confirmation will be coming pretty fast, from
4 what I read in the papers on the new candidate
5 for --
6 **DR. MELIUS:** But somebody is acting, so I
7 think...
8 **DR. ZIEMER:** By the time this gets up and into
9 the system --
10 **DR. MELIUS:** You may have trouble how to
11 address your letter, because it could happen
12 while it's --
13 **DR. ZIEMER:** To whom it may concern.
14 **DR. MELIUS:** Be careful, Paul.
15 **DR. ANDERSON:** Dear Secretary.
16 **DR. ZIEMER:** Well, I have a bit of a concern on
17 the timing issue, although actually there won't
18 be a big lag time before our next meeting and
19 the other reports. This -- the chance of this
20 being approved before our next meeting may be
21 fairly slim. But I don't think there's a big
22 time lag involved between when we would get it
23 and when our meeting occurs. I mean we may --
24 we may need to operate under what we think the
25 policy is now, unless it can -- unless we can

1 find out one way or the other, we don't know.
2 We don't know.
3 Are you ready to vote on the motion then?
4 Okay, all who favor this motion signify by
5 saying aye.
6 (Affirmative responses)
7 **DR. ZIEMER:** And those who oppose, say no.
8 (No responses)
9 **DR. ZIEMER:** And any abstentions? We have one
10 abstention. The record will show that Wanda
11 abstained. The Chair has voted yea.
12 Then I declare that the motion has carried.
13 Thank you very much.
14 Yeah, Larry.
15 **MR. ELLIOTT:** I think you do need to come up
16 with whatever the cover sheet will say and give
17 that to your contractor. I -- I don't know
18 where they're at with regard to the last -- to
19 the next three site profiles. My understanding
20 was Mallinckrodt, Savannah River and Hanford
21 were very close, should be at the next meeting
22 -- is that right, February meeting, Dr. Mauro?
23 **DR. MAURO:** The only proviso is we are awaiting
24 certain documents with respect to --
25 **MR. ELLIOTT:** You're not on there, sir.

1 **DR. MAURO:** The answer to your question is yes,
2 regarding the three site profile reviews, with
3 the exception of Savannah River, which might be
4 delayed. We are currently awaiting certain
5 documents that we requested in a letter that we
6 submitted to you folks. As soon as those
7 documents come in, we will move expeditiously,
8 so it may be possible to have all three
9 reports.
10 **MR. ELLIOTT:** But the point being is at least
11 one or more are coming for the February
12 meeting.
13 **DR. MAURO:** Yes.
14 **MR. ELLIOTT:** And in order to comply with the
15 intent of your -- of your consensus here,
16 you're going to need to provide that so that
17 your contractor can put that on the cover to
18 effect the transmittal to us.
19 Let me just explain -- my reaction to the
20 Bethlehem Steel site profile, when I sent out
21 my e-mail, was that it come as a final report,
22 which it wasn't. It is final for the
23 contractor, perhaps, but it's not final as a
24 decisional document. That's why I sent you the
25 e-mail. That's why it was labeled

1 predecisional, do not disclose. I remind the
2 Board that this is -- you had a pilot process
3 here. You agreed to a process, and I think we
4 all can go back to the transcript and look and
5 see where you talked about it being a pilot, a
6 learning experience.
7 I have been dismayed by this process, actually.
8 I think it has been disjointed and I look
9 forward to working together with this Board to
10 make it a more transparent process, a more
11 informative process. But taking this motion
12 now, we're going to have to go back and Liz and
13 the general counsel team are going to have to
14 look at what can be done and what cannot be
15 done. And we're going to have to do that very
16 quickly, because we're anticipating that in
17 February you're going to want to deal with the
18 next set of site profile reviews that come
19 forward. And whether we can get anybody in the
20 Secretary's Office to respond --
21 **DR. ZIEMER:** Well, that's why I asked --
22 **MR. ELLIOTT:** -- to your -- to your motion, I'm
23 not sure --
24 **DR. ZIEMER:** -- the question because I'm not
25 sure it will be in place in time for that

1 meeting, which means that we're under the
2 present conditions.
3 **MR. ELLIOTT:** My intent here is -- I've heard
4 you out, and we want to proceed as best we can
5 here. So please come forward --
6 **DR. ZIEMER:** And we can go ahead and get the
7 language that we'll --
8 **MR. ELLIOTT:** -- yeah, come forward with the
9 language so that your contractor can put that
10 on there, and that's going to I think go a long
11 way toward putting a document out there that
12 would be construed by the public as a decision
13 of this Board. And that's what you want to
14 avoid until you have your deliberation and you
15 come to consensus, and that's what we're
16 waiting on, your consensus.
17 **DR. ZIEMER:** Thank you. Jim and then Wanda.
18 **DR. MELIUS:** Yeah, two things. One is that I
19 agree on the language and we should be ready to
20 implement this. I'm not sure where the
21 decision point is in the Department and whether
22 -- you may very well be able to reach a
23 decision at -- at some level while this is
24 going on, and maybe by the time it comes back
25 down from the Secretary it's -- the point may

1 be moot. It may have to go up through the
2 Secretary and sit there. It's hard to tell --
3 and do that. And I think we have to recognize
4 we're putting you in an awkward position of --
5 you know, if someone raises a fuss about the
6 next report, you know, you're going to have the
7 Board on record saying it -- it should be this
8 way, so hopefully it could get resolved sooner
9 rather than later, but I think we recognize the
10 frustrations with that.
11 I think it's also we may look at this process,
12 you know, a few site profiles down and maybe
13 want to change it in some way. I think this is
14 the best we can do at this point in time, and
15 we'll have to continue to look at how to best
16 work this -- this overall process.
17 **DR. ZIEMER:** Wanda?
18 **MS. MUNN:** In the interest of collegial
19 discussion and suggestion, it would be awfully
20 nice if the individuals who were very strong in
21 their concern with respect to how we approach
22 these things and worked to make sure that --
23 that the Buffalo News and various elected
24 officials saw our deliberations as being
25 inadequate, it would be very nice if those same

1 individuals now pointed out to them what
2 efforts the Board had made to bring the light
3 of day to the transparency that was so
4 desirable, and that perhaps the same kinds of -
5 - of effort could be shown in a positive light,
6 now that what we have undertaken today is in
7 fact complete.
8 **DR. ZIEMER:** Thank you very much for that
9 comment.
10 Are there any other comments? After lunch,
11 during our work session today, if we're able to
12 we may be able to work on some wording. And
13 Tony, if you want to do a straw man for us
14 between now and then, that would be great.
15 **DR. ANDRADE:** Okay.
16 **DR. ZIEMER:** Then let's recess for lunch for --
17 until 1:00 o'clock.
18 **DR. ROESSLER:** Do you have Henry's travel
19 schedule?
20 **DR. ZIEMER:** Oh --
21 **DR. ROESSLER:** He's going to leave.
22 **DR. ZIEMER:** Henry, we're -- yeah, you need to
23 make sure Cori has your availability dates when
24 we talk about...
25 (Whereupon, a lunch recess was taken from 11:45

1 a.m. to 1:05 p.m.)

2 **ADMINISTRATIVE HOUSEKEEPING**

3 **DR. ZIEMER:** We'll continue this working
4 session for this Board meeting. We have some
5 housekeeping items to take care of, the first
6 of which will be scheduling of future meetings.
7 I think many of you already know that,
8 partially as the result of non-availability of
9 room space in the Tampa area, we're not able to
10 schedule our February meeting in Tampa, as
11 originally anticipated.
12 Plan B I believe was St. Louis, and we need to
13 re-examine calendars so that we give Cori some
14 flexibility in trying to find some time there.
15 We actually are thinking about looking a little
16 later in the month for St. Louis, because if we
17 go first week of February, we're only six weeks
18 off, which really pushes some of the things
19 that are in the chair -- pipeline for us that
20 might not otherwise even be ready. But we're
21 wondering how the calendars are the second and
22 third week of February.
23 **DR. ROESSLER:** The third week is the Health
24 Physics Society meeting in New --
25 **DR. ZIEMER:** I have it down for the second.

1 **DR. ROESSLER:** I have it down for the 13th
2 through the 16th and 17th.
3 **DR. ZIEMER:** I do, too, is that the third week?
4 **DR. ROESSLER:** Well, I call it the third week.
5 **DR. ZIEMER:** Oh, okay. So when you said second
6 week is a possibility, then --
7 **MS. HOMER:** I was meaning the 7th through the
8 11th.
9 **DR. ZIEMER:** Oh, 7th through the 11th. Well,
10 let's check -- 7th through 11th, let me see
11 who's got serious conflicts 7th through the
12 11th.
13 **DR. MELIUS:** I have them at the end of the
14 week.
15 **DR. ZIEMER:** Early in the week is okay?
16 **DR. MELIUS:** Early in the week is okay.
17 **MS. HOMER:** 14th, 15th and 16th are okay?
18 **DR. MELIUS:** No, no --
19 **MS. HOMER:** I'm sorry, 7th, 8th and 9th are
20 okay.
21 **DR. MELIUS:** 7th, 8th and --
22 **DR. ZIEMER:** Others have conflicts earlier in
23 the week there? And you have Henry's calendar?
24 **MS. HOMER:** I do, but not in front of me,
25 unfortunately.

1 **MR. GRIFFON:** He's no good for February.
2 **DR. MELIUS:** He's said February's bad.
3 **DR. ZIEMER:** Regardless, so we may have to go
4 ahead without him.
5 **DR. MELIUS:** I mean I -- well, those following
6 weeks are bad for me.
7 **DR. DEHART:** The following weeks I'm out of
8 country.
9 **DR. MELIUS:** Yeah, country, and I mean I don't
10 see what we gain by moving a week.
11 **MS. HOMER:** We gain a week.
12 **DR. ZIEMER:** We gain the ability to find a
13 hotel. This just gives you some options.
14 Right?
15 **MS. HOMER:** It gives me some options, yes, and
16 it gives a little extra leeway for, you know,
17 preparation and working through the holidays.
18 **DR. MELIUS:** I mean I don't mean to cause a
19 hard time about this, but we all work our
20 calendars around these dates. I've changed a
21 whole bunch of things that would have been the
22 week of the 31st in order to keep that week
23 open for you, and now you change it and -- and
24 you change it -- you know, you changed it two
25 weeks ago it would have helped me a lot.

1 **MS. MUNN:** It is a problem.
2 **DR. MELIUS:** I mean I understand your problems.
3 I don't want to minimize those. But...
4 **MS. MUNN:** Yeah, my -- my personal issues
5 around changing this California meeting were
6 just enormous, affected every member of my
7 family.
8 **DR. ZIEMER:** Okay, you have the information.
9 **MS. HOMER:** I do.
10 **DR. ZIEMER:** We're not --
11 **MS. HOMER:** I do.
12 **DR. ZIEMER:** -- locking that date in, we're --
13 **MS. HOMER:** Okay.
14 **DR. ZIEMER:** -- simply trying to provide some
15 options in terms of --
16 **MS. HOMER:** Did we --
17 **DR. ZIEMER:** -- flexibility.
18 **MS. HOMER:** -- want to look anywhere in the
19 future?
20 **MR. ELLIOTT:** Cori, before we go there, though,
21 can we just --
22 **DR. MELIUS:** Cori --
23 **MR. ELLIOTT:** I'm sorry, Jim. Go ahead.
24 **DR. MELIUS:** I just was going to speak to Henry
25 Anderson. I know if we're going to keep it

1 that first week in February, 3rd and 4th are
2 bad for him. He's got an IOM committee meeting
3 that -- that week.
4 **DR. ZIEMER:** Right.
5 **DR. MELIUS:** Those two days. I thought he said
6 he was bad -- be bad the rest of February I
7 guess for...
8 **MS. HOMER:** Okay. So we might want to look at
9 the 31st, 1st and 2nd?
10 **DR. MELIUS:** Uh-huh.
11 **UNIDENTIFIED:** That'll work.
12 **DR. ZIEMER:** And then those other --
13 **MS. HOMER:** I was trying to avoid a Monday
14 start date for some -- I didn't think anybody
15 cared to travel on Sunday, so...
16 **DR. MELIUS:** Are we doing a three-day meeting,
17 a two-day meeting, subcommittee? I mean that's
18 also --
19 **MR. GRIFFON:** To be determined.
20 **MR. ELLIOTT:** I think we also need to discuss
21 thoughts on agenda items --
22 **DR. ZIEMER:** Agenda items.
23 **MR. ELLIOTT:** -- and let the agenda items kind
24 of drive --
25 **DR. MELIUS:** Yeah.

1 **MR. ELLIOTT:** -- how we --
2 **DR. ZIEMER:** Yeah, we can identify --
3 **MR. ELLIOTT:** -- construct the days.
4 **DR. ZIEMER:** We can identify a number of those
5 right away. We know that we have the first 20-
6 case -- the next step of that first 20 cases to
7 handle. We have -- I believe we'll have the --
8 **MS. MUNN:** The Mallinckrodt SEC.
9 **DR. MELIUS:** And Iowa.
10 **DR. ZIEMER:** -- Special Exposure Cohort --
11 **MR. ELLIOTT:** We hope to --
12 **DR. ZIEMER:** -- we may have --
13 **MR. ELLIOTT:** -- we hope to have two site
14 petitions for you -- evaluation reports for you
15 to review.
16 **DR. ZIEMER:** For evaluation. What else?
17 **MR. GRIFFON:** At this point I'm assuming that
18 that 20-case process comes back to the full
19 Board. You know, originally -- Originally it
20 was a sort of a scope item for the
21 subcommittee, but we haven't really --
22 **DR. ZIEMER:** Oh, you -- the first 20?
23 **MR. GRIFFON:** Yeah. I mean the -- if you look
24 at the items on scope for the subcommittee, one
25 of the intent was to avoid that the whole Board

1 had to be involved in rolling those -- those
2 things together and presenting -- you know, it
3 was to save -- so that everybody didn't have to
4 travel three days --
5 **DR. ZIEMER:** We can still ask that that be the
6 case.
7 **MR. GRIFFON:** Yeah.
8 **DR. MELIUS:** So if the subcommittee met on
9 either Monday --
10 **MS. HOMER:** Uh-huh.
11 **DR. MELIUS:** -- and then have a two-day Board
12 meeting.
13 **DR. ZIEMER:** We can still do that.
14 **DR. MELIUS:** Yeah.
15 **MR. ELLIOTT:** Is there enough work for the
16 subcommittee to work all day or do they need a
17 half a day? And we also need to determine
18 whether or not the subcommittee and/or the full
19 Board needs a closed session in those reviews
20 or are we going to redact those reviews and
21 you'd have an open session. You need to come
22 to grips with that.
23 So I'm sorry to lay out so many question at one
24 --
25 **MR. GRIFFON:** No, no, you're right.

1 **DR. MELIUS:** Since you've already redacted the
2 original reports -- is that my understanding?
3 Not -- not from when we looked at them, but
4 there's a redacted version out there. Is that
5 --
6 **DR. ZIEMER:** If you deal with the redacted
7 version, you will --
8 **MR. GRIFFON:** Of the individual case reviews.
9 **DR. ZIEMER:** -- have much more limited
10 information on individual cases. One of the
11 issues will be --
12 **MS. MUNN:** You won't know what you're looking
13 at.
14 **DR. ZIEMER:** -- at this point, having reviewed
15 them individually and then looking -- looked at
16 their kind of the first wrap-up, do you still
17 need the individual cases or can you deal with
18 the wrap-up plus having redacted information as
19 reference material?
20 **DR. MELIUS:** Can I ask procedurally a --
21 whoever can answer this is -- I presume you
22 could have a -- say a subcommittee meeting that
23 would be partially open and reserve an hour or
24 two closed again?
25 **MR. ELLIOTT:** Yes, we could do that. We could

1 -- we can do that, yes.

2 **DR. MELIUS:** So that you'd leave --

3 **MR. ELLIOTT:** You can have an open session, and

4 then you have a closed session.

5 **DR. MELIUS:** So if there were issues from the

6 summary reports that people felt it was

7 necessary to refer to the individual case

8 reports --

9 **MR. GRIFFON:** We could go into closed after and

10 --

11 **DR. MELIUS:** Go into closed --

12 **MR. GRIFFON:** -- we could table them for the

13 time and go into closed.

14 **DR. MELIUS:** Yeah.

15 **MR. GRIFFON:** Yeah, I think that makes --

16 **MR. ELLIOTT:** Yes, you could do that.

17 **DR. MELIUS:** And that would avoid the re--

18 having to redact everything -- prepare a

19 redacted version.

20 **MR. ELLIOTT:** The only difficulty would be that

21 when we go forward for a determination to close

22 for a closed session, we have to put in when

23 the time is, and we can't change that time --

24 **DR. MELIUS:** Yeah. No, you're --

25 **MR. ELLIOTT:** -- once we get the approval.

1 You're locked into that time. And if you don't
2 need it, that's okay, you don't have to use it.
3 **DR. MELIUS:** Yeah.
4 **DR. ZIEMER:** Okay. I'm thinking half a day
5 would be enough, but that's intuitive.
6 **MR. GRIFFON:** I -- I think we need a -- I -- I
7 would say a full day and leave the aft-- leave
8 like 2:00 to 4:00 for the closed session, but
9 have the regular open meeting start in the
10 morning, 9:00 o'clock or whatever.
11 **DR. ZIEMER:** You're thinking you would look at
12 individual cases after you looked at the wrap-
13 up?
14 **MR. GRIFFON:** No, I'm thinking that we can do
15 it without looking at individual, but we leave
16 that --
17 **DR. ZIEMER:** But if you're unable to --
18 **MR. GRIFFON:** We reserve that --
19 **DR. ZIEMER:** -- we'd go to closed?
20 **MR. GRIFFON:** -- yeah. I mean I guess you
21 could --
22 **DR. ZIEMER:** But then you're -- then you can't
23 really tie things up, can you? Unless you go
24 closed/open -- open/closed -- closed --
25 open/closed/open.

1 **MR. GRIFFON:** I mean we have -- we have
2 redacted versions of these reports anyway --
3 **DR. ZIEMER:** Right.
4 **MR. GRIFFON:** -- so I don't know why we can't
5 just deal with that.
6 **MS. HOMOKI-TITUS:** If you guys are going to
7 have a closed session, we have to know about it
8 because it has to be properly announced in the
9 *Federal Register* --
10 **DR. ZIEMER:** Right.
11 **MR. GRIFFON:** We understand that.
12 **MS. HOMOKI-TITUS:** -- and we have to do the
13 determination to close and the holidays are
14 coming up and there's a lot of work to be done,
15 so you guys are going to have to decide now or
16 you don't get to have a closed session.
17 **DR. MELIUS:** Well, we don't even have a date
18 yet, so this makes it even more complicated.
19 **MR. GRIFFON:** I mean I would argue that we have
20 all these cases redacted. We have redacted
21 versions available. Right? For these first 20
22 cases?
23 **DR. ZIEMER:** They can be made available --
24 **MR. GRIFFON:** No, they -- they are. I mean
25 they're ready, they're done, they went through

1 the process, so we can --
2 **DR. MELIUS:** I thought you had --
3 **MS. HOMOKI-TITUS:** We would have -- you have to
4 -- is this on?
5 We have to finish up the redactions on the
6 documents that SC&A gave us yesterday that we
7 hadn't seen before, but the first report I
8 think we have done.
9 **MR. GRIFFON:** So -- so I would -- I would say
10 let's just force ourselves to use that and --
11 and --
12 **DR. ZIEMER:** You're suggesting we schedule a
13 day?
14 **MR. GRIFFON:** Open.
15 **DR. ZIEMER:** With some closed time?
16 **MR. GRIFFON:** Well, forget the closed time if
17 we have --
18 **DR. MELIUS:** I would leave some closed time at
19 the end of the day -- I think...
20 **MS. MUNN:** But --
21 **DR. ZIEMER:** Are --
22 **MS. MUNN:** -- using fully-redacted cases really
23 reduces the amount of information you can get.
24 **DR. MELIUS:** Yeah.
25 **MS. MUNN:** It really does. It's not just a

1 matter of taking out --
2 **DR. ZIEMER:** You're going to lose the job --
3 job title information.
4 **DR. DEHART:** You'd lose time of employment.
5 **MS. MUNN:** Yeah, time of employment and --
6 **MR. ELLIOTT:** It depends upon the case. You
7 may lose job title, you may lose -- there's
8 various information that you could lose, which
9 the Privacy Act officer could deem -- if it was
10 still in the report -- could be used to breach
11 the confidence, so...
12 **DR. MELIUS:** Can I -- can I recommend that one
13 thing the subcommittee might look at is -- is
14 schedule a closed session and that the
15 subcommittee do the comparison and -- and with
16 both the open and -- the redacted and the non-
17 redacted in the closed session so that you can
18 -- we can make a determination how to do this
19 in the future. 'Cause I mean this is a --
20 **MR. GRIFFON:** Yeah.
21 **DR. MELIUS:** -- it's a lot of work for NIOSH to
22 redact, and it causes obviously problems -- you
23 want to be open in terms of the committee, but
24 I mean it's just -- but I think we really -- if
25 we'd take a real look at, see how we could

1 operate with and without, I think it might be
2 helpful.
3 **MS. MUNN:** Well, yeah, if your decision isn't
4 going to be a scientific one anyway, then...
5 **MS. HOMOKI-TITUS:** So does that mean you want a
6 closed subcommittee meeting, but not a closed
7 meeting for the Board? Well, you guys just
8 need to --
9 **DR. ZIEMER:** No, we're still -- we haven't
10 decided yet.
11 **DR. MELIUS:** So I guess it would be an open
12 subcommittee, leaving an hour or two at the end
13 of the day closed, I think would...
14 **DR. ZIEMER:** I'm still having a little trouble
15 seeing why you would put the closed part at the
16 end. It seems to me you'd want to be looking
17 at the --
18 **DR. MELIUS:** Either way, it doesn't --
19 **DR. ZIEMER:** -- at the front end of the
20 process, discuss whatever issues you had with
21 the individual cases, and then go out and talk
22 about the rest.
23 **DR. MELIUS:** Yeah, that makes sense.
24 **MR. GRIFFON:** All right, why don't you do it
25 that way -- but I'd say do the morning closed -

1 -

2 **DR. ZIEMER:** And you could -- you could also at
3 that point examine whether or not -- what you
4 would have to work with in the open session.

5 **DR. MELIUS:** Right.

6 **MR. ELLIOTT:** Let me propose this, see what
7 your thoughts would be. We start at 9:00 on
8 the first day with an open session that would -
9 - for the subcommittee and whoever wants to
10 show up for that. It could be the entire
11 Board, if they wish, or it can be -- as long as
12 we have a quorum for the subcommittee, and you
13 take care of the minutes from this meeting for
14 that subcommittee, which will be very short --

15 **MR. GRIFFON:** Right.

16 **MR. ELLIOTT:** -- so we maybe have -- have the
17 open session only open for a half an hour or an
18 hour. Then you'd go into closed session, say
19 10:00 o'clock to noon. You come out of that
20 and you have an open session for the remainder
21 of the afternoon.

22 **MR. GRIFFON:** That sounds fine.

23 **MR. ELLIOTT:** Okay? Does that work for
24 everybody or does that seem palatable?

25 **MR. GRIFFON:** That's perfect.

1 **DR. ZIEMER:** Seems to be consensus. This would
2 involve the individuals that were sort of on
3 that original subset -- I'm trying to remember
4 who they were, I think five individuals. You
5 remember who you were?
6 **MR. ELLIOTT:** It could be anybody that shows
7 up.
8 **DR. ZIEMER:** Everyone else could show up. But
9 as a minimum, those individuals would have to
10 be there. Who -- who was in that group? I
11 was, Mike was, Tony, Mark --
12 **MS. HOMER:** Dr. Anderson.
13 **DR. MELIUS:** Henry.
14 **DR. ZIEMER:** -- and Henry.
15 **UNIDENTIFIED:** And Wanda?
16 **DR. ZIEMER:** Or Wanda, were you in that group?
17 **MS. MUNN:** I'm not sure which subcommittee
18 we're talking about. I'm not that much of a
19 politician, you've lost me. I don't know where
20 I am.
21 **DR. ZIEMER:** We can look it up, I think it was
22 Henry.
23 **MR. GRIFFON:** Henry --
24 **DR. MELIUS:** I know it was Henry.
25 **MR. ELLIOTT:** Yeah, Henry was in there.

1 **DR. ZIEMER:** Rich?
2 **MR. ESPINOSA:** I believe it's just a minimum of
3 five, that you don't have to have the same
4 members.
5 **DR. ZIEMER:** No, you don't have to, right. But
6 as a starting point, we -- we had that
7 particular group because it had some broader
8 representation, which we wanted.
9 Okay. So we're looking then at one day that
10 would involved the subcommittee, two more days
11 for the rest of the items -- those items to
12 include Board action then on that final
13 document on those first 20. Presumably that
14 group might also be looking at some things on
15 the second 20 during that first day. If SC&A
16 has the second 20 available, they would have
17 those possibly to deal with, as well.
18 **MR. ELLIOTT:** Is that possible? I don't know
19 if Dr. Mauro's here.
20 **DR. ZIEMER:** We don't know for sure 'cause
21 that's coming up in less than two months.
22 **DR. BEHLING:** Dr. Mauro's not here so I'm going
23 to have to speak in his behalf, and I guess one
24 of the key factors here is the time. And I
25 guess we have not yet decided firmly on a date

1 for this next meeting, or have we?
2 **DR. ZIEMER:** It's -- at the earliest, it's the
3 first week of February. It could be the first
4 week of February, which might be a problem, or
5 the second week.
6 **DR. BEHLING:** That will certainly be a real
7 pressure cooker for us --
8 **DR. ZIEMER:** Yeah.
9 **DR. BEHLING:** -- to get both the first and the
10 second set of --
11 **DR. ZIEMER:** Right, 'cause you're going to be
12 working on this first --
13 **DR. BEHLING:** Yes.
14 **DR. ZIEMER:** -- set. So perhaps the likelihood
15 of the second 20 is not so great then.
16 **MR. ELLIOTT:** I agree, Dr. Behling --
17 **DR. BEHLING:** I would certainly put that on
18 hold.
19 **MR. ELLIOTT:** I agree with you, I think it
20 would be unlikely. But just so everybody
21 knows, we will get the 20 cases to you and --
22 and --
23 **DR. ZIEMER:** You can be on your way with them.
24 **MR. ELLIOTT:** -- as we did, in CD's and to the
25 Board members as soon as we're back in the

1 office. Those will be out the first of next
2 week, I hope. We'll work towards that.
3 **DR. BEHLING:** And could I ask for some
4 clarification? In the event that you're going
5 to be asking for the second set of 20's, would
6 you also want to have a preliminary draft
7 report of those 20's that we can advance for
8 you to review, which would certainly add
9 another dimension to the limited time that's
10 available.
11 **DR. DEHART:** Plus the conference call.
12 **DR. MELIUS:** Plus the conference call.
13 **DR. ZIEMER:** Yeah --
14 **MR. GRIFFON:** I don't think it's doable.
15 **DR. ZIEMER:** -- it looks like it's going to be
16 unlikely. The answer's yes, we would want all
17 those intermediate steps, yeah.
18 **DR. BEHLING:** Okay.
19 **DR. ZIEMER:** Okay, so the focus is going to be
20 on those first 20. On the agenda for the
21 general meeting would also be the Mallinckrodt
22 Special Exposure Cohort petition. We would
23 have -- we'd -- we'd have some more things on
24 the Bethlehem Steel site profile to follow up
25 on. What else?

1 **DR. MELIUS:** I would ask that we have the
2 Mallinckrodt site profile review on the agenda,
3 and that we have it on the agenda prior to
4 discussing the SEC issue, 'cause I think doing
5 it the other way's going --
6 **DR. ZIEMER:** Right, right.
7 **DR. MELIUS:** -- to be difficult. Larry, are we
8 going to get our diskettes under our Christmas
9 tree?
10 **DR. ZIEMER:** We have a number of our regular
11 reports, as well.
12 **MR. ELLIOTT:** Remember -- again, I'd ask Dr.
13 Behling to help us out here, but I think
14 there's a deliverable on task two -- or the
15 procedure reviews. That should be ready by the
16 February meeting, you think?
17 **DR. BEHLING:** I think task three is ready, and
18 if we can schedule that for the next meeting,
19 we'll be prepared to provide you with a draft
20 report. And again, I would ask your guidance
21 as to how soon you want a draft copy made
22 available both to NIOSH or to you, or both, so
23 that you'd have a chance to review them prior
24 to the meeting.
25 **DR. ZIEMER:** Well, I think on a procedure

1 review, probably a week before the meeting
2 would be adequate. I think that's -- my take
3 on it. Anyone else? It seems to be -- a week
4 before the meeting is a final, drop-dead -- or
5 earlier.
6 **DR. BEHLING:** Okay.
7 **DR. ZIEMER:** Thank you. Were there other items
8 that we should consider on that agenda, Gen?
9 **DR. ROESSLER:** We often have an update on some
10 scientific issue, and I think in view of our
11 past discussions we might want to have somebody
12 talk to us about ICRP-30 and 68 and 66 and
13 whatever it -- I don't remember the exact
14 titles, but I think in order -- if we're going
15 to have to make a recommendation -- prefer to
16 make a recommendation to NIOSH about which
17 models they use as a result of the Bethlehem
18 Steel profile, I think we need an update on --
19 ourselves on the two models that are under
20 discussion.
21 **DR. ZIEMER:** Let's ask Jim if that's something
22 that...
23 **DR. NETON:** I'm a little confused as to what
24 the discussion topic is, the use of ICRP-30
25 versus ICRP-66?

1 **DR. ROESSLER:** It's 68, I think.
2 **DR. NETON:** 68 -- in relation to what issue?
3 That was not brought up in the Bethlehem Steel
4 review. There was an ICRP-74 -- 75 issue,
5 which had to do with air sampling.
6 **DR. ROESSLER:** Okay.
7 **DR. NETON:** I think you might be thinking --
8 **MR. GRIFFON:** It came up in Savannah River.
9 **DR. NETON:** The Savannah River high five
10 approach --
11 **DR. ROESSLER:** Yes, yes.
12 **DR. NETON:** -- and that was not so much a
13 debate about the use of the models, but the
14 fact that we would -- we relied on data that
15 were analyzed using ICRP-30 when we committed
16 to using 66.
17 **DR. ROESSLER:** 66?
18 **DR. NETON:** Right, the lung model. It has to
19 do with the lung model, class S solubility
20 versus class Y and that sort of thing, and we
21 believe that we made an appropriate adjustment
22 and that would be a topic of discussion for the
23 next --
24 **DR. ROESSLER:** So we don't have to have an
25 update on --

1 **DR. NETON:** I don't think there's an issue
2 there that is beyond that, which is did we
3 properly use -- was it appropriate that we used
4 ICRP-30-derived values when we committed in our
5 rule that we'd use ICRP-66.
6 **DR. ROESSLER:** Yeah, okay.
7 **DR. MELIUS:** And -- and can I just weigh in on
8 that? I think when the Savannah River Site
9 profile review is complete may be the time to
10 make a determination, do we delve into that
11 further or not to --
12 **DR. NETON:** I don't think that that's covered
13 in the Savannah River profile.
14 **DR. MELIUS:** Okay.
15 **DR. NETON:** This is sort of one of those side
16 Technical Information Bulletins. It may
17 actually be covered in Hans's procedure review.
18 Is that one of the procedures?
19 **DR. BEHLING:** No, the -- the procedure review
20 is not covering the site profiles. It's
21 strictly the 30 procedures that were identified
22 to us by -- by NIOSH. So the issue that is
23 under discussion from Dr. Roessler with regard
24 to this ICRP-30 versus 66 will probably be
25 addressed in the review of the Savannah River

1 Site profile.
2 **DR. NETON:** It's not in the profile, though.
3 **DR. BEHLING:** Well, it makes indirect
4 reference.
5 **DR. NETON:** Okay. If not then, I think it will
6 certainly be covered in the review of the first
7 20 procedures -- dose reconstructions, because
8 it was raised in two or three of them --
9 **DR. ZIEMER:** Right.
10 **DR. NETON:** -- and we prepared a slight draft
11 response for your -- your information, but
12 we'll be prepared to talk about it in much more
13 detail at the next meeting.
14 **DR. ZIEMER:** Okay.
15 **MR. GRIFFON:** And I think a more useful -- or
16 maybe not more useful, but something that the
17 Board had talked about before was -- was
18 training in Cincinnati to go -- and I -- I was
19 talking to Gen earlier about this. I thought,
20 you know, if people were briefed on IMBA and --
21 and also at the same time brought through that
22 SRS spreadsheet that I have that -- that is not
23 completely user-friendly. I mean I've waded my
24 way through it, and then there's another one
25 for the 28 radionuclides, I think it's called a

1 max dose calculation spreadsheet or whatever.
2 Those both are where you get your intake
3 numbers to put into IMBA, and the how IMBA
4 works, and that sort of ties into the ICRP
5 models and, you know, you could -- that would
6 be a good -- I think a good way, just so
7 everybody's up to speed on what's going on with
8 the --
9 **MR. ELLIOTT:** So let me be clear. Are you
10 asking for kind of a walk-through of IMBA --
11 **MR. GRIFFON:** Right, but not -- not --
12 **MR. ELLIOTT:** -- for the Board in front of --
13 **MR. GRIFFON:** -- in the Board meeting.
14 **MR. ELLIOTT:** -- with the public --
15 **MR. GRIFFON:** I don't know that --
16 **MR. ELLIOTT:** -- at another Board meeting?
17 **MR. GRIFFON:** -- it needs to be at a Board
18 meeting. I thought we'd talked about training
19 in Cincinnati where we could go --
20 **DR. ZIEMER:** Wasn't that more on an individual
21 or --
22 **MR. GRIFFON:** Yeah.
23 **DR. ZIEMER:** -- small group basis for those --
24 **MR. GRIFFON:** Right.
25 **DR. ZIEMER:** Not -- not everybody on this Board

1 is going to be interested in running IMBA, is
2 my impression from talking to some.
3 **MS. MUNN:** I tried and failed.
4 **DR. ZIEMER:** Well, but -- but can't that be
5 arranged on an individual basis?
6 **MR. ELLIOTT:** It can -- it certainly can be
7 arranged on an individual basis. We welcome
8 any of the Board members to our offices at any
9 point in time and we'll, you know, give you
10 whatever training or access you need.
11 **DR. DEHART:** It can be done by phone with --
12 with computer --
13 **DR. ZIEMER:** Right.
14 **DR. DEHART:** -- back and forth. That's the way
15 I -- I worked it.
16 **MR. ELLIOTT:** It could be done that way.
17 **MR. GRIFFON:** I mean I'm not saying at a Board
18 meeting. I'm saying -- yeah, on small groups
19 or individually based on --
20 **MR. ELLIOTT:** Sure.
21 **MR. GRIFFON:** -- however, but I think -- you
22 know, there's -- it -- it sort of helps to
23 translate some of the summary reports, 'cause
24 you say 28 nuclides, assuming worst case, and
25 it refers to the Technical Basis Document, but

1 the spreadsheet's not part of that document.
2 You've got to go -- you've got to get the
3 spreadsheet and look at the -- you know. I
4 don't know, I found it useful to wade through.
5 Others might not want to.
6 **DR. MELIUS:** Just to follow up on Gen's
7 suggestion, though, I think it -- that type of
8 a session where we'd bring somebody in for a
9 briefing and so forth on particular technical
10 issues, maybe a way we want to follow up and
11 try to resolve some of the issues that were
12 raised, for example, in the Bethlehem site
13 profile, so bringing in someone to talk about
14 ICPR-75 (sic) or this -- the triangular
15 distribution issue and so forth may be a way we
16 can think about resolving it. I don't think
17 it's ready for the next meeting, but at some
18 point after that.
19 **DR. ZIEMER:** Well, there may be issues that
20 that would be helpful.
21 **DR. MELIUS:** Exactly, and those may not be the
22 ones.
23 **DR. ZIEMER:** Let's go back and see if we've
24 identified all the main -- aside from the
25 regular reporting things, are there other

1 issues for this next meeting that --
2 **MR. ELLIOTT:** I think I heard yesterday Dr.
3 Mel-- or maybe it was today Dr. Melius
4 suggested that -- and I believe you brought
5 this up before at the last meeting that you
6 wanted to hear more about our modifications to
7 site profiles and what's the status.
8 **DR. ZIEMER:** Or the schedule for --
9 **DR. MELIUS:** Your process for and schedule --
10 sort of discussion of that, yeah, on how site
11 profiles are to be modified and what's the best
12 process for doing that.
13 **DR. ZIEMER:** And Roy?
14 **DR. DEHART:** We've talked around the issue of
15 inadequate budget for continuing audit. Is
16 this a time to begin to address that or try to
17 find out whether we're going to have to go
18 forward and recommend that additional --
19 **DR. ZIEMER:** Well, I think Lew told us that at
20 the next meeting he would have additional
21 information on when and what needs to be done
22 on those audit -- or budget issues, and so I
23 assume that Lew will follow up, or David will,
24 and we'll have some -- and that certainly ought
25 to be on the agenda.

1 **MR. ELLIOTT:** Yes, I -- I don't know that it'll
2 be a standing item on the agenda, but I
3 certainly think that next meeting you'll have
4 an agenda item that talks about the task orders
5 and the status of the task orders and the costs
6 associated with those.
7 **DR. ZIEMER:** And remember, Dr. Wade is going to
8 be working with the folks from SC&A to look at
9 the incremental budget changes associated with
10 these additional tasks -- they're sort of sub-
11 tasks that the Board has placed upon our
12 contractor in lieu of -- or in light of the
13 handling of the first 20 cases and so on, as
14 well as the -- the site profile review, so
15 there are some additional costs. And Lew is
16 going to work with them on that and he will be
17 reporting back, as well.
18 Okay. And Jim?
19 **DR. MELIUS:** No, I actually don't have
20 anything.
21 **MR. ELLIOTT:** Cori, could I ask you when you
22 think you're going to have a final
23 determination on which week is going to work
24 best for the hotel?
25 **MS. HOMER:** I hope to have that today.

1 **DR. ZIEMER:** So we'll --
2 **MR. ELLIOTT:** That'd be great.
3 **DR. ZIEMER:** -- know very soon then.
4 **MS. HOMER:** Uh-huh.
5 **DR. ZIEMER:** Okay. Now what I'd like to do
6 today, if we can do this, is identify dates for
7 the whole year.
8 **MR. ESPINOSA:** There's not much year left.
9 **DR. ZIEMER:** Well, yeah, we're going to run
10 out. We can identify dates for this year,
11 can't we? There's the 15th, the 16th.
12 I'm wondering if the Board would like to do
13 time set-asides now at the front end of things
14 so we don't get into this situation of having
15 to rearrange calendars on down.
16 **MS. MUNN:** Yes.
17 **MR. ELLIOTT:** I asked -- I asked Dr. Ziemer if
18 he would bring this to the Board, because we
19 think -- from our perspective -- it makes a lot
20 of sense to schedule -- have a schedule, a set
21 schedule for your meetings so that we can plan
22 our work to deliver our work in that schedule.
23 And the way we've been functioning up to this
24 point is look at everybody's calendars, figure
25 out when we can meet and get it -- get it done.

1 If we have a set schedule, I think it's going
2 to aid us in getting our work planned better
3 and getting it in front of you.
4 **DR. MELIUS:** Well, my only caution is if we get
5 too far ahead, try to -- just -- we don't know
6 when certain meetings take place now, so we try
7 to do next April or something -- not -- April
8 2006, that's too far into --
9 **DR. ZIEMER:** I'm talking about 2005.
10 **MR. ELLIOTT:** One year. One year.
11 **DR. ZIEMER:** The next handful of meetings,
12 number one. Number two, and do it with the
13 recognition that there may be situations,
14 particularly on the Special Exposure Cohorts,
15 where we have to have a, quote, emergency
16 meeting, a one-day meeting, perhaps going to a
17 location where the petition comes from, and
18 addressing that as a single item on a -- on a -
19 - like a one-day meeting. 'Cause that -- that
20 could happen anyway, and we'd have to allow for
21 that.
22 Let's see -- Tony?
23 **DR. ANDRADE:** Yeah. I was going to say that
24 actually I was prepared, but I didn't bring my
25 calendar along. I know more or less when my

1 other professional society meetings are and so
2 on for pretty much the rest of the year, but if
3 you could hold off until next meeting, I think
4 maybe it'll give everybody a chance to prepare
5 for such a thing. I don't think that we can do
6 it right now, not today.
7 **DR. ZIEMER:** At least your day, you'd rather we
8 didn't.
9 **DR. ANDRADE:** Not me.
10 **DR. ZIEMER:** Okay. Rich --
11 **MR. ELLIOTT:** Are you amenable to this concept,
12 though?
13 (Multiple affirmative responses)
14 **MR. ELLIOTT:** So -- so if we do that, could you
15 send your availability to Cori --
16 **MS. MUNN:** Yes.
17 **MR. ELLIOTT:** -- so that we could lock it in on
18 -- let's say a quarterly basis?
19 **DR. ZIEMER:** Come back at our meeting and
20 identify those slots that appear to be good
21 ones?
22 **MR. ELLIOTT:** We could use your availability to
23 identify --
24 **DR. ZIEMER:** For the whole year.
25 **MR. ELLIOTT:** -- which weeks the majority of

1 the Board, if not everybody on the Board, is
2 available, and then come to you in February and
3 say here's the weeks we've got planned for
4 February, May -- or February's taken care of,
5 so we're talking May, August and...
6 **DR. MELIUS:** I don't think we need to wait to
7 February, though. I think we can do this by e-
8 mail --
9 **MR. ELLIOTT:** Yeah, that's what I'm saying.
10 **DR. MELIUS:** -- and do some and then go back
11 and forth, and if we respond to -- reply to
12 everybody, then everybody can sort of -- we can
13 sort of work out some things.
14 **DR. ZIEMER:** Cori can work that out with us.
15 **DR. MELIUS:** 'Cause there may be some that --
16 that --
17 **DR. ZIEMER:** Additional --
18 **DR. MELIUS:** -- Dr. Ziemer's going to have to
19 make the call on.
20 **DR. ZIEMER:** Right. Additional guidance,
21 though. How many times a year -- I said to
22 Larry I'd sort of like to see us do four times
23 a year, and then have some space for those
24 special meetings if we need to. I don't know
25 from a staff point of view -- they may prefer,

1 for example, six times a year, like every two
2 months. Because as we move forward, we're
3 going to be now in a position where we're going
4 to be looking at some very specific things --
5 the dose reconstruction reviews, the site
6 profile reviews and the Special Exposure Cohort
7 reviews. Those are going to be the driving
8 items before us, and that's going to be a
9 fairly regular thing now.
10 I don't have a good feel for it. I'm -- I'm
11 looking -- you know, I'm saying would four
12 meetings of three days each be better or --
13 three days in a row is a pretty rugged
14 schedule, actually. Or is six meetings of two
15 days each better? But even on the two-day
16 meetings, we end up with at least part of the
17 group maybe having to do three days because of
18 the preliminary reviews of the dose
19 reconstruction reviews, and that's -- so a
20 little feedback, what's your feeling on
21 frequency? 'Cause we need to say to Cori, find
22 four slots or six slots or something like that.
23 **DR. MELIUS:** Well, my view is that -- I think
24 four three-day meetings may be workable. I
25 think we have to have a real functioning

1 subcommittee, though, that could meet in
2 between. And we're going to have to be willing
3 to vest that subcommittee with some real powers
4 to make some decisions on our behalf, to the
5 extent that they're allowed to, in between --
6 at least to keep some of the processes moving
7 and -- particularly with our contractor and so
8 forth.
9 Secondly, that there has to be -- we can't wait
10 until a meeting takes place, say in -- February
11 1st and then say well, our next emergency
12 meeting or in-between meeting -- one-day
13 meeting's going to be, you know, February 21st
14 or something. I mean sched-- trying to
15 schedule something, at least for me, and I know
16 for Henry and some of the other people have --
17 with like three or four weeks notice -- is
18 impossible. Now if we do it -- you know, set a
19 date aside in between, or a couple dates aside
20 for --
21 **DR. ZIEMER:** Identify emergency dates is what
22 you're saying.
23 **DR. MELIUS:** Emergency dates, I think that
24 would be -- be helpful, recognizing that we may
25 or may not use them, but at least we'd have

1 them on the calendar and we'd know that they
2 were available. And albeit there may be --
3 because of our contract, because of this SEC
4 process, we may have to try to schedule
5 something in between without a lot of notice.
6 But to the extent we can avoid that, I think
7 we're better off.
8 **DR. ZIEMER:** Other input? Yeah, Roy?
9 **DR. DEHART:** I would suggest that we look at
10 the three-day meeting four times a year. That
11 -- if we did it six times, actually it's going
12 to take more time out of the office because it
13 -- we have to travel. We're killing two days -
14 - at least in my case -- almost every meeting
15 we have, the beginning and at the end, for
16 travel. So instead of two days, it become four
17 days out of the office, versus five days if we
18 have a three-day meeting.
19 **MR. ELLIOTT:** So as you send your availability
20 in to Cori, please look -- I think, if you
21 would, at -- like we're going to -- we've got
22 February set aside, but look at -- target May,
23 target August, target November, and then look
24 at the months between each and say here's a
25 couple days where we could -- I could be

1 available for emergency meeting or a special
2 meeting. Does that seem reasonable?
3 **MR. ESPINOSA:** Say those --
4 **DR. ZIEMER:** February, May, August, November,
5 and --
6 **MR. ELLIOTT:** Quite frankly, meeting in
7 December --
8 **DR. ZIEMER:** -- I think we need to avoid --
9 **MR. ELLIOTT:** -- is just not good for us --
10 **DR. ZIEMER:** -- December.
11 **MR. ELLIOTT:** -- in the government.
12 **DR. ZIEMER:** I don't think it's good for most
13 people.
14 **MR. ELLIOTT:** There's too many people with --
15 **DR. ZIEMER:** You have folks trying to burn up -
16 -
17 **MR. ELLIOTT:** We've got folks trying to burn up
18 leave that they're going to lose, and it's so
19 hectic with the holiday season, December is not
20 a good month for us.
21 **DR. ZIEMER:** Okay. Is that agreeable then? We
22 need to -- Cori, you want that information
23 ASAP. Right?
24 **MS. HOMER:** Absolutely. Do we want to discuss
25 locations or is that up for discussion at a

1 later time?

2 **DR. ZIEMER:** The key point here is to -- is to

3 get the calendar --

4 **MS. HOMER:** Dates, uh-huh.

5 **DR. ZIEMER:** -- reserved. We're focusing on

6 St. Louis for the February meeting.

7 **MS. HOMER:** Yes.

8 **DR. ZIEMER:** You want to -- you want to try to

9 identify location for the one following that?

10 **MS. HOMER:** I don't know that that's possible.

11 I guess OCAS will have to tell us what the...

12 **MR. ELLIOTT:** I think it's enough for us to

13 know that this Board wants to meet in the

14 general vicinity of the sites that we have

15 claims at. Is that -- that's true. Right?

16 That's your --

17 **DR. ZIEMER:** Right.

18 **MR. ELLIOTT:** -- consensus.

19 **DR. MELIUS:** And the second point is, we would

20 like to be near SEC sites at the time we're --

21 **DR. ZIEMER:** Right.

22 **MR. ELLIOTT:** Understood. Understood,

23 recognizing full well that we may be dealing

24 with multiple SEC petitions and we can't visit

25 everybody's site in that one meeting.

1 **DR. ZIEMER:** We might pick one of them.
2 **MR. ELLIOTT:** We can pick one of them. That's
3 why we're looking at St. Louis for Iowa and
4 Mallinckrodt, but yes, we understand that, too.
5 So if -- if that's a general understanding that
6 we have, could you allow us then to look at the
7 work load in this context and see where those
8 things are going to come to fruition and then
9 strategically plan the meeting in that -- in
10 those --
11 **DR. ZIEMER:** Any objection --
12 **MR. ELLIOTT:** -- locations that --
13 **DR. ZIEMER:** -- to doing that?
14 **MR. ELLIOTT:** -- that merit that meeting?
15 **DR. ZIEMER:** I don't think there's any
16 objection. Let's do that.
17 **MS. HOMER:** Okay.
18 **MR. ELLIOTT:** We've heard you mention a number
19 of sites -- Tampa being one that we weren't
20 able to go to. But we'll work with that, if
21 that's -- if that's okay with the Board.
22 **DR. ZIEMER:** Okay?
23 **MS. HOMER:** Okay.
24 **DR. ZIEMER:** You have enough at this point on
25 that issue now?

1 **MS. HOMER:** On that issue, yes.
2 **DR. ZIEMER:** So please get your calendars --
3 information in.
4 **MR. ESPINOSA:** Just -- with that issue alone,
5 you know, depending on where we travel to, also
6 kind of makes the -- my calendar go back and
7 forth 'cause there's some -- there's some
8 places that I can fly back the day of the
9 meeting and other places that I can't.
10 **DR. ZIEMER:** Yeah, this is true of many of us,
11 I think. I know it's true of Wanda.
12 **MS. MUNN:** Always, no matter where you decide.
13 **DR. ZIEMER:** Always, yeah. Thank you. Okay.
14 Other housekeeping things?
15 **MS. HOMER:** Other housekeeping items. Please
16 write down your prep time, work group time,
17 subcommittee time and divide your prep time --
18 or identify your prep time as closely as
19 possible to what you spent it on, work group,
20 subcommittee, et cetera, and provide that to
21 Larry so he can initial it. I want to be able
22 to submit your salary requests this week, if at
23 all possible.
24 I've already recorded your Board and
25 subcommittee time, so the prep time and work

1 group time is really all I need.
2 And also --
3 **DR. DEHART:** Could we have some blank paper?
4 There's no pads on the table.
5 **MS. HOMER:** They're on the corner. Sorry about
6 that.
7 **MR. ELLIOTT:** You can give them to me on paper
8 now, or you can e-mail them to me --
9 **DR. ZIEMER:** Either way.
10 **MR. ELLIOTT:** -- at your convenience.
11 **DR. ZIEMER:** Get them in, though.
12 **MS. HOMER:** I'd prefer -- yeah, I need to have
13 them by Friday -- Friday morning.
14 I've provided you with your earnings
15 statements, and I want you to check your
16 address on the bottom of your earnings
17 statements. The human resources office has
18 asked for address updates. If that is not
19 where you want your W-2 to be mailed, fill out
20 that home -- change of home address record form
21 I've provided in your binder and just give that
22 to me before we leave today. I want to make
23 sure that you get your W-2s to the correct
24 address.
25 The annual report to GSA is scheduled to be

1 approved by GSA and released this week. I
2 don't know for sure that it will be 'cause I
3 haven't spoken to committee management about
4 it, but as soon as I receive it I will forward
5 it to you.
6 If you have your CDs from IMBA and the analysis
7 records, please provide those to me.
8 **MR. ELLIOTT:** We need to know who's given up
9 their CDs 'cause we --
10 **MS. HOMER:** Yes.
11 **MR. ELLIOTT:** -- have to check this off, so...
12 **MS. HOMER:** I have to provide those to -- I
13 believe Paula Coker*.
14 And for those of you that did not attend the
15 INEEL tour last August, we were -- it was an
16 interesting tour, for one. But the -- we were
17 watching an SL-1 accident tape, I believe it
18 was. We didn't get to finish it, so they
19 provided us with a copy. If you want to check
20 that out, let me know and I will be more than
21 happy to send that to you on loan.
22 **DR. ZIEMER:** What format is that in?
23 **MS. HOMER:** VHS.
24 **MR. ELLIOTT:** VHS.
25 **DR. ZIEMER:** VHS? Okay.

1 **MS. HOMER:** I guess that's about it.
2 **MR. ELLIOTT:** We are -- as many of you know, we
3 are going through the annual disclosure of
4 conflict and conflict waiver generation. Many
5 of you have been working through this with us.
6 If you haven't, that's because your anniversary
7 hasn't happened yet, but it will shortly
8 happen, I'm sure, so we're -- just to let you
9 know, we're working on that. So if you -- if
10 there's any -- if there's any difficulties in
11 that process, let us know because we seem to
12 have a number of these floating -- they -- they
13 route all around through CDC and the
14 Department, and so we're trying to do our best
15 to keep track of these, but if you don't get
16 your waiver letter as soon as you think you
17 should, let us know. Just drop us an e-mail.
18 **MS. HOMER:** Please let me know as soon as
19 possible. I've been working with committee
20 management to make sure that everything is on
21 time and to where it should be.
22 **MR. ELLIOTT:** These become very important now
23 that you are engaged in reviewing individual
24 dose reconstructions and SEC petitions, as you
25 know. That's what your waivers speak to, so we

1 want to make sure we're up to date on those.
2 **DR. MELIUS:** If we're -- you think -- some -- I
3 received something in the mail recently, I
4 think it's the ethics sign-off annual thing,
5 isn't it?
6 **MS. HOMER:** Your 450, I'm sure.
7 **DR. MELIUS:** Yeah, but like it had a date on it
8 that was -- on the letter or something that was
9 like a month ahead of when I got it and, you
10 know, it's overnighted to you. I mean they --
11 **MS. HOMER:** That's interesting.
12 **DR. MELIUS:** Yeah, something like -- something
13 struck me --
14 **MR. ELLIOTT:** A month ahead of when you got --
15 like it was dated June 4th and you got it
16 August 4th?
17 **DR. MELIUS:** Yeah, something like that -- or
18 July 4th.
19 **MR. ELLIOTT:** So it had been laying around
20 somewhere for a month?
21 **DR. MELIUS:** Somewhere it'd been -- somebody'd
22 run them off at a time and then they mailed --
23 which isn't -- you know, nobody bugged me or
24 anything. But you know, if you hear one of us
25 -- if like I'm in trouble or somebody's in

1 trouble for not re-- being responsive, e-mail
2 us or something and see if we got it.
3 **MS. HOMER:** I'll definitely do that.
4 **MR. GIBSON:** I got the same thing.
5 **MS. HOMER:** Did you really? Isn't that
6 interesting? I'll have to --
7 **MR. ELLIOTT:** That's why I brought this up. I
8 want to know where these things are at because
9 they're floating all over the place.
10 **DR. MELIUS:** Either way, it was plenty of time
11 before it was due, so it wasn't --
12 **MR. ELLIOTT:** Yeah.
13 **DR. MELIUS:** -- that one wasn't an issue. I
14 worry more about this other one where you've
15 got more people involved and...
16 **DR. ZIEMER:** Okay, any other housekeeping
17 items?
18 **MS. HOMER:** That'll be it.
19 **DR. ZIEMER:** Okay. Thank you, Cori.
20 **SCIENTIFIC RESEARCH ISSUES UPDATE**
21 We're going to move along here. We have
22 a scientific research issues update.
23 This is the one that Russ ordinarily
24 brings us, but I think today we have
25 Brant -- is it Ulsh? How do we

1 pronounce -- close enough, right, Ulsh?
2 Brant, welcome.
3 **DR. ULSH:** Thank you.
4 **DR. ZIEMER:** Give us the update.
5 **DR. ULSH:** I answer to anything close.
6 **DR. ZIEMER:** Anything close, right.
7 **MR. ELLIOTT:** Brant -- Brant is a health
8 physicist who applied for a position in Jim's
9 science team as a senior research scientist,
10 and so he's moved from being a -- strictly a
11 health physicist doing dose reconstruction
12 review to now aiding the scientific aspects of
13 our programs, so Russ was not able to be with
14 us today and this gave Brant an opportunity to
15 present to you.
16 **DR. ULSH:** Well, there went my first three
17 slides.
18 **MR. ELLIOTT:** I'm sorry.
19 **DR. ULSH:** I'll be able to contribute a little
20 bit to getting us back on schedule. I know
21 it's been a pretty tough haul for -- for all of
22 us.
23 As Larry mentioned, I am the new research
24 health scientist for OCAS, and before that I
25 was serving in a health physics capacity.

1 And if you'd allow me just a couple of seconds
2 to give a couple of personal words, I managed
3 to fly in last night in time to get to the
4 public comment session. And this is only my
5 second Board meeting. I went to the one in
6 Cincinnati some time ago. And speaking for
7 myself only, I found it very useful to get that
8 perspective from the public, to hear all those
9 stories last night of your experiences. And
10 so, at least from my standpoint, please know
11 that you've been heard, and it was valuable to
12 me. I changed the way I'm going to deliver
13 some of my comments today in light of what I
14 heard last night. So thank you for -- for
15 providing those perspectives.
16 Like I said, I know it's been a tough haul, so
17 I'll keep my remarks pretty brief. But I would
18 encourage any members of the Board to interrupt
19 at any time -- I'll survive the interruption --
20 if there's a clarification that you need or if
21 I'm not being clear.
22 So here's a list of the topics that I'm going
23 to discuss with you today. I'm going to start
24 with an update on compensation rates, and this
25 will look very familiar to you. Russ Henshaw

1 gave you some numbers back in April and I'll
2 just update those.
3 I'm also going to talk to you about some of the
4 adjustments to the risk models that we use in
5 our risk tables in IREP, some that we're
6 considering and some that we're in the process
7 of implementing.
8 Then I'm going to move on to tell you a little
9 bit about what we're doing with regard to CLL
10 and also a re-examination of the target organs
11 that we use for dose reconstruction with regard
12 to certain cancers of the lymphatic and
13 hematopoietic systems. That's the blood
14 cancers like leukemia and also lymphomas.
15 And I'll close with some remarks on our
16 activities looking at occupational studies and
17 what we might be able to do with those, and
18 also a re-examination of how cancers are
19 grouped in the risk models in IREP that we use.
20 Okay. So let's start with the compensation
21 rates. As I mentioned, this is an update.
22 These numbers that I'm going to present in the
23 next few slides reflect the data that we have
24 through September 30th of this year, and they
25 include only claims for which we have heard

1 back from the Department of Labor about a
2 compensation decision. So you might notice
3 some discrepancies in the total number of
4 claims that we say we've completed and the
5 numbers that I present here because these are
6 only the ones that DOL has given us a
7 compensation decision on.
8 The results are going to be skewed by the
9 efficiency process. As you know, our early
10 case selection was impacted very heavily by the
11 efficiency process, so we picked cases at
12 either end of the compensability spectrum --
13 those that were most likely going to be
14 compensable and those at the other end of the
15 spectrum, as well. And so, as they say in the
16 financial world, past performance is not an
17 indication of -- or it's not predictive of
18 future results.
19 So these results -- I've got written here they
20 may not be predictive of future results. I
21 would strengthen that and say that they are
22 definitely not going to be predictive. If they
23 are, it's just coincidence. We've moving into
24 the middle of that compensability spectrum and
25 so we can't really expect that the rates that

1 we see now are going to hold.
2 Unless otherwise noted, the numbers that I'm
3 going to present to you show only those cases
4 for which there was only one primary cancer,
5 and I'll explain -- I'll point out a couple of
6 situations where that'll make a big difference.
7 So with those caveats, here's the first set of
8 cancers. They're listed by ICD-9 code, that's
9 the first column there. In the second column,
10 that gives you the number of cases that we've
11 completed for each of those cancers, and then
12 the third column tells you the compensation
13 rates.
14 So you can see in this first group we've
15 completed a fair number of colon cancers, and
16 those have tended not to be very compensable.
17 They -- the compensation rates for the rest of
18 the cancers on this page are also fairly low,
19 with the possible exception of oral cavity and
20 pharynx where about ten percent have been
21 compensated.
22 In this next group we come to lung cancer, and
23 lung cancers comprise a very large percentage
24 of the cases that have wound up being
25 compensable, with about three-quarters. You

1 also see that liver cancers have been very
2 compensable, but we have not done a lot of
3 liver cancers yet. And about ten percent of
4 the gallbladder cancers, as well.
5 About a third of the other respiratory cancers
6 have been compensated, and we've done a fair
7 number of those, in the fifties. About a
8 quarter of the non-melanoma skin cancers, the
9 basal cell carcinomas -- and this is the cancer
10 for which that caveat I told you where we only
11 consider the cases with one primary cancer,
12 that's very important for the BCCs, basal cell
13 carcinomas, because we frequently see with skin
14 cancers there are multiple primary cancers.
15 And those are not reflected in this -- this
16 number here. And we've compensated about a
17 quarter of the BCCs. Excuse me, DOL has
18 compensated about a quarter of the basal cell
19 carcinomas.
20 The squamous cell carcinomas, on the other
21 hand, the SCCs have tended not to be very
22 compensable. And none of the other cancers
23 listed on this slide have been very
24 compensable, either. I would point out the all
25 male genitalia includes prostate cancers, and

1 we've done far and away more prostate cancers
2 than any others. And those tend to be very low
3 compensability.
4 Here you can see some more of the cancers.
5 About ten percent of the urinary organs,
6 excluding the bladder, have been compensated,
7 and the rest have been pretty low.
8 And here the other endocrine glands, about a
9 third have been compensated. And then we move
10 into leukemias, which tend to be very
11 radiogenic cancers, so as you might expect, a
12 higher percentage of those have been
13 compensated. We have not done a lot of
14 leukemias yet, though.
15 Here's a few more leukemias, and finally the
16 unknown primary cancers. You'll notice we've
17 compensated about three-quarters. That's very
18 reflective of lung cancer, because in cases
19 where we have only a secondary cancer listed
20 with no known primary, very often it reverts to
21 the assumption that the primary site was lung
22 cancer, so that's why those numbers are very
23 similar. And finally for the multiple primary
24 cancers, a large part of these are skin
25 cancers, but not only skin cancers. There's

1 also a fair number where there are other types
2 of cancers involved. About half of those
3 claims have been compensated.
4 And that gives you a total of 3,731. I think
5 our total now is about 6,000 that we've
6 actually completed, but for the remainder we
7 have not yet heard back from DOL. And that
8 gives you a final tally of about 20 percent
9 having been compensated.
10 Okay. Before I move on, this is a good place
11 to stop and ask if there are any questions
12 before I move on to the next topic.
13 (No responses)
14 Okay, seeing none -- well, I jumped the gun a
15 little bit. Here's the big picture. I'm going
16 to present this in graphical form for you.
17 This is limited only to the cancers -- the
18 types of cancers where we've completed greater
19 than 30 claims. And you can see -- these are
20 listed in decreasing order, so starting with
21 lung, we've compensated about three-quarters,
22 and moving down through the rest of the cancers
23 down to about ten percent of the thyroid
24 cancers.
25 About ten percent of the oral cavity cancers

1 and lesser numbers of the malignant melanoma,
2 bladder, esophagus and squamous cell
3 carcinomas.
4 Lymphoma and multiple myeloma, colon, breast,
5 male genitalia are pretty low.
6 And there have been no claims compensated for
7 this list of cancers: stomach, rectum,
8 pancreas, connective tissue, female genitalia
9 and nervous system.
10 Okay. So now I'd like to move into some of the
11 adjustments that we're making to a few of our
12 risk models, starting with the lung cancer
13 model. We're evaluating this at the moment.
14 The National Institute of Health has a new
15 vers-- has a version of IREP where they have
16 updated the lung model, and we are currently
17 evaluating that for applicability to the NIOSH
18 version. This update changes the way smoking
19 is handled, and it also changes the methodology
20 for considering alpha radiation. Basically the
21 NIH model includes four more years of follow-up
22 on the Japanese atomic bomb survivor cohort,
23 and it assigns more weight to an additive model
24 versus a multiplicative model.
25 Now our NIOSH -- our NIOSH version of IREP does

1 not presently include these updates because it
2 came out before the datas that -- the studies
3 that initiated this came out, a study by Pierce
4 and Preston.
5 Now what does that mean to an average claimant,
6 multiplicative versus additive? Our friends at
7 SENES pulled together some numbers, and here's
8 what it looks like. Just for a hypothetical
9 claimant who received an acute exposure of high
10 energy gammas, 50 rem -- and this is a male,
11 exposed at age 20 and diagnosed with lung
12 cancer at age 40. And what you can see here is
13 that for non-smokers, the current version --
14 the current NIOSH version of IREP tends to be a
15 bit more -- tends to yield a bit higher number
16 for probability of causation. But for all of
17 the smoking categories, the NIH model yields a
18 higher probability of causation.
19 Now if we change this to a chronic exposure of
20 alpha -- to alpha radiation, but keep all the
21 other parameters the same, you see a similar
22 pattern but less of a difference. For the non-
23 smokers the NIOSH version is very slightly more
24 claimant-favorable, and for the smoking
25 categories the NIH version tends to yield

1 higher PC results.
2 The differences between the two models. NIOSH
3 -- the current NIOSH version is more claimant
4 favorable for people who have never smoked and
5 for females exposed at older ages. The NIH
6 version gives higher PC results for male
7 smokers and for females exposed at younger
8 ages.
9 I might also mention here that the NIH version
10 includes a dependency on age at exposure, and
11 also at attained age.
12 And so in response to this update to the NIH
13 version that the National Cancer Institute
14 recommended, OCAS has commissioned five experts
15 to review whether or not we should also adopt
16 this model. We expect to have those
17 recommendations back in mid-February.
18 We're in the process of adjusting our thyroid
19 model, and the reason that we're doing this --
20 this gets down in the technical weeds a little
21 bit, and I'll try to make it understandable.
22 But if I don't, please let me know.
23 The IREP -- the thyroid model includes data
24 from two types of studies, first the Japanese
25 bomb survivors, and also from childhood X-ray

1 studies. When we combined those datasets or
2 when NCI combined those datasets, they applied
3 a reduction to the effectiveness of the
4 childhood X-ray studies, based on the
5 assumption that X-rays are more carcinogenic
6 than the high-energy gamma rays that the atomic
7 bomb survivors were exposed to.
8 Here's what this update means to a typical
9 claimant. There are a couple of points I want
10 to point out here. First of all, notice that
11 this affects a very limited age window, between
12 -- I think the youngest exposures that we have
13 are about 15 years of age, and it only goes up
14 to age 20.
15 The second thing to notice is that the
16 adjustment results in a higher -- slightly
17 higher PC in all cases. The reason that we see
18 that is because the update removes that
19 reduction that was applied to the childhood X-
20 rays. The reason that we're doing that is
21 because, upon examination, NCI discovered that
22 the risk coefficients that they were getting
23 from the childhood X-ray studies were in fact
24 not different -- not significantly different
25 from the Japanese atomic bomb survivors. And

1 so applying that reduction was inappropriate,
2 they decided. And so the reason for that is
3 possibly fractionation.
4 If you compare an acute exposure of X-rays to
5 an acute exposure of high-energy gamma rays,
6 the X-rays will be more efficient. But that's
7 not what we have here with the childhood X-ray
8 studies. They got a little bit of dose today,
9 a little bit tomorrow, a little bit next week.
10 So the dose was fractionated. We know that
11 that type of exposure regime is less efficient
12 at causing cancer, and so that's probably why
13 they didn't see any difference, so they're
14 removing that reduction.
15 And this update that we're in the process of
16 making will bring us into alignment with the
17 NIH model. It is al-- it is claimant-
18 favorable, and it also only affects a very
19 small number of cases.
20 We're also updating our bone model in IREP. We
21 previously modeled the latency period -- the
22 latency relationship for bone cancer to that
23 for other solid tumors. But upon re-
24 examination, NCI decided that in fact the
25 latency relationship for bone cancer more

1 closely resembled that for thyroid, and so they
2 changed that so that the latency period now for
3 bone cancer will be modeled on the thyroid.
4 This is also a claimant-favorable adjustment in
5 all cases, and it also will affect a very small
6 number of cases.
7 Okay, chronic lymphocytic leukemia. This is a
8 topic that has generated a great deal of
9 interest, I think. In response to that, the
10 Health and Energy-related Research Branch of
11 NIOSH, HERB, held a public meeting this past
12 July in Washington, D.C., and they empaneled a
13 group of experts to look at the assumption that
14 there is no relationship between ionizing
15 radiation exposure and CLL. And that's pretty
16 much conventional wisdom in radiation
17 epidemiology.
18 And this group of experts took a look at the
19 data, and they decided that the evidence is
20 actually inconclusive. It doesn't say that
21 there is a relationship, but it doesn't say
22 that there's not a relationship.
23 They identified some real problems with the
24 data. First of all, inappropriate lag periods
25 were used. Other forms of leukemia tend to be

1 very fast-developing, and they have lag periods
2 typic-- on the order of about five years.
3 Well, that's not really appropriate for CLL.
4 It's a very slowly-developing disease, much --
5 it's distinct from the other forms of leukemia.
6 There's also a classification and diagnosis
7 issue. Up until recently, diagnosis of CLL was
8 based on cell morphology. In other words, you
9 looked at the cells under a microscope and,
10 based on what they looked like, determined that
11 you were looking at CLL. But the problem is
12 that there are other related types of leukemia,
13 for instance, hairy cell leukemia -- which, by
14 the way, is a covered condition under our
15 program. So it's not too hard to see that
16 someone who might have had hairy cell leukemia
17 had a non-trivial chance of being mis-diagnosed
18 with CLL, and they would not be eligible for
19 coverage under our program. So that's a real
20 problem.
21 That has changed recently with the advent of
22 molecular biology techniques. It's much more
23 definitive of a diagnosis, but in the early
24 days it was a bigger problem.
25 There's also the problem of transference

1 between the two populations, between Japanese
2 atomic bomb survivors and the North American
3 population that we're dealing with. The
4 problem there is that Asian populations have a
5 very low background incidence of CLL compared
6 to North American populations. So there is a
7 question of relevance there.
8 In light of those problems we are reconsidering
9 our exclusion of CLL from EEOICPA. And we have
10 commissioned five experts -- you can see a
11 pattern here; we like to commission experts to
12 get their opinions -- to review the basis for
13 exclusion of CLL. Those reports are coming in
14 now. We expect to have them this month.
15 If appropriate, once we've received all those
16 opinions, we will initiate rule-making to
17 change the PC rule and include CLL, if
18 appropriate. If we do that, that would be very
19 significant because we would be the only
20 radiation compensation program in the world to
21 cover that condition.
22 Okay. Target organs for hematopoietic and
23 lymphatic cancers. These are the leukemias and
24 lymphomas. We are re-examining which target
25 organs we use in these cancers. What I mean is

1 -- take for instance external radiation
2 exposure, radiation that comes from outside the
3 body. It's measured on a film badge, but we
4 don't apply that number directly. We apply an
5 organ dose conversion factor. So we figure out
6 what fraction of what was measured on that
7 badge actually reached the organ of interest.
8 So you can see it's pretty important to pick
9 the right organ 'cause we have different
10 factors for different organs.
11 And the question that's motivating this re-
12 examination is how does the site where you find
13 a lymphoma, for instance, relate to the site of
14 the original radiation injury. In other words,
15 if you find a lymphoma in a lymph node in your
16 armpit, do we use the lymphatic tissue as the
17 target organ? Might it be the lung? Might it
18 be the bone marrow? The bone marrow is where
19 lymphocytes start as stem cells, so where did
20 the actual radiation injury occur?
21 Well, these are pretty technical questions, so
22 we've secured the services of a hematologist to
23 help us review the target organs we pick for
24 lymphomas. As long as we have a hematologist
25 on board, we decided to throw in the leukemias,

1 as well, although we don't really have as many
2 questions there. We're much more confident in
3 our target organ selection for the leukemias.
4 Okay. We're nearing the end here. Just hold
5 with me for a couple more minutes.
6 Occupational studies. This is also a topic
7 that has generated great interest among the
8 Board, I think also the public. We are in the
9 process of assembling a database of worker
10 cohort studies, and we're looking specifically
11 for dose response data that we can use to
12 either modify our existing risk models or to
13 come up with entirely distinct risk models.
14 I did a first cut on the literature search for
15 these studies, and I found very easily 167
16 studies, but I guarantee there will be more. I
17 did this right before I started getting ready
18 for this meeting and kind of put it on hold for
19 that. Once I start digging into this first
20 group of 167, I will find more. That total,
21 that 167, includes 153 peer-reviewed journals
22 and about a dozen NIOSH reports.
23 Here's how it breaks down by populations
24 examined. Far and away, about -- at about
25 three-quarters, the largest group of these are

1 nuclear workers, about three-quarters. And
2 that's a good thing, because that's of course
3 the most relevant type of study that -- that we
4 could have, all other things being equal.
5 We've also included an equal num-- about an
6 equal number of uranium miners, radiologists,
7 air crew type studies, and a few more general
8 studies.
9 Dovetailing with that last project, that
10 occupational study project, is a re-examination
11 of the way cancers are grouped in IREP. This
12 was originally done with the Japanese bomb
13 survivors. Biological plausibility was
14 certainly considered, but the motivator was,
15 for certain rare types of cancer, there weren't
16 enough numbers to come up with a risk model.
17 And so they were combined together to come up
18 with a workable risk model.
19 We're taking a new look at that, a fresh look
20 at the way that was done. And there are three
21 criteria that we're using. The first thing
22 that we're going to look at is the availability
23 of risk coefficients for individual cancer
24 types. And an example here is salivary gland,
25 can we parse that out from the oral cavity and

1 pharynx model? Might we be able to split up
2 multiple myeloma and lymphoma? And of course
3 prostate, we're interested in whether or not we
4 can split the prostate out from the other male
5 genitalia. Those are just examples. They're
6 not meant to be exhaustive.
7 A second criteria that we use -- that we're
8 looking at is transport between populations. I
9 mentioned that with regard to CLL, but the
10 question also applies to some other cancers, as
11 well. And the question here is -- we're
12 looking at the appropriateness of transferring
13 groups of cancers from the Japanese population
14 to the North American population versus doing
15 that on an individual basis. We're taking a
16 look to see whether that was appropriate in all
17 cases.
18 And finally the application of more recent or
19 different risk coefficients for individual
20 cancer types. An example here is a study
21 published a couple of years ago by Dale Preston
22 looking at nervous system cancers in the A-bomb
23 survivors, and also some melanoma numbers that
24 Elaine Ronn* put out a few years ago. Those
25 are just a couple of examples.

1 And so that concludes my prepared remarks, and
2 I'd be happy to entertain any questions you
3 might have.
4 **DR. ZIEMER:** Okay. Thank you very much, Brant.
5 Let's open the floor for questions. Gen
6 Roessler?
7 **DR. ROESSLER:** Before you started I thought I
8 was going to have a lot of questions, but you
9 answered every one of them. I guess my
10 impression at this point is that -- well, I'm
11 impressed that NIOSH indeed is keeping up to
12 date very much on the scientific developments,
13 and it looks to me like it's -- most of the
14 changes are claimant friendly.
15 **DR. ULSH:** Yes, yes, they are. We would
16 certainly have a higher bar to jump if we were
17 going in the opposite direction, if we were
18 making it less claimant friendly. Although
19 keep in mind, with the lung model it's not an
20 across-the-board claimant-favorable move. I --
21 **DR. ROESSLER:** But what you're doing is valid,
22 and I --
23 **DR. ULSH:** I hope so.
24 **DR. ROESSLER:** I mean my interpretation is that
25 everything that you've introduced as new

1 science is valid --

2 **DR. ULSH:** Thank you.

3 **DR. ROESSLER:** -- based on more data and more

4 evaluation and more expert evaluation.

5 **DR. ULSH:** Thank you.

6 **DR. ZIEMER:** Brant, many of these epi studies,

7 even the larger ones, are still seen as lacking

8 the statistical power, for example, of the

9 Japanese studies.

10 **DR. ULSH:** Right.

11 **DR. ZIEMER:** In fact, that's one of the main

12 shortcomings, and perhaps one of the reasons

13 they have had less stature as sort of

14 benchmarks.

15 **DR. ULSH:** Right.

16 **DR. ZIEMER:** However, there are some groups

17 that are doing -- I guess you would call it

18 sort of meta-analysis, combining many studies

19 and pulling those together. I think there's

20 maybe some European groups doing that, as well

21 as US. Are the one -- articles you're

22 reviewing, are you -- you're going beyond those

23 individual studies and looking at those pooled

24 studies, as well?

25 **DR. ULSH:** Yes. Yes, where appropriate we will

1 check out whether or not we can do some meta-
2 analysis. I think the study -- the European
3 one that you mentioned, you might be thinking
4 of the IARC 15-country study --
5 **DR. ZIEMER:** Yes.
6 **DR. ULSH:** -- which is --
7 **DR. ZIEMER:** Yes, exactly.
8 **DR. ULSH:** -- expected -- I don't know exactly
9 when, but yeah, it's on the horizon.
10 **DR. ZIEMER:** Some of those studies reach pretty
11 large population groups when you pool them.
12 **DR. ULSH:** Right.
13 **DR. ZIEMER:** And hopefully the statistical
14 power will be there and allow us to have a
15 little more reliable risk coefficients.
16 **DR. ULSH:** Well, you hit it dead-on. The
17 problem with occupational studies is they --
18 because of the lower numbers involved, they
19 don't typically have the power of the Japanese
20 studies. On the other hand, they tend to be
21 more relevant in terms of the types of exposure
22 that the --
23 **DR. ZIEMER:** Yes.
24 **DR. ULSH:** -- populations receive.
25 **DR. ZIEMER:** Right, they are more chronic

1 exposures of the type that we have in the
2 workplace, so that's --
3 **DR. ULSH:** So there are pluses and minuses
4 there, you hit it.
5 **DR. ZIEMER:** Okay. Other -- Gen Roessler
6 again? No. Mark?
7 **MR. GRIFFON:** I just have a question about the
8 CLL.
9 **DR. ULSH:** Yeah.
10 **MR. GRIFFON:** In the cases -- the early -- you
11 mentioned potential for mis-diagnosis --
12 **DR. ULSH:** Right.
13 **MR. GRIFFON:** -- especially among the earlier
14 cases. Have you made any policy decisions to
15 view them as hairy cell -- or --
16 **DR. ULSH:** We haven't really got that far.
17 We're still wrestling with the question of
18 whether or not to include CLL, but --
19 **MR. GRIFFON:** Right, but in that case you could
20 -- you know, it would be claimant favorable,
21 obviously.
22 **DR. ULSH:** One would think, yeah.
23 **MR. GRIFFON:** Yeah.
24 **DR. ULSH:** Those are ideas that we have talked
25 about in terms -- if we do decide to include

1 CLL, the next question of course becomes what
2 risk model do you use, and that's -- that's the
3 hard part. We haven't really begun to wrestle
4 with that yet, but yeah, those types of
5 considerations will come into play, for sure.
6 **DR. ZIEMER:** Tony?
7 **DR. ANDRADE:** Brant, what -- what sort of
8 general results have you seen from the worker
9 studies insofar as the miners -- the miner
10 population is concerned? In general what sorts
11 of things are you seeing --
12 **DR. ULSH:** Higher lung cancers.
13 **DR. ANDRADE:** Higher lung cancers or --
14 **DR. ULSH:** Oh, yeah, for sure.
15 **DR. ANDRADE:** -- a lower threshold for lung
16 cancer?
17 **DR. ULSH:** I'm not quite sure what you mean
18 when you say that.
19 **DR. ANDRADE:** Well, for a given exposure --
20 okay? -- for an inhalation exposure --
21 **DR. ULSH:** Yeah.
22 **DR. ANDRADE:** -- chronic, over a long period of
23 time --
24 **DR. ULSH:** Right.
25 **DR. ANDRADE:** -- how shall I say it, lower

1 concentration to the point where you see the
2 onset of cancer?
3 **DR. ULSH:** I'm not quite sure how to answer
4 your question. What I can say is that in the
5 uranium miner population there is definitely --
6 it's pretty well accepted that there's
7 increased incidences of lung cancer.
8 **DR. ANDRADE:** Right.
9 **DR. ULSH:** In terms of a dose response
10 relationship, I haven't dug into it yet enough
11 to -- to be able to say what they're seeing,
12 you know, and whether we'll find any useful
13 data in terms of a dose response relationship
14 other than that they do have a higher
15 incidence.
16 **DR. ANDRADE:** Higher -- well, okay, yes. I
17 mean we knew that, but is there anything new
18 coming out of that? The other -- the other
19 problem with the miner population was that a
20 lot of -- a lot of miners tend to be smokers,
21 as well.
22 **DR. ULSH:** Right, right.
23 **DR. ANDRADE:** And so when you mix the alpha
24 radiation with the smoke, that's always a
25 deadly combination. Even in dog studies that's

1 been shown to be the case.
2 **DR. ULSH:** Sure.
3 **DR. ANDRADE:** Is there -- is there anything new
4 emerging?
5 **DR. ULSH:** Jim has jumped up. He might have
6 more to add than I do.
7 **DR. NETON:** The uranium miner data has a unique
8 conundrum in the sense the irradiation of the
9 sensitive cells is very different than you
10 might experience from say a uranium-exposed
11 cohort working in a rolling mill, for example.
12 Typically the lung cancers in uranium miners
13 show up in the third and fourth bifurcations of
14 the tracheobronchial tree, and that has more to
15 do with physics and aerosol deposition patterns
16 of the ultrafine aerosols than -- than what you
17 experience with the particle size distribution
18 in an occupational environment. The point is,
19 it's not necessarily -- the risk -- the risk
20 coefficients are not necessarily relevant to
21 our -- our population other than the uranium-
22 exposed population, which we do have some.
23 **DR. ULSH:** Well, and the radon -- the radon-
24 exposed population, right.
25 **DR. ZIEMER:** I noticed Owen was about to make a

1 remark. Can you add to that, Owen?
2 **DR. HOFFMAN:** (Off microphone) Yes, Brant
3 (unintelligible) --
4 **DR. ZIEMER:** For the record, Owen, give the --
5 **DR. HOFFMAN:** Owen Hoffman. Brant, really fine
6 presentation. I just wanted to add an item of
7 clarification. When you showed the bar graph -
8 -
9 **DR. ULSH:** Yes.
10 **DR. HOFFMAN:** -- of the probability of
11 causation and the comparison between the new
12 update to be consistent with the NIH approach
13 and the old -- or the current approach with
14 NIOSH-IREP for lung cancer in smoking
15 categories, of course that's the comparison at
16 the upper 99th percentile -- the upper 99th
17 credibility limit of PC. The differences
18 between the approach are marked at lesser
19 percentiles of the -- of the distribution of
20 PC. But because there is -- there is always
21 some fraction of the interaction of either
22 approach that's multiplicative, they tend to
23 come closer together and that's why they look
24 so similar throughout those categories.
25 **DR. ULSH:** Thank you, Owen. I should mention -

1 - I should have mentioned this earlier. Those
2 numbers were prepared for us by SENES, so Owen
3 is really the expert on -- on those numbers.
4 Thanks, Owen.
5 **MR. ELLIOTT:** We should talk a little bit about
6 process here. According to our rule,
7 probability of causation rule, we're required
8 to bring to the Board any substantive change
9 that we would make or propose to make in our
10 risk models. And what you've seen here today
11 in Brant's presentation is some of the -- some
12 imminent effort in that regard. We are
13 tasking, as you've seen indicated in his
14 slides, subject matter experts to bring
15 scientific opinion to bear on these particular
16 questions. We will bring that forward with our
17 proposal, if there is a proposal, for
18 substantive change to this Board and get your
19 thoughts and your comments on that. We're not
20 at that point yet.
21 We're probably as close as we're going to get
22 for thyroid, I think. We're probably looking
23 to you today to say what are you -- what's your
24 thoughts about thyroid. We don't -- we didn't
25 commission any subject matter experts. It's

1 pretty straightforward in our mind that that's
2 something we ought to do and we ought to make
3 that change and incorporate it immediately. It
4 is for a small group. Those very -- people in
5 our case file load that would have started work
6 at a very young age, and it's a very limited
7 number.
8 But the other -- the other issues that Brant
9 has raised on CLL, that's a rule-making effort.
10 Once we get our subject matter experts'
11 comments in place and we work up our rule-
12 making effort, we'll come forward with pub--
13 you know, public comment in that per-- in that
14 effort and seek the Board's comment as part of
15 that like we've done in our other rule-making
16 efforts.
17 And then lung cancer model adjustment, we'll
18 see what our subject matter experts say about
19 that, bring a proposal to the Board on that.
20 **DR. ULSH:** Bone cancer's in the same category
21 as thyroid.
22 **MR. ELLIOTT:** Yeah, bone cancers -- as I said,
23 we're seeing nods around the table about bone
24 and thyroid. I think we're ready to make those
25 changes happen.

1 **DR. ZIEMER:** Larry, are you asking for formal
2 action on those --
3 **MR. ELLIOTT:** I think it's --
4 **DR. ZIEMER:** -- today or is this a heads-up for
5 next time?
6 **MR. ELLIOTT:** Well, you -- you can -- you could
7 -- you have an option here, I believe. You
8 could say to us that you want to see more --
9 more informative work done on -- on either one
10 of those, or you could be satisfied with what
11 we presented. Basically you've heard about the
12 lung for a couple of other sessions from Russ,
13 so it's not a new topic. The thyroid I think
14 you've heard once before. You haven't seen
15 these data that SENES helped generate for us.
16 These are new. But they show you the slight
17 changes that these modifications would result
18 in, so you have an option I think to say to us,
19 if you're satisfied with what you see, they're
20 -- we think they're based on sound science, I
21 mean limited as it is. But what's your
22 pleasure?
23 **DR. ZIEMER:** While you're thinking about your
24 pleasure, the thyroid model adjustment, as I
25 look at it, doesn't really look to be an

1 adjustment -- at least -- or maybe in that
2 little window of age 18 to 20 there's a slight
3 --
4 **DR. ULSH:** Exactly.
5 **DR. ZIEMER:** -- nudge on the midpoint of the
6 range, but -- and it's all captured within the
7 error/era* of it, so it might have a little
8 effect on a few cases.
9 **DR. ULSH:** It's very slight, and it is a very
10 low number of cases, yeah.
11 **DR. ZIEMER:** So that's the only -- that is what
12 your recommendation is then on the -- on the
13 thyroid model, to basically alter that factor
14 for that -- what is it, people who started to
15 work before age 20?
16 **DR. ULSH:** Yeah, they were exposed before age
17 20.
18 **DR. ZIEMER:** Only the exposure -- years it
19 occurred before 20.
20 **DR. ULSH:** Exactly.
21 **DR. ZIEMER:** Which for --
22 **DR. ULSH:** There's not many.
23 **DR. ZIEMER:** Not many people and it's a very
24 small number of -- a couple years at most for
25 those for whom it's in operation.

1 **DR. ULSH:** Right.
2 **DR. ZIEMER:** Okay. Who had a comment on that?
3 Yes, Tony?
4 **DR. ANDRADE:** I was just curious as to when the
5 jury's supposed to be back in insofar as your
6 SMEs on the other research efforts that are
7 going on. Or -- well, not research, but their
8 efforts to consider the data.
9 **DR. ULSH:** CLL, we expect to have them all back
10 this month. The lung cancer SMEs, back by mid-
11 February. The lymphatic target organs, that's
12 not a panel. That's just one --
13 **DR. ANDRADE:** Person.
14 **DR. ULSH:** -- one hematologist, and it'll come
15 back pretty quick. I can't say exactly when,
16 but pretty quick.
17 **DR. ANDRADE:** I would like -- I would like to
18 suggest that we either have an update or
19 perhaps the result of their consideration
20 presented at our next meeting in February, if
21 that is possible.
22 **DR. ULSH:** I have no objection to that.
23 **DR. ZIEMER:** The update on these others?
24 **DR. ANDRADE:** Yes.
25 **MR. ELLIOTT:** Please consider what we would

1 bring you as -- what we would like to bring you
2 would be our proposal, and so yes, we can
3 certainly give you an update, but my intent
4 would be --
5 **DR. ZIEMER:** That would be the update.
6 **MR. ELLIOTT:** My intent would be to come before
7 this Board and say here's our proposal, our
8 recommended -- recommendation for modification.
9 And it's -- we're not trying to put any
10 criteria on what substantive is here -- a
11 substantive change. We see these as fitting
12 that model. We want to bring them before you
13 and have the public observe this process and
14 see what changes are being proposed here.
15 **DR. ZIEMER:** The thyroid probably is just on
16 the borderline of being substantive, but --
17 comment? Jim and then Roy.
18 **DR. MELIUS:** Comment I guess is -- one is sort
19 of practical, and I'm -- our next agenda's
20 already pretty tight and I'm not sure there's a
21 lot of time there, particularly if we're going
22 to be discussing these and a procedure in some
23 detail and so forth, but we -- we can see.
24 The other one -- question I have is a practical
25 one. From your point of view and perspective

1 in terms of adopting these, is it easier to do
2 them like as a group, so you know, do -- do we
3 wait and do them all -- or is it easier to do
4 them incrementally --
5 **MR. ELLIOTT:** I think --
6 **DR. MELIUS:** -- and just adopt them as we --
7 **MR. ELLIOTT:** I think we're ready to take on
8 thyroid and we're -- and bone. We can make
9 those changes if -- if there's no objection.
10 That's what I'm looking for. Is there an
11 objection to us doing that?
12 **DR. ZIEMER:** We'll take formal action here in a
13 moment. Roy, did you have a comment?
14 **DR. DEHART:** I felt prepared to comment on
15 thyroid, having some familiarity with the
16 literature. I think that the direction you're
17 proposing is appropriate and I would suggest we
18 go forward.
19 A second question I would have, as well, do you
20 automatically go back into the records that you
21 have where thyroid has been an issue and
22 recalculate?
23 **DR. ZIEMER:** Yes.
24 **DR. ULSH:** For those cases for which this
25 change would -- would have an impact, we would

1 definitely go back to look and see if it might
2 change anyone's decision, definitely.
3 **DR. ZIEMER:** For the record, I'd simply like to
4 call for a motion to have the Board endorse
5 these modifications, first to the thyroid model
6 and then to the bone model, as described. Is
7 there such a motion?
8 **DR. DEHART:** I would move that we adopt the
9 thyroid adjustment as provided.
10 **DR. ROESSLER:** Second.
11 **DR. ZIEMER:** Okay. You're wanting to act
12 separately on them?
13 **DR. DEHART:** I'm not as comfortable to go
14 forward with the -- with the bone.
15 **DR. ZIEMER:** Okay. We'll do the thyroid first.
16 Discussion on the thyroid model?
17 (No responses)
18 It seems to be fairly straightforward. All in
19 favor, say aye.
20 (Affirmative responses)
21 **DR. ZIEMER:** Opposed, no? Any abstentions?
22 (No responses)
23 **DR. ZIEMER:** So the Board endorses proceeding
24 with the thyroid model.
25 Just for clarification, on the change to the

1 bone model, this has to do with the latency
2 period --
3 **DR. ULSH:** Yes, it does.
4 **DR. ZIEMER:** -- where previously they used for
5 the latency period an ill-defined or --
6 **DR. ULSH:** It was other solid tumors.
7 **DR. ZIEMER:** -- a generally defined...
8 **DR. ULSH:** I can give you a couple more
9 details, and if you --
10 **DR. ZIEMER:** How -- what will be the new --
11 tell us how it changes then so --
12 **DR. ULSH:** Yeah.
13 **DR. ZIEMER:** -- under the new latency period,
14 what...
15 **DR. ULSH:** Before, with the other solid tumors
16 -- and Owen, perhaps you can correct me if I
17 say anything wrong -- for the cancers that
18 occurred very shortly after exposure, so we're
19 talking about within a -- what, two, maybe
20 three years, Owen? -- the PC value was zero.
21 It was a zero. When we switch it over to the
22 thyroid, it gives a very low but still positive
23 PC result. That's the major impact.
24 Do I have that about right, Owen?
25 **DR. HOFFMAN:** Yes.

1 **DR. ZIEMER:** Yes, and didn't we have one like
2 that before where we went from a zero step
3 function -- or is this the one?
4 **DR. ULSH:** I think that was the thyroid -- the
5 thyroid used to be that way --
6 **DR. ROESSLER:** We had a leukemia one, I think,
7 that was similar.
8 **DR. ZIEMER:** Well, this is a similar sort of
9 change.
10 **DR. ULSH:** Yes, a similar sort of change.
11 **DR. ZIEMER:** It actually takes that period
12 between exposure and onset of the tumor and --
13 it's sort of like under the old system. If you
14 were a day early, it didn't count --
15 **DR. ULSH:** Yes, exactly.
16 **DR. ZIEMER:** -- and then the next day it was
17 okay to count it. And they're saying well,
18 let's make that more of a --
19 **DR. ULSH:** Smooth function.
20 **DR. ZIEMER:** -- smooth function.
21 **DR. ULSH:** Right.
22 **DR. ZIEMER:** That's the nature of the proposed
23 change.
24 **DR. ULSH:** And it is claimant favorable in all
25 cases. It doesn't result in a penalty for

1 anyone.

2 **DR. ZIEMER:** Yes, Leon?

3 **MR. OWENS:** Dr. Ziemer, I'd like to make a
4 motion that the Board allow NIOSH to move
5 forward with the bone adjustments.

6 **DR. ZIEMER:** Okay. Is there a second to that
7 motion?

8 **MR. PRESLEY:** I'll second it.

9 **DR. ZIEMER:** Seconded. Discussion? Yes, Jim?

10 **DR. MELIUS:** And I apologize, I had to take a
11 phone call and got -- missed some of this, but
12 I think it would be helpful to these future
13 discussions of these, and even maybe to this
14 one, to actually have a written proposal from
15 NIOSH on what the changes are going to be,
16 rather than just slides and then your verbal
17 description, captured in the record of the
18 meeting.

19 **MR. ELLIOTT:** That's fair and we can do that.
20 We just thought you'd seen these two --

21 **DR. MELIUS:** And I'm not --

22 **MR. ELLIOTT:** -- several times before and knew
23 the background on it, so -- but I understand
24 your point.

25 **DR. MELIUS:** And I'm not saying that would

1 change how I would vote or feel on bone, but I
2 just think for future -- if you want -- feel
3 ready to take action, come -- let's have a
4 proposal so we -- that we can refer to and
5 adopt and I think it would be easier for
6 everybody.
7 **DR. ZIEMER:** It appears the Board is ready to
8 act on this one. All in favor, aye?
9 (Affirmative responses)
10 **DR. ZIEMER:** Any opposed, no? And any
11 abstentions?
12 (No responses)
13 **DR. ZIEMER:** Thank you. Then NIOSH will
14 incorporate these changes right away, and also
15 go back and check previous dose reconstructions
16 to determine if there are significant changes
17 to probabilities of causation for other cases.
18 **DR. ROESSLER:** Take a break.
19 **DR. ZIEMER:** Yes, that completes this
20 discussion, and we're on schedule for a break -
21 - 15-minute break and we reconvene at quarter
22 of. We have a public comment session coming
23 up.
24 (Whereupon, a recess was taken from 2:35 p.m.
25 to 2:50 p.m.)

1
2 **PUBLIC COMMENT**
3 **DR. ZIEMER:** Know that the sooner we go --
4 started, the sooner we'll be finished. It's
5 been a marathon for many of the Board members
6 today. Thank you for bearing with us.
7 At this time on our agenda it's the period for
8 public comments. The first commenter this
9 afternoon will be Joyce Brooks from Livermore.
10 Joyce, are you here?
11 **MS. BROOKS:** (Off microphone) Yes.
12 **DR. ZIEMER:** Yes, please take the microphone.
13 Thank you.
14 **MS. BROOKS:** (Off microphone) Right here?
15 **DR. ZIEMER:** That's fine right there, sure.
16 Thank you. Just make sure that it's on.
17 **MS. BROOKS:** Thank you. Okay, I am Joyce
18 Brooks, a claimant and the co-leader of the
19 Sick Worker and Family Member support group
20 here in Livermore. My husband Carl worked at
21 Livermore Lab for 32 years. He did everything
22 from machining beryllium, uranium, and other
23 substances, to engineering work. I knew he was
24 very smart, even though he did not have a
25 college degree. And when I reviewed his

1 records, I saw the commendations he received.
2 I was truly amazed.
3 I also need to tell you that one of the most
4 difficult things in my life was watching the
5 person I love die because he was unable to
6 breathe. I won't go into details about my
7 case, because it is a beryllium case, except to
8 share a couple of details that I think apply to
9 dose reconstruction work.
10 While working at Livermore Lab Carl traveled to
11 many sites to work, such as Rocky Flats, Y-12,
12 Pantex, Bendix, Paducah, and for long periods
13 of time every week on the corporate jet to
14 Nevada Test Site. He was exposed to radiation,
15 as well as beryllium. Although he believed in
16 the end that the beryllium killed him, I also
17 saw that his immune system was weakened, and I
18 believe that was due to the radiation exposure
19 that he had.
20 The reason I bring this up is that the Lab
21 supposedly gave me all of his records, but many
22 of his records from these other sites,
23 especially dose readings, are not available.
24 Therefore, if I was filing under cancer claim,
25 the dose reconstruction would not be complete

1 without all these records. This is an
2 important point because so many in our support
3 group are in this situation.
4 Although my claim has been denied three times,
5 I now feel fairly confident because of the
6 medical evidence that I put together about
7 Carl's lung problems prior to 1993. The only
8 reason I am currently in this position is
9 because of the help of Tri-Valley Cares, the
10 Government Accountability Project, and Dr.
11 Lawrence Fortas* at the Medical Screening
12 Program at University of Iowa.
13 The programs that are being funding (sic) are
14 not really helping us. Because of this, many
15 people have given up and many will not apply
16 because they feel it is impossible.
17 I want a fair hearing. I can accept whatever
18 the result, payment or no payment. I just want
19 a fair shake for myself, my family, and for all
20 the families. And I want to fulfill my
21 commitment to Carl to find out what happened to
22 him.
23 I appreciate so much that you have held this
24 meeting in Livermore so that so many of the
25 support group who are older and sick could

1 come. I feel optimistic if we all work
2 together we can come up with a model here for
3 service, for the site profile, and for
4 cooperation between the community and the
5 government.
6 Thank you for allowing me to speak. I
7 appreciate the important work you are doing,
8 and I hope that we can build something together
9 that helps the sick workers and their families,
10 and that we all feel proud of. Thank you.
11 **DR. ZIEMER:** Thank you very much for your
12 comments. I'm sorry, I turned off here.
13 Thank you very much for your comments to us
14 today. Next I have Beverly Wooster, I believe
15 it is. Beverly, are you here? Thank you.
16 **MS. WOOSTER:** I'm not prepared like my
17 predecessor, but my husband, David Wooster,
18 worked for the Livermore Lab from 1958 until
19 1991 when he died of lymphoma, which I
20 personally know was brought on by his exposure
21 to radiation. Much of that time he was working
22 at Nevada Test Site, but was also mentioned by
23 my friend that the people from the Lab travel -
24 - traveled a lot. And they went to a number of
25 places that are not on your list of where --

1 the places that you use for checking the amount
2 of radiation and so forth.
3 I do recall one trip that he came home from, a
4 field trip -- sometimes he was gone for weeks
5 at a time. And when he came home he told me
6 that they'd been working in a tunnel, that
7 there was a geiger counter put up outside the
8 tunnel and when he came out he set off the
9 geiger counter rather loudly. Now they're not,
10 so far as I know, given any extra clothing. He
11 continued to wear whatever he took with him on
12 the trip, and this was just an example of some
13 of the other things that could happen besides
14 all the radiation from the test site.
15 That's all. Thank you.
16 **DR. ZIEMER:** Thank you very much again for
17 sharing that with us. Those two individuals,
18 Joyce and Beverly, are the only ones that had
19 signed up, but I do want to give opportunity if
20 there's -- yes, sir, please. And identify for
21 the record your name.
22 **MR. GLENN:** Okay. I -- I'd like to sit down,
23 if I may, because --
24 **DR. ZIEMER:** You certainly may, yes. You can
25 sit right there and they'll provide you with a

1 mike. That's good.
2 **UNIDENTIFIED:** I'll hold it for you.
3 **MR. GLENN:** Okay, thank you. My name is David
4 Glenn. I'm a health physicist. I'm also a
5 Ph.D. in physics, experimental and theoretical.
6 I was a Lab employee from 1966 to about 1991.
7 I had a -- there was a three-year break in
8 there, but at that time I also worked at the
9 Test Site. During that time I was a physicist,
10 devoted almost entirely to containment of
11 underground nuclear tests, and I directed many
12 of those efforts. I published almost 100
13 papers in that area, 60 or 70 are out in the
14 open literature.
15 Review of the NTS test schedule is
16 approximately -- I'd like to review that for
17 you. Approximately 1,000 tests have been
18 conducted there. Prior to -- prior to 1963
19 several hundred nuclear air blast tests
20 occurred. In that time -- this is in the open
21 -- there's -- there's a pamphlet that shows you
22 the announced tests -- as many as six in one
23 day occurred there on -- on an occasion -- on
24 one occasion. This is published in the open
25 literature, as I mentioned.

1 Now that -- tests were suspended because of the
2 contamination in the populated areas in the --
3 like in Utah, and I think you're probably well
4 aware of that. Then we started underground
5 tests, and I became intimately involved with
6 that effort. And I worked -- and I'm going to
7 give you an example of what the test site is
8 like.
9 After you've had these hundreds of air blast
10 tests, there's no effort at all made to contain
11 those because, being air blasts, you know,
12 there's no way you can do that. The radiation
13 just spreads over whichever way the wind blows,
14 and it's deposited typically on the surface,
15 what doesn't blow off the site.
16 An example, because I worked in a high yield
17 series of tests, a selected group of wives were
18 granted the opportunity to make a day tour of
19 the test site. The tour director was Roger
20 Ide*. He took them to the Sedan Crater, and he
21 told them they can only spend five minutes
22 there because -- for viewing on the viewing
23 platform because of the high level of
24 radiation.
25 Now I was on a committee that evaluated -- on

1 many committees, I should say, that evaluated
2 nuclear test sites for many, many years at --
3 at the -- at the LLNL, never considered whether
4 a site was unacceptable because of
5 contamination levels. What was the primary
6 concern was whether or not that site had
7 characteristics, geologically speaking, for
8 containment. That was the only goal -- only
9 site -- only reason.
10 Finally applied in July of 19-- 2001 to this
11 program, submitted eight years' blood tests and
12 an oncologist's findings. Application rejected
13 as not recognized cancer. I cited the fact
14 that my high mitotic index in fact proved it
15 was a cancer. They submitted my application
16 then and my appeal to the National Institute of
17 Health, and they agreed with me that both forms
18 of cancer that I have, polycythemia vera and
19 thrombocytosis, are cancers. So one and a half
20 years later they accepted my application and
21 resigned -- assigned me an ID of 10,643 --
22 which, to a certain extent, I should have been
23 accepted a year and a half prior to that.
24 Now they talk about here as a bone marrow not
25 being accepted, but in fact is -- the cancer

1 that I have often progresses into leukemia.
2 About a year and a half ago my white count
3 started up and my doctor was somewhat
4 concerned, and he gave me what's called bone
5 cores out of my hip, and I've had three since
6 because of the high level of my white count.
7 Fortunately I did not have any sign of
8 Philadelphia chromosome or of one other "blast"
9 so that they could not identify that. I had
10 not progressed into leukemia yet, but that is a
11 natural progression from my disease that'll
12 occur over probably the next few years.
13 And so what I'm speaking now -- actually I have
14 no recriminations about my service at the Lab,
15 that they have done this to me, because if I
16 could do it all over again, I would in fact do
17 it. Because I feel humbled when I see, every
18 day, young men that are killed in Iraq. I have
19 given very little in comparison. Yet I feel
20 that I would like some remuneration because of
21 the expenses associated with my treatment.
22 Sometimes they are in excess of $1,000 a month.
23 And so I'm sorry to have taken up your time and
24 I'm not in better voice. Thank you.
25 **DR. ZIEMER:** Thank you very much. You

1 certainly don't need to be sorry for sharing
2 your story with us today. Thank you.
3 Are there any other members of the public who
4 do wish to speak to the Board today? Yes,
5 ma'am, please -- and identify yourself for our
6 recorder, please.
7 **MS. BLEWITT:** My name is Beryl Blewitt and I
8 live in Stockton. I'm here to speak for my
9 son, David Dwight Blewitt, who as a very young
10 man went out to Livermore Lab and was a
11 driller. He drilled the soil and I'm not sure
12 that I can really describe in an intelligent
13 way what his work was like because I wasn't
14 there and I'm not trained in that. But he is -
15 - he's unable actually to come here and speak
16 to you himself because he is not emotionally
17 able.
18 He went to Lawrence Livermore Lab as a young
19 married man and would have done anything that
20 they told him to do. And in drilling for --
21 drilling the soil, much strange substance was
22 spewed into the air and they all touched all
23 this stuff and there were many chemicals
24 around. And we feel quite sure that beryllium
25 was one of them because he continued to do this

1 work for quite a long time, maybe four years,
2 until he just wasn't able to continue.
3 And now he has a very short memory. He is not
4 able to focus on things. He has -- he is very,
5 very depressed, constantly, every day. He has
6 been given by this group, or was given about
7 two years ago, this -- these forms that he was
8 told to take to the doctors whom he visited
9 with, and he has visited with at least 15
10 different doctors and has told them that he
11 doesn't feel well. He doesn't know what's
12 wrong with him. His stomach constantly hurts.
13 He has no drive, no ambition, nothing. He's
14 depressed, and he wants the doctor to help him
15 find out what is wrong. And the doctors all
16 said oh, I understand you worked at Lawrence
17 Livermore Lab? Yes, sir. Well, try these
18 pills, and if they don't help you, try these,
19 try these, try these, try these. He must have
20 had between 50 and 100 different kinds of pills
21 -- which made him more ill. He would throw up.
22 He would sleep for 20 hours at a time. He
23 would be completely disoriented and have no
24 memory.
25 One doctor -- and we asked -- I said David, ask

1 the doctor if he can put you in touch with
2 someone who can diagnose you more specifically,
3 because none of this is helping. It's making
4 it -- it worse. David would fall on the ground
5 unexpectedly. He was in his thirties. His
6 children were frightened. What's wrong? We
7 don't know. Well, take these pills, these
8 pills and these pills. And he would vomit. He
9 would sleep. And nothing made him better. So
10 I said see if you can find a doctor who knows
11 something about the action of those chemicals
12 on the human body and maybe we can trace down
13 and see what's wrong. And if they say no,
14 there's nothing here, it's all in your head,
15 that's one thing. But I don't think that it's
16 in his head 'cause I have seen his reactions.
17 His wife threw up her hands and said I don't
18 want any more of this. She divorced him.
19 Because of the heavy financial impact on -- all
20 the drugs, buying all these drugs and throwing
21 them out, they were not able to keep their
22 house, so they lost their house.
23 What does David have now? Two sons who wonder
24 about him. Are you a druggie, Dad? That's all
25 he has -- and me. I'm not an eloquent speaker.

1 I have prepared nothing. I just know this from
2 first-hand experience. If you have a question
3 you'd like to ask me, I'd like to help by
4 answering. But unless you direct me, I don't
5 know how to expand further except to say that
6 one doctor found a lump about that big around
7 at the base of his skull. He didn't know what
8 it was and he said well, we'll watch it for a
9 while. So three or four months went on and
10 nothing changed. They continued to take brain
11 scans and that sort of thing, and it didn't
12 change in its diameter or in any other way
13 within that three or six-month period, so they
14 didn't know what it was. They didn't want to
15 operate because it would be possibly fatal if
16 it were incorrectly done and they didn't know
17 what it was all about anyway.
18 So my request is, is there some way that I can
19 reach someone here to put me in touch with some
20 doctor somewhere who will help me and help my
21 son? Thank you.
22 **DR. ZIEMER:** Thank you.
23 **MS. BLEWITT:** Is there a question?
24 **DR. ZIEMER:** Your -- your remarks have been
25 heard by a variety of folks from different

1 agencies, and perhaps after the meeting someone
2 may be able to direct you. I -- I don't know
3 the answer to your question at this point, but
4 we've heard what you've said and it -- it
5 appears to me that this may be a Department of
6 Labor issue. It's apparently not involving a
7 cancer case, which we're dealing with here, but
8 perhaps there are some here -- but thank you
9 for sharing that with us, yes.
10 Were there any others -- members of the public
11 that did wish to speak today?
12 Okay, thank you very much. We'll proceed with
13 our agenda items.
14 **BOARD WORKING SESSION**
15 We're going back to our Board working session.
16 We have a number of -- a variety of items we
17 need to finish up here quickly.
18 First of all, the quality assurance and the
19 conflict of interest plans for our contractor,
20 SC&A. Those are in your notebook. These are
21 the final versions which, as I said, had mainly
22 editorial changes from the -- from the versions
23 that we looked at at our previous meeting. I'd
24 like to ask Hans or any of the SCA people, can
25 you confirm for us there are no substantive

1 changes other than those editorials that we
2 talked about last time?
3 **DR. BEHLING:** To my knowledge, no. I think
4 we've pretty much discussed the issues that we
5 need to address in our revised version here, so
6 --
7 **DR. ZIEMER:** And most of those changes were
8 labeling some -- can you remind us of what
9 those changes were? The notebooks have the new
10 version but not the old. Or do you recall what
11 the changes -- just describe the changes.
12 **DR. BEHLING:** Well, I'm not sure which document
13 we're referring to.
14 **DR. ZIEMER:** The conflict of interest plan --
15 **DR. BEHLING:** Well --
16 **DR. ZIEMER:** -- and the quality assurance plan.
17 You had some --
18 **DR. BEHLING:** -- there were some --
19 **DR. ZIEMER:** -- a number of places where you
20 were changing some minor wording things.
21 **DR. BEHLING:** The person who could probably
22 address that better than I can is Steve Ostrow,
23 who is one of our SC&A team members, but I'm
24 not really sure -- I've signed all the
25 documents he's asked me to sign, but quite

1 honestly --

2 **DR. ZIEMER:** Okay.

3 **DR. BEHLING:** -- the specific changes that have
4 been incorporated I'm not that familiar with,
5 so I'm going to defer to Dr. Ostrow, perhaps in
6 writing, if there's an issue that needs to be
7 resolved here.

8 **DR. ZIEMER:** I'm not aware of any issue that
9 needs to be resolved. I'm simply pointing out
10 to the Board that we had -- we had in essence
11 agreed with the substance of the documents and
12 we wanted a clean version --

13 **DR. BEHLING:** Okay.

14 **DR. ZIEMER:** -- for final action, which is what
15 you have provided for us, so then --

16 **DR. BEHLING:** Okay.

17 **DR. ZIEMER:** Is the Board prepared to actually
18 take action today?

19 (Affirmative responses)

20 **DR. ZIEMER:** Yes, we are? Okay. Motion to
21 approve the quality assurance and the conflict
22 of interest plans? Tony?

23 **DR. ANDRADE:** So moved.

24 **DR. ZIEMER:** And seconded?

25 **DR. DEHART:** Second.

1 **DR. ZIEMER:** Are there any questions or
2 discussion on those? Apparently not.
3 All in favor, say aye?
4 (Affirmative responses)
5 **DR. ZIEMER:** Any opposed, no?
6 (No responses)
7 **DR. ZIEMER:** And any abstentions?
8 (No responses)
9 **DR. ZIEMER:** Okay, then those two stand
10 approved and are in effect. For all practical
11 purposes, they were in effect anyway, the
12 quality assurance and the conflict of interest,
13 but we needed to finally approve them.
14 I wanted to clarify or make sure that the
15 working group -- which is Tony Andrade, Mark
16 Griffon, Rich Espinosa, Wanda Munn and Mike
17 Gibson -- that you have a formal wording of
18 your charge for -- this is the working group
19 now that will be in place before our next
20 meeting. We're calling this the -- it says
21 here case and audit review work group. This is
22 the work -- it's the dose reconstruction --
23 **MR. GRIFFON:** Case review work group.
24 **DR. ZIEMER:** Case review, yes. The charge is
25 to meet with NIOSH and SC&A personnel on an ad

1 hoc basis as they carry out their activities to
2 resolve and to clarify issues that have arisen
3 in the dose reconstruction reviews, and to
4 conduct preliminary review of the SCA report
5 that addresses the issues raised by NIOSH.
6 That -- that's the charge that comes from the
7 Chair to you for your work.
8 The implication is that if the two groups meet
9 in person -- that is, face-to-face -- that you
10 will be there pres-- we want a Board's presence
11 there. You are not making any decisions on
12 behalf of the Board, but you are there to
13 provide a Board presence as they seek to
14 resolve or deal with differences. And then any
15 subsequent report that comes out of that --
16 that is, revisions the SC&A may make -- you
17 will do a preliminary review of that prior to
18 its coming to the Board for action.
19 So this is mainly to assure that that presence
20 is there. If it turns out that NIOSH and SC&A
21 find that they need to meet by telephone rather
22 than in person, then we want to make sure that
23 you are involved in the teleconference, as
24 well.
25 It was also agreed that -- for example, on a

1 face-to-face meeting -- that at least three of
2 the five would be present there. We weren't
3 mandating that all five be present, but if --
4 if possible, but at least three of the five.
5 So that's just to clarify the charge to the
6 working group.
7 Any questions on that? This does not require
8 any action. I'm just clarifying -- the Chair
9 has established the work group and is giving
10 this charge for them for the next meeting.
11 **MS. MUNN:** Will you be chairing it, Dr. Ziemer?
12 **DR. ZIEMER:** No, that -- Tony will be chairing
13 it, yes.
14 **MS. MUNN:** That's what I remembered. I wanted
15 to be sure.
16 **MR. GRIFFON:** And Paul, I guess -- I'm just
17 sort of -- it's probably going to happen in
18 January, so will we have e-mail contacts from -
19 - from you to --
20 **DR. ZIEMER:** Tony will take the lead and make
21 sure -- and -- and -- and I want to make sure
22 that both NIOSH and SC&A are both aware of
23 this, that Tony needs to be kept informed, and
24 please inform the Chair, as well, if and when -
25 - or when such meetings occur. I'd simply ask

1 that that be done. Okay. And NIOSH will --
2 NIOSH will actually make sure that it occurs.
3 Right?
4 **MR. ESPINOSA:** Tony, would you like a list of
5 available dates, maybe for January?
6 **DR. ANDRADE:** That would be helpful. However,
7 I think that really we're going to be kind of
8 at the mercy of when it's most convenient for
9 NIOSH and for SC&A to meet. So I will -- I
10 will try and get that information out to you as
11 -- as soon as I can. I will either be calling
12 Larry and/or Jim for NIOSH and John or Joe for
13 SC&A.
14 **DR. ZIEMER:** Okay, thank you. Let's proceed
15 then. We had a question on the status of the
16 Q-clearance access. Who raised that issue?
17 Was that -- Jim had raised it. Maybe -- maybe
18 -- I think it was just a request for a report
19 on that, and is there anyone here that can tell
20 us where that stands? I know that -- I believe
21 either John Mauro or Joe had written a letter -
22 - Larry does --
23 **MR. ELLIOTT:** I can help out, I think.
24 **DR. ZIEMER:** Can you tell us the status of
25 that?

1 **MR. ELLIOTT:** I hope. I hope I can. The two -
2 - two individuals from Sanford Cohen &
3 Associates that applied for Q clearance have
4 now received their background checks and have
5 been, I believe, granted the top secret
6 clearance necessary for HHS. We have sent a
7 letter to DOE asking them to expedite transfer
8 of the Q based upon the background check and
9 top secret status of those two individuals.
10 Both individuals are with one of the teaming
11 partners with Sanford Cohen & Associates, so
12 Salient has to go forward to DOE and -- and
13 explicitly make the request to make this happen
14 and make the transfer, but we have entered a
15 letter on their behalf to make sure that that
16 is expedited, so it should be forthcoming. It
17 should be imminent.
18 **DR. ZIEMER:** So that's moving along then.
19 Thank you. And I think all that we asked for
20 was that status report. Next --
21 **MR. GRIFFON:** Before we get off that, were
22 there any issues -- I think it's only Savannah
23 River where there's been -- where SCA is still
24 having data access issues. Are those -- is
25 that an ongoing issue or is that -- most of

1 those been resolved?
2 **MR. ELLIOTT:** Jim, can you speak to that -- or
3 Stu? Stu's got that?
4 **MR. HINNEFELD:** Are we on? Yeah. It's not
5 resolved, but we're resolving. We're engaged
6 with Savannah River. There is an open request
7 for documentation that I kind of put into three
8 categories, mentally. There was some copied
9 information apparently at Savannah River that
10 the understanding was Savannah River was going
11 to send to Sanford Cohen & Associates that
12 didn't get there. And I don't have an update
13 on that, but I'm -- have asked the question. I
14 think I -- I know who had the custody or who --
15 who had control of the documents at Savannah
16 River, so I -- I'm pretty confident that will
17 be pretty soon.
18 There was an itemized list of documents in the
19 letter that they -- that Sanford Cohen &
20 Associates sent to us saying can you help us
21 get these things. Some portion of that is
22 being burned onto a disk and should be
23 available shortly after Christmas. A portion
24 of it -- there was apparently some
25 misunderstanding about what the request was

1 for, and so I have clarified the request back
2 to Savannah River in terms of what exact
3 documents are -- were being asked for.
4 And then there were some microfilm images that
5 were requested, certain specific microfilm
6 images off of certain specific spools of
7 microfilm, which is proving pretty problematic
8 for Savannah River to obtain and pull off. And
9 so a suggestion from Savannah River was that
10 perhaps the principal from SC&A could go to
11 Savannah River. They would make access
12 available to the film machine and copying so
13 that that person could select the images
14 desired and -- in that fashion, and they
15 thought -- Savannah River thought that would be
16 quicker than -- than having the specific person
17 at Savannah River who had to go look at it, who
18 could interpret the images and knew what was
19 being asked for, to have time to go do it.
20 Okay?
21 Third category in the letter was actually a new
22 request within the past week and a half having
23 to do some things that we do have control of,
24 and we should have that from our contractor
25 relatively -- relatively straightfor--

1 relatively soon. There was a request for
2 minutes of a meeting where no minutes were
3 taken, no minutes were generated, so I don't
4 know exactly what we do about that, but -- I
5 don't know if there's some notes that can be
6 compiled or not, but that is the status of the
7 Savannah River request.
8 **DR. ZIEMER:** Okay. Thank you, Stu. Yes, Hans?
9 **DR. BEHLING:** Could I ask Mr. Elliott to
10 clarify who the two individuals are whose Q
11 clearance is imminent, because I think --
12 **MR. ELLIOTT:** I'll do that off-line with you.
13 Okay? I don't do that in public.
14 **DR. BEHLING:** Okay. But there are multiple
15 people and on -- on -- and I just -- you know
16 what my role is.
17 **MR. ELLIOTT:** Understood, but I --
18 **DR. BEHLING:** Right.
19 **MR. ELLIOTT:** If you're familiar with national
20 security interests, these people with Qs are
21 supposed to protect that information, so I'll
22 share that with you before we depart.
23 **DR. ZIEMER:** John Doe and John Smith.
24 **MR. GRIFFON:** Are there -- are there -- just to
25 follow up on that, are there any other out--

1 outstanding data requests that -- that are
2 problematic, I guess, either SCA or...
3 **UNIDENTIFIED:** Well --
4 **MR. GRIFFON:** It sounds like no is the answer,
5 I don't know.
6 **DR. BEHLING:** That I'm not sure of. The people
7 who are requesting that information are members
8 of the SC&A team, and two of them were here,
9 but I'm not really party to that particular
10 request so I'm not in a position to comment.
11 **MR. HINNEFELD:** I don't know of any outstanding
12 questions, although there was a request for
13 access for site experts at the Hanford facility
14 for -- as part of the profile review, and the
15 contact at Richland, how-- or DOE Richland
16 office, for SC&A to make contact with to
17 arrange those discussions has been provided to
18 SC&A, and that should proceed -- they will run
19 into vacation issues for the rest of December.
20 It'll be unlikely that they'll have very much
21 success at all talking to anybody at Hanford
22 until after the first of the year.
23 **DR. ZIEMER:** Okay, thank you. Another
24 carryover item we had from our earlier work
25 session was the wording of some caveats that

1 would appear on future copies of our
2 contractor's reports -- dose reconstruction
3 review reports. We had tasked Tony during the
4 break to come up with those caveats, which
5 would include the statement that the report had
6 not yet been accepted by the Board and that it
7 had not yet been reviewed by NIOSH, or
8 something to that effect, and you were going to
9 -- you perhaps had some additional -- do you
10 want to tell us what you are proposing, Tony?
11 **DR. ANDRADE:** Sure. Of course this is my
12 draft. I have -- it certainly can be edited as
13 -- as you see fit. However, it does
14 incorporate the elements that I also brought up
15 during the discussion of develop-- about
16 developing this particular set of caveats and
17 disclaimers, if you will. What I can do is
18 read it.
19 **DR. ZIEMER:** Yes --
20 **DR. ANDRADE:** The recorder can take it and --
21 **DR. ZIEMER:** -- you're going to propose this
22 and let's see.
23 **DR. ANDRADE:** -- we can either act on it now or
24 I can send it around by e-mail to everybody,
25 but --

1 **DR. ZIEMER:** No, we need to act on it in open
2 session, so --
3 **DR. ANDRADE:** Okay.
4 **DR. ZIEMER:** -- we'll either --
5 **DR. ANDRADE:** All right.
6 **DR. ZIEMER:** We'll either accept it or reject
7 it or do something with it. We're going to --
8 **DR. ANDRADE:** Okay.
9 **DR. ZIEMER:** You're going to propose and we'll
10 dispose.
11 **DR. ANDRADE:** All right. There are some
12 abbreviations here, but these could be spelled
13 out. The ABRWH and SC&A note that the attached
14 report is predecisional -- all in caps. This
15 implies that the contents regarding NIOSH
16 methods herein have not been reviewed by the
17 ABRWH or NIOSH for -- first dash -- scientific
18 accuracy -- and second dash -- or applicability
19 within the context of the provisions of -- and
20 I think this is correct -- 40 CFR 22. Is that
21 dose reconstruction?
22 **MR. ELLIOTT:** 82.
23 **DR. ANDRADE:** 82. 42?
24 **MR. ELLIOTT:** 42 CFR part 82.
25 **DR. ZIEMER:** Incidentally, I believe the

1 statement on technical accuracy probably won't
2 be correct. That will have been done, will it
3 not? Or factual accuracy.
4 **DR. NETON:** (Off microphone) Not technical
5 (unintelligible).
6 **DR. ZIEMER:** What were the words that you used?
7 **DR. ANDRADE:** I said scientific, but I don't
8 know if factual is even there. I thought that
9 we had agreed that it would be reviewed for
10 privacy information. Okay?
11 **DR. ZIEMER:** Yeah.
12 **DR. ANDRADE:** Okay. So I'll reread the last
13 phrase there -- has not been reviewed by the
14 ABRWH or NIOSH for factual accuracy or --
15 second dash -- applicability within the context
16 of the provisions of 42 CFR 22, dose
17 reconstruction, period.
18 **UNIDENTIFIED:** (Off microphone) 82.
19 **DR. ANDRADE:** 82. 82, okay. This also implies
20 that once -- that once reviewed by the ABRWH,
21 its conclusions are subject to change, comma,
22 or deletion, period. Hence, this report is for
23 information only and notice is given that
24 premature interpretations regarding its
25 conclusions may be irresponsible.

1 **DR. ZIEMER:** Okay. And that is your proposal?
2 **DR. ANDRADE:** Yes.
3 **DR. ZIEMER:** And you're making that as a motion
4 then --
5 **DR. ANDRADE:** Yes.
6 **DR. ZIEMER:** -- and I'll ask for a second, and
7 then we'll discuss it.
8 **MR. PRESLEY:** Second.
9 **DR. ZIEMER:** Seconded. Actually I believe
10 there's three different sort of parts to this,
11 the first part being that this is -- you said
12 the Board and SCA note that this is
13 predecisional?
14 **DR. ANDRADE:** Right.
15 **DR. ZIEMER:** And has not been reviewed for
16 factual accuracy or applicability within the
17 requirements of 10 CF -- not 10 -- of 42 CFR
18 82. Is that -- am I correct so far?
19 **DR. ANDRADE:** Yes.
20 **DR. ZIEMER:** That's -- that's part one.
21 **DR. ANDRADE:** One.
22 **DR. ZIEMER:** Part two, this also implies that
23 once --
24 **DR. ANDRADE:** Reviewed.
25 **DR. ZIEMER:** -- reviewed, the -- what, the

1 content or the --

2 **DR. ANDRADE:** By the ABRWH --

3 **DR. ZIEMER:** Uh-huh.

4 **DR. ANDRADE:** -- its conclusions are subject to

5 --

6 **DR. ZIEMER:** The report's conclusions here,

7 you're --

8 **DR. ANDRADE:** Yes.

9 **DR. ZIEMER:** -- not the Board's.

10 **DR. ANDRADE:** Are subject to change or

11 deletion.

12 **DR. ZIEMER:** All right. And the third part is?

13 **DR. ANDRADE:** Okay. Hence this report is for

14 information only and -- well, we can throw this

15 other stuff out -- that premature

16 interpretations regarding its conclusions --

17 the report's conclusions -- may be

18 irresponsible.

19 **DR. ZIEMER:** Okay. Now what I'd like to do, I

20 think, is -- with your permission, is divide

21 the motion into three parts, because I can see

22 -- at least it appears to me that one might

23 favor portions of this and be concerned about

24 other portions and -- or want to handle them in

25 a different way.

1 Is that an agreeable approach or do you want to
2 do it as one whole fell swoop?
3 **DR. ROESSLER:** I'd like to try the first -- all
4 in one...
5 **DR. ZIEMER:** Well, let me open the floor for
6 discussion and we'll just do it that way. It's
7 one motion right now.
8 Let me point out something, just as kind of a -
9 - sort of informational item here. I believe
10 that the report is the report. That report is
11 not subject to change -- I mean that's the --
12 they -- they will be delivering to us the
13 product. That's -- the task says bring us your
14 report. What is -- I'm trying to differentiate
15 here between what we do with it.
16 Now it's true, we could say go back and give us
17 a different report, or we could say the -- the
18 conclusions may not be accepted or may -- or
19 whatever. I'm not sure we want to necessarily
20 say that the report itself is going to change.
21 **DR. ANDRADE:** I didn't --
22 **DR. ZIEMER:** You know what -- how I'm trying to
23 distinguish between --
24 **DR. ANDRADE:** Right.
25 **DR. ZIEMER:** -- what we do and what our

1 contractor's done. They bring us a report,
2 which I think in a sense is the final product.
3 **DR. ANDRADE:** Right.
4 **DR. ZIEMER:** We can always go back and say we
5 don't -- we didn't like that report; we want a
6 different one.
7 **DR. ANDRADE:** That's why I said the report's
8 conclusions, I didn't say the report was
9 subject to change.
10 **DR. ZIEMER:** I gotcha.
11 **DR. ANDRADE:** But maybe conclusions is too
12 closely tied to the report, hence there --
13 there may be a better word.
14 **DR. ROESSLER:** Interpretations?
15 **MR. GIBSON:** Content of the report?
16 **MR. PRESLEY:** Interpretation of the report.
17 **MR. GIBSON:** Content or its findings?
18 **DR. ZIEMER:** The thrust of what we want to
19 accomplish, I believe, is to indicate that the
20 Board may accept, may reject or may change what
21 it believes its con-- the Board's conclusions
22 may be different from the report's. That's
23 what we're trying to point out.
24 **DR. ANDRADE:** Right.
25 **MR. GRIFFON:** Why don't we state it that

1 simply? I mean, you know...
2 **DR. ZIEMER:** Once reviewed, the -- once the
3 report is reviewed, the Advisory Board may
4 reach conclusions that differ from those in the
5 report.
6 Is that -- is that the thrust of it? You're
7 simply trying to point out that this -- at this
8 juncture it doesn't represent the Board's view,
9 and the Board's views may or may not be
10 different.
11 **DR. ANDRADE:** That's fine.
12 **MR. GRIFFON:** And then the last part of Tony's
13 sentence there would be -- and therefore this
14 report is for information purposes only. I
15 agree with that. The part after "only" I have
16 a little bit of heartburn about. I could agree
17 with everything up till the "only", probably.
18 **DR. ANDRADE:** That's --
19 **MR. GRIFFON:** Yeah.
20 **DR. ANDRADE:** That's where I...
21 **DR. ZIEMER:** Well --
22 **DR. ANDRADE:** The part after that is...
23 **DR. ZIEMER:** -- let me take the second part and
24 see if you want -- you're regarding that as a
25 friendly amendment? Do you want to just say

1 this also implies that the re-- the report's
2 conclusions may not -- or the Board's -- the
3 Board's positions -- position may not be the
4 same as the --
5 **DR. DEHART:** May differ.
6 **DR. ZIEMER:** -- may differ from the report's
7 conclusions. Okay.
8 **DR. ANDRADE:** That's fine.
9 **DR. ZIEMER:** So the second part would be the
10 Board's position may -- after review, the
11 Board's position may differ from the report's
12 conclusions.
13 And then the third one -- Mark, you're
14 proposing, I think --
15 **MR. GRIFFON:** The Board's positions or the
16 Board's recommendations?
17 **DR. ZIEMER:** The Board's position -- positions
18 and recommendations --
19 **DR. DEHART:** There are no recommendations in
20 there, per se, are there -- in that report?
21 **MS. MUNN:** The Board's conclusions.
22 **DR. DEHART:** But the conclusions.
23 **MS. MUNN:** Uh-huh, the Board's conclusions.
24 **MR. GRIFFON:** Positions is fine, I guess.
25 **DR. ZIEMER:** The Board's positions may differ

1 from those -- from the report's conclusions.
2 And then the third item would be this report is
3 released for information only, and that
4 premature interpretation regarding its use may
5 be irresponsible.
6 Mark, you're proposing that the last phrase be
7 dropped, and I think I'll interpret that as a
8 proposed amendment and ask if there would be a
9 second to dropping that phrase -- and it's
10 seconded. Any discussion on dropping the
11 phrase? Yes.
12 **DR. ANDRADE:** That was my whole driver. Okay?
13 That was my bottom line driver for even
14 volunteering to put this together. That, I
15 believe, has to be in there. I am sick and
16 tired of personalities taking things out of
17 context. I believe either that word stays or
18 we just change the word.
19 **DR. ZIEMER:** Other -- other comments on that?
20 Wanda?
21 **MS. MUNN:** I think a statement of that type
22 definitely needs to be there. I would tweak
23 the words a little bit, but from my
24 perspective, this statement is part and parcel
25 of the message that needs to be conveyed.

1 In the same tone, I would begin that statement
2 with the reader should be cautioned, or the
3 reader should be warned that -- before the rest
4 of the words flow.
5 **DR. ZIEMER:** Be cautioned that what?
6 **MS. MUNN:** That this document has not seen the
7 light of day.
8 **DR. ZIEMER:** Well, we basically said that in
9 the first two items.
10 **MS. MUNN:** I know, but I'm -- I'm speaking to
11 two different things here. First I'm
12 responding to the question with respect to the
13 final statement, and I'm also saying in
14 addition to that, before any of the beginning
15 statement, I would have added the reader should
16 be cautioned or the reader should be warned.
17 **DR. ZIEMER:** Well, the reader should be
18 cautioned that this report is for information
19 only? Is that still friendly? And that
20 premature interpretation of its conclusions --
21 **MS. MUNN:** And interpretation of its
22 conclusions is unwarranted and unwise, I would
23 say.
24 **DR. ROESSLER:** How about unprofessional? We
25 need to tone it down maybe a little bit.

1 **MR. GRIFFON:** Yeah.
2 **DR. ZIEMER:** Well --
3 **DR. ROESSLER:** Shouldn't have quite so much
4 emotion.
5 **DR. ZIEMER:** -- unprofessional, irresponsible,
6 all are pretty judgmental. It seem-- why can't
7 we just say please don't do it.
8 **MR. GRIFFON:** And interpretation of -- of -- I
9 was just going to stop it at "is premature", or
10 --
11 **DR. ZIEMER:** The reader should be cautioned
12 that this report is for information only and
13 premature --
14 **MR. GRIFFON:** And drawing conclusions from this
15 report at this point --
16 **DR. ZIEMER:** Is unwarranted --
17 **MR. GRIFFON:** -- is premature or is --
18 **DR. ZIEMER:** How about drawing premature
19 conclusions is unwarranted? How would -- is
20 that --
21 **UNIDENTIFIED:** (Off microphone) That's fine.
22 **MS. MUNN:** How about just drawing conclusions?
23 **DR. ZIEMER:** Is that strong enough, Tony,
24 without being too harsh, or --
25 **DR. ANDRADE:** That's like -- that's like

1 putting a really big fat boxer's glove my right
2 hand instead of letting me hit it with a fist.
3 **DR. ZIEMER:** That's sort of what I'm trying to
4 do.
5 Well, look, can I make the glove any smaller
6 and still...
7 **DR. ANDRADE:** I'll accept that. That's fine.
8 **DR. ZIEMER:** Drawing premature -- drawing
9 premature -- what was it?
10 **DR. ROESSLER:** Interpretations.
11 **DR. ZIEMER:** -- interpretations, I can't read
12 my own writing at this moment --
13 interpretations regarding its content is not
14 warranted -- is unwarranted?
15 **MR. PRESLEY:** Is unwarranted.
16 **MR. GRIFFON:** Either way. Paul, can I -- can I
17 --
18 **DR. ZIEMER:** I'm going to send Tony after you.
19 **DR. ANDRADE:** One of my cousins.
20 **MR. GRIFFON:** Can I ask to go back to the
21 beginning part again, just to -- just to hear -
22 -
23 **DR. ZIEMER:** I will read you what I have, and I
24 may need help.
25 The Advisory Board -- ABRWH, the Advisory

1 Board, and SC&A note that the attached reports
2 -- report is predecisional and has not yet been
3 reviewed for factual accuracy or applicability
4 within the requirements of 42 CFR 82 -- is that
5 the right one?
6 This also implies that the report's -- this
7 implies that the report's conclusions -- I'm
8 trying to read my writing. This -- this
9 implies that the report's conclusions have not
10 been reviewed by the Advisory Board -- wait a
11 minute. I've made so many changes I'm having
12 trouble reading this. This implies that until
13 reviewed by the Advisory Board, the report's
14 conclusions are subject to change or deletion.
15 The reader should be cautioned that this report
16 is for information only, and that premature
17 interpretations regarding its conclusions are
18 unwarranted.
19 **MR. GRIFFON:** I'm con-- now I'm a little
20 confused 'cause I thought you were going to
21 change that part of subject to change or
22 deletion to the Board's positions may differ.
23 **DR. ZIEMER:** That's where I -- I've made so
24 many changes that I can't read it. Yes, I
25 found it. Yes, the wording is the Board's

1 positions may differ from the report's
2 conclusions, rather than subject to change or
3 deletion.
4 Now do you want to see this before you
5 somewhere on the board or...
6 **MR. GRIFFON:** (Off microphone) I don't know
7 (unintelligible) time but...
8 **DR. ZIEMER:** Are you comfortable enough, with
9 some -- some polishing, that --
10 **MR. GRIFFON:** Just that front end I wanted to
11 discuss for one more --
12 **DR. ZIEMER:** Yeah.
13 **MR. GRIFFON:** -- one more --
14 **MS. MUNN:** And me.
15 **MR. GRIFFON:** The factual accuracy review, I
16 thought -- I thought that was going to take
17 place prior to --
18 **DR. ZIEMER:** Yes, that's why I asked that
19 question originally when --
20 **MR. GRIFFON:** Yeah.
21 **DR. ZIEMER:** Was factual accuracy the words you
22 used in your -- or was it technical -- it's
23 factual.
24 **DR. ANDRADE:** Okay, I said scientific.
25 **MS. MUNN:** Scientific.

1 **DR. ANDRADE:** But I mean --
2 **MR. GRIFFON:** Yeah.
3 **DR. ANDRADE:** -- it implies factual. When Dr.
4 Melius was here, I --
5 **MR. GRIFFON:** That was different, though.
6 **DR. ANDRADE:** -- thought it was agreed that
7 this process --
8 **DR. ZIEMER:** Factual accuracy would -- would
9 occur.
10 **DR. NETON:** There is a factual accuracy review
11 by NIOSH, but the Board certainly hasn't done
12 any factual accuracy review, and that's what I
13 was interpreting that to say, but...
14 **DR. ANDRADE:** Exactly. And I thought that key
15 in the review process would be that SC&A sends
16 the report to NIOSH, and there is perhaps a
17 factual accuracy review, but most importantly,
18 there will be a Privacy Act review, and then
19 it's sent out --
20 **DR. ZIEMER:** So you're talking about a review
21 by us.
22 **DR. ANDRADE:** Yes.
23 **DR. ZIEMER:** Okay, understood. Are you ready
24 to vote on the motion? Yes, Wanda?
25 **MS. MUNN:** One more requested word change. In

1 the very first line, instead of "note", can we
2 say "warn" -- "warns" rather than "notes",
3 because this is intended -- the entire
4 statement is intended to be a warning, a
5 cautionary statement.
6 **MR. GRIFFON:** How about "cautions"?
7 **MS. MUNN:** We've used "caution" down below, but
8 -- I really have no objection, I just think
9 "notes" is kind of a --
10 **DR. ZIEMER:** Does "cautions" --
11 **MS. MUNN:** -- weak...
12 **DR. ZIEMER:** -- sound okay with everybody?
13 **MS. MUNN:** "Cautions" is fine with me.
14 **DR. ZIEMER:** Okay. We ready to vote on this?
15 We may have to do a little polishing, but you
16 understand what the content will be. Okay.
17 Yes, Leon?
18 **MR. OWENS:** Would you read the entire language,
19 please, Dr. Ziemer, for my --
20 **MR. GRIFFON:** This is just a test, you
21 understand.
22 **DR. ZIEMER:** I'll try to read --
23 **MR. GRIFFON:** We want to see if you can.
24 **DR. ZIEMER:** Somebody take notes.
25 **MS. MUNN:** Someone write this down.

1 **DR. ZIEMER:** Okay. One, the Advisory Board and
2 SCA caution that the -- that the attached
3 report -- attached -- or that this report --
4 **UNIDENTIFIED:** (Off microphone) It should be
5 attached.
6 **UNIDENTIFIED:** (Off microphone) This is a
7 cover...
8 **DR. ZIEMER:** Okay. Well, doesn't this have to
9 be stamped on the report? It should be in the
10 report, not a -- not a -- not as a cover
11 letter. I think it should be stamped on the
12 report.
13 **UNIDENTIFIED:** Okay.
14 **DR. ZIEMER:** Caution that this report is
15 predecisional and has not yet been reviewed for
16 factual accuracy or applicability within the
17 requirements of 42 CFR 82.
18 Two. This implies that the report's content,
19 until reviewed by the Advisory Board, is --
20 until reviewed by the Advisory Board, may
21 differ -- this is the one I'm having trouble
22 with all my mark-up. This implies that the --
23 **MR. GRIFFON:** Board's positions may differ.
24 **DR. ZIEMER:** That until reviewed by the
25 Advisory Board, the...

1 **MR. GRIFFON:** No, no, no.
2 **DR. ZIEMER:** The positions in the report may
3 differ from -- or the -- wait a minute.
4 **MR. GRIFFON:** One -- this implies that once
5 reviewed by the Advisory Board --
6 **DR. ZIEMER:** Yes, that -- there's the word,
7 once reviewed --
8 **MR. GRIFFON:** -- the positions may --
9 **DR. ZIEMER:** This implies that once reviewed by
10 the Advisory Board, the Board's positions may
11 differ from the report's conclusions.
12 That's the word I missed, once. Okay, thank
13 you.
14 Three -- we okay, Leon? Okay.
15 Three, the reader should be cautioned that the
16 report is for information only and that
17 premature interpretation regarding its
18 conclusions is unwarranted.
19 **MR. GRIFFON:** And just one question that I just
20 thought about. At the very beginning we say
21 the Board and SCA caution. I don't know that
22 we can speak for SCA in our -- in our -- just a
23 -- just a question I have.
24 **MR. PRESLEY:** Shouldn't it just be the Board
25 cautions?

1 **MR. GRIFFON:** Yeah, yeah.
2 **DR. ZIEMER:** We're asking SCA to put this in
3 the report.
4 **MR. GRIFFON:** That's true.
5 **DR. ZIEMER:** We can ask them to do that, and so
6 this caution would come from us and from our
7 contractor.
8 **MR. GRIFFON:** Okay. I just wanted to point
9 that out.
10 **DR. ZIEMER:** I believe we can do that. Anyone
11 disagree?
12 Are you ready to vote on this then? Mike, you
13 have a comment?
14 **MR. GIBSON:** One more comment. I think we may
15 be better served -- it's just my opinion --
16 that we turn this around to make it positive
17 and say that it's the Board's intention to
18 share all information that we're legally
19 allowed to share with the public until we have
20 to enter into deliberations, yada, yada, yada.
21 However --
22 **MR. GRIFFON:** The Board cautions, yeah.
23 **MR. GIBSON:** I mean make it -- make it that
24 we're trying to make ourselves --
25 **MR. GRIFFON:** That's a good point.

1 **DR. ZIEMER:** It's certainly a good point. Do
2 you regard that as a friendly amendment, or you
3 can add that -- we could add that as an
4 addition, as a separate motion, if you wish?
5 You just want --
6 **MR. GIBSON:** (Unintelligible)
7 **DR. ZIEMER:** I -- it sounds like -- does it
8 sound like a friendly amendment that we don't
9 go through the voting process here? Give us
10 your wording on that. Now you have to do it.
11 **MS. MUNN:** We the members of the Advisory Board
12 --
13 **MR. GIBSON:** The Advisory Board on Radiation
14 and Worker Health strongly believe that the
15 public has the right to information -- public
16 information, and we will -- has a right to
17 public information. This report is
18 predecisional -- this report has not been
19 reviewed by the Advisory Board -- and however
20 you want to finish it up.
21 **DR. ROESSLER:** Just tie it together with the
22 however.
23 **MR. GRIFFON:** Yeah, go into the however. The
24 Board --
25 **DR. ZIEMER:** The Advisory Board strongly

1 believes that the public has a right to early
2 access to its --
3 **MR. GIBSON:** To public information.
4 **DR. ZIEMER:** Well, the public has a right to
5 public information --
6 **MR. GIBSON:** That's right.
7 **DR. ZIEMER:** -- to early access to the Board's
8 --
9 **MR. GIBSON:** Work products or predecisional --
10 **DR. ZIEMER:** The Board --
11 **DR. DEHART:** This information, just -- early
12 access to this information.
13 **DR. ZIEMER:** To the information herein.
14 **MR. GRIFFON:** Yeah, that's fine.
15 **DR. ZIEMER:** However, and then the rest of it.
16 We okay on that?
17 Thank you, that's a good suggestion.
18 **MS. HOMOKI-TITUS:** Can you just read that over?
19 **DR. ZIEMER:** I don't know if I can.
20 **MR. ESPINOSA:** Motion to adjourn?
21 **DR. ZIEMER:** You want everything or just this
22 last addition?
23 **MS. HOMOKI-TITUS:** Just the new part.
24 **DR. ZIEMER:** The Advisory Board on Radiation
25 and Worker Health strongly believes that the

1 public has the right to early access to the
2 information contained herein. However -- and
3 then we can continue with the cautionary stuff.
4 **MS. MUNN:** Can we not say in accordance with
5 the strong position of the ABRWH --
6 **DR. ZIEMER:** Yes.
7 **MS. MUNN:** -- regarding --
8 **DR. ZIEMER:** That's a better --
9 **MS. MUNN:** -- public access --
10 **DR. ZIEMER:** That's a better way of saying the
11 same thing. In accordance with the --
12 **MS. MUNN:** Strong position --
13 **DR. ZIEMER:** -- strong position --
14 **MS. MUNN:** -- of ABR--
15 **DR. ZIEMER:** -- of the Advisory Board --
16 **MS. MUNN:** -- on Radiation --
17 **DR. ZIEMER:** -- to provide the public with
18 early access --
19 **MS. MUNN:** To provide all possible access -- or
20 you know, all -- it's -- it depends on which
21 way you want to cast the light.
22 **DR. ZIEMER:** In accordance with the Advisory
23 Board's strong position that --
24 **MS. MUNN:** Regarding open access --
25 **DR. ZIEMER:** -- that the public should have --

1 **DR. DEHART:** (Off microphone) (Unintelligible)
2 use transparent?
3 **DR. ZIEMER:** -- have what, open access?
4 **MS. MUNN:** Uh-huh.
5 **DR. ZIEMER:** -- to the information contained
6 herein --
7 **MR. GRIFFON:** No.
8 **DR. ZIEMER:** Now I've lost some continuity
9 here. In accordance with the Advisory Board's
10 --
11 **DR. ROESSLER:** Well, saying the Advisory Board
12 unanimously -- something and make a sentence
13 out of it.
14 **MS. MUNN:** In accordance with the na, na, na,
15 na, na, na, na, this material is made available
16 for public viewing, then period. However...
17 **DR. ZIEMER:** Now this is -- this is starting to
18 get a little thorny for a last-minute -- would
19 you like the Chair to simply -- I think we know
20 the intent of this. Do you want to do the
21 wordsmithing at the table or do you just want
22 to authorize -- and if you don't like the way -
23 - and we're going to -- this is going to appear
24 -- what -- what we'll do is get a version that
25 you can see and look at and really embrace. I

1 think we're going to get too fragmented here.
2 We'll have something that they can use before
3 the next meeting, if necessary. And if it
4 isn't quite right, we'll -- is that agreeable?
5 I want you to vote on this and tell us this is
6 the idea, and we may have one or two words that
7 aren't quite right --
8 **MR. GRIFFON:** But the intent will remain.
9 **DR. ZIEMER:** Huh?
10 **MR. GRIFFON:** The intent will remain.
11 **DR. ZIEMER:** The intent is there. Allow us a
12 little bit of -- of wordsmithing. Wanda, you
13 can help me get that sentence before you leave
14 today.
15 **MS. MUNN:** I will.
16 **DR. ZIEMER:** Okay. Now let's vote on this and
17 move forward. All in favor, aye?
18 (Affirmative responses)
19 **DR. ZIEMER:** Any opposed, no?
20 (No responses)
21 **DR. ZIEMER:** Any abstentions?
22 (No responses)
23 **DR. ZIEMER:** Good, we'll -- we'll polish that
24 up. Thank you. And -- and Liz, we'll get you
25 a -- some kind of clean copy before we leave

1 here. Okay? Or do you need it today?
2 **MS. HOMOKI-TITUS:** Just whenever. It doesn't
3 have to be today.
4 **DR. ZIEMER:** Oh, okay.
5 **MS. HOMOKI-TITUS:** I was just a little lost on
6 it.
7 **DR. ZIEMER:** Now the other item I have on this,
8 but we -- we may have already solved it, at
9 least for the next meeting. That's the dose
10 reconstruction subcommittee's role as we go
11 forward.
12 **MR. GRIFFON:** We've solved it for the next
13 meeting?
14 **DR. ZIEMER:** No, we haven't, for the long
15 range. But Mark, that was --
16 **MR. GRIFFON:** Yeah.
17 **DR. ZIEMER:** You asked that that be on the work
18 group agenda at least, so --
19 **MR. GRIFFON:** Yeah, I mean understanding that
20 it's a little late in the day to -- to wrap our
21 brains around this, I -- I think that -- you
22 know, the original intent had about eight scope
23 item -- as we pointed out the other day, and
24 especially -- you know, I don't mind the idea
25 of four Board meetings a year, but with that in

1 mind, I think we're going to have issues about
2 what goes on in those three-month periods.
3 There -- there could be activities where we
4 need some sort of Board process to take place
5 to keep things moving along, you know, and I
6 think that was part of the original idea of the
7 formation of the subcommittee, that we could do
8 -- do some of those functions on behalf of the
9 Board and --
10 **DR. ZIEMER:** Right.
11 **MR. GRIFFON:** You know, some of those scope
12 items I think involved even the interaction
13 with the contractor on issues -- clarification
14 of scope was one thing. Certainly the notion
15 of trying to do some of these roll-up reports
16 ahead of time, then to bring to the Board so
17 that everyone didn't have to go through every -
18 - every piece. And I think also the original
19 intent of the subcommittee was to sort of have
20 a rotating -- and I know now we have everyone
21 on listed, but I thought we were -- originally
22 intended to have initial five people, and then
23 sort of rotate it so we rotated the burden of -
24 -
25 **DR. ZIEMER:** Right.

1 **MR. GRIFFON:** -- of that work.
2 **DR. ZIEMER:** And also to use them as the teams,
3 as we did before.
4 **MR. GRIFFON:** Right.
5 **DR. ZIEMER:** One of the issues now that will be
6 an ongoing issue with that is that any time
7 that subcommittee is going to meet, we have to
8 go through the announcement process. It's an
9 open meeting.
10 **MR. GRIFFON:** Right, right.
11 **DR. ZIEMER:** And the only -- only way to
12 authorize that group to act on our behalf is to
13 specify, I believe in advance, what they're
14 authorized to do and --
15 **MR. ELLIOTT:** That's correct.
16 **DR. ZIEMER:** -- Liz or somebody -- in other
17 words, they do not have a free hand simply to
18 act for the Board -- sort of an ad hoc basis.
19 It has to be specified in advance, you are
20 authorized to make a decision on our behalf on
21 this particular issue. So that all has to be -
22 -
23 **MR. ELLIOTT:** No, no, you cannot authorize them
24 to make decisions. You can authorize them to
25 perform work --

1 **DR. ZIEMER:** Oh.
2 **MR. ELLIOTT:** -- and bring a recommended
3 decision to the Board --
4 **DR. ZIEMER:** Oh, it's to perform work.
5 **MR. ELLIOTT:** -- or recommended product to the
6 Board.
7 **DR. ZIEMER:** They cannot act on behalf of the
8 Board then -- I mean --
9 **MR. ELLIOTT:** They can act on behalf of the
10 Board in doing work --
11 **DR. ZIEMER:** But not decisions.
12 **MR. ELLIOTT:** -- but not making -- not coming
13 forward with a decision that the rest of the
14 Board has to swallow.
15 **MR. GRIFFON:** Right, right. And -- and I -- I
16 -- you know, I almost think that what we've
17 done for this -- between now and next meeting,
18 by setting up the work group to work with NIOSH
19 and SCA with those first 20 cases, I sort of
20 originally viewed that as sort of a
21 subcommittee task, that that's what the
22 subcommittee would be doing. Now maybe -- I
23 mean -- you know, the only thing -- the only
24 reason I wouldn't want to continue that
25 function with a work group is actually two-

1 fold. One is that work groups aren't supposed
2 to do ongoing work, as we've heard before. And
3 secondly, that it -- you know, it would appear
4 maybe to be as these behind-the-doors process
5 that we want to -- you know, we want to try to
6 keep this as --
7 **DR. ZIEMER:** Right, and if it's --
8 **MR. GRIFFON:** -- as much open as possible.
9 **DR. ZIEMER:** If it's a subcommittee, if you're
10 going to have, for example, three or four or
11 five people do all 20 cases for a particular
12 batch, then there's a tremendous burden on --
13 **MR. ELLIOTT:** No. If you have the subcommittee
14 do this, you have to have a *Federal Register*
15 notice. It has to be available to the public -
16 -
17 **MR. GRIFFON:** Right, I -- I understand.
18 **MR. ELLIOTT:** -- in an open forum --
19 **MR. GRIFFON:** I'm trying --
20 **MR. ELLIOTT:** -- or a closed forum, depending
21 upon --
22 **MR. GRIFFON:** Right, right, right.
23 **MR. ELLIOTT:** -- the discussion topic.
24 **MR. GRIFFON:** I understand.
25 **MR. ELLIOTT:** If you have a work group do it,

1 it doesn't have to be publicly announced. I'm
2 not --
3 **MR. GRIFFON:** I know.
4 **MR. ELLIOTT:** -- steering you one way or the
5 other, I'm just trying --
6 **MR. GRIFFON:** Well, I --
7 **MR. ELLIOTT:** -- to remind you of what a work
8 group can do versus a subcommittee.
9 **MR. GRIFFON:** I understand. I --
10 **DR. ZIEMER:** Our understanding was the ongoing
11 routine handling of these, in essence, removes
12 it from being eligible for work group kinds of
13 activities. It's --
14 **MR. ELLIOTT:** That is correct.
15 **DR. ZIEMER:** It's a repetitive kind of function
16 that is --
17 **MR. GRIFFON:** Right.
18 **MR. ELLIOTT:** But I understood this work group
19 is to deal with this first --
20 **DR. ZIEMER:** Oh, this --
21 **MR. ELLIOTT:** -- 20 cases.
22 **MR. GRIFFON:** Yeah, this one, but --
23 **DR. ZIEMER:** Oh, no, no, no, no. Oh, this --
24 this work group that we just described was to -
25 - to deal with those first 20 in the sense of -

1 -
2 **MR. GRIFFON:** Yeah.
3 **DR. ZIEMER:** -- getting that final report in
4 place.
5 **MR. GRIFFON:** But I'm saying for future --
6 yeah.
7 **DR. ZIEMER:** Yeah.
8 **MR. GRIFFON:** Moving forward, but --
9 **DR. ZIEMER:** But moving forward in terms of
10 handling on-- upcoming cases and so on --
11 **MR. GRIFFON:** I mean can we -- can we assign a
12 new work group each time we -- you know, I --
13 **DR. ZIEMER:** I think the answer no, since it's
14 a reoccurring --
15 **MR. GRIFFON:** Because it's a --
16 **MR. ELLIOTT:** Because the charge you're giving
17 is the same charge, you're just realigning the
18 work group. That's not going to work. FACA
19 won't let you do that.
20 **MR. GRIFFON:** That's what I mean, so this is
21 what I've been struggling with for the last
22 year is how can -- you know, we want to have
23 the ability to work with the contractor, but
24 the subcommittee process makes it difficult.
25 **DR. ZIEMER:** Very difficult.

1 **MR. GRIFFON:** On the other hand, we -- you
2 know, you want to -- openness to the process.
3 **DR. ZIEMER:** Right, it's very difficult.
4 **MR. GRIFFON:** So it's very difficult, right.
5 **DR. ZIEMER:** Yeah.
6 **MR. GRIFFON:** But I think, you know -- one
7 reason I think we have to do something is, you
8 know, we've got -- I guess I'm getting tired of
9 throwing up our hands and saying -- you know,
10 'cause we're going to have train wrecks like we
11 did the other day at every meeting, where we
12 come with 20 cases and as a full Board we try
13 to sort through them and we -- we get nowhere.
14 **MR. ELLIOTT:** We've been over this ground and
15 over this ground, and I thought you'd come to a
16 decision that a subcommittee was the way you
17 wanted to go, that -- that it would be a public
18 forum --
19 **MR. GRIFFON:** Right.
20 **MR. ELLIOTT:** -- unless you needed to have a
21 disc-- closed session discussion on Privacy
22 Act-related --
23 **MR. GRIFFON:** Right.
24 **MR. ELLIOTT:** -- stuff.
25 **MR. GRIFFON:** So that's what I'm saying. I

1 think we just have to set up some in between
2 the meetings prob-- or I don't know if we -- if
3 it's premature to set them up, but we have to
4 try to time that --
5 **DR. ZIEMER:** To set up what, though?
6 **MR. GRIFFON:** So --
7 **MR. ELLIOTT:** I think that's the key. I think
8 you have to come -- I think what's -- what's
9 being missed here is you have to tell the
10 subcommittee what it is you want them to do at
11 the next -- their next scheduled meeting. Of
12 the eight -- eight tasks within their charge,
13 they have to understand what they're to be
14 working on. That's the authority the Board
15 gives them. You go work on task three this
16 next meeting. That's what we want you to do.
17 Come back with --
18 **MR. GRIFFON:** And I'm saying -- I'm saying the
19 charge would be similar to what the work group
20 is charged with this time, that the charge
21 would be to -- you know, it -- I'm not saying
22 for the subcommittee to do all 20 cases. I'm
23 saying we have the same process where we assign
24 cases to all -- all members of the Board, and
25 then --

1 **DR. ZIEMER:** And then take the wrap-up and then
2 --
3 **MR. GRIFFON:** The member -- all -- each two-
4 team group submits their comments to the
5 subcommittee, and the subcommittee meets with
6 SCA/NIOSH and goes through this deliberative
7 process to come out with a final roll-up report
8 to bring back --
9 **DR. ZIEMER:** To the full Board.
10 **MR. GRIFFON:** -- to the full Board, yeah.
11 That's the notion -- that's what -- sorry,
12 maybe I wasn't very clear with that. And then,
13 you know, I -- I mean it's -- certainly we have
14 everybody on the subcommittee --
15 **DR. ZIEMER:** So the only real difference in
16 what we did this time would be that that sub--
17 that part of the subcommittee would get the --
18 the stuff from each of our teams and -- and
19 assist in the wrap-up process --
20 **MR. GRIFFON:** Right.
21 **DR. ZIEMER:** -- prior to the full Board.
22 **MR. GRIFFON:** Right.
23 **DR. ZIEMER:** And that could either be done in a
24 separate meeting -- you know, a couple of weeks
25 before the meeting --

1 **MR. GRIFFON:** Or the day before.
2 **DR. ZIEMER:** -- or it could be done the day
3 before.
4 **MR. GRIFFON:** Right. Right.
5 **DR. ZIEMER:** In which case it would be doing
6 what we did Monday of this week.
7 **MR. GRIFFON:** Yeah, but we -- we -- but we
8 didn't do it.
9 **DR. ZIEMER:** Well --
10 **MR. GRIFFON:** That's what I'm saying.
11 **DR. ZIEMER:** Well --
12 **MR. GRIFFON:** I mean where you're putting that
13 middle step in there to get some of that work
14 done, the real work where you take 20 cases and
15 you look for tren-- I mean summarize all -- you
16 summarize what you can from the 20 cases.
17 You're not going to go case -- you're not going
18 to come back to the Board and say okay, let's
19 go through case one, case two, case three.
20 You're going to say out of this batch, here's
21 some of what was found.
22 **MR. ELLIOTT:** That's function number seven of
23 your --
24 **MR. GRIFFON:** Right, right.
25 **MR. ELLIOTT:** -- subcommittee ta-- charge.

1 **MR. GRIFFON:** I remember writing it, yeah.
2 **MR. ELLIOTT:** Function number seven says
3 compile the review panel's recommendations and
4 findings, including dose reconstruction review
5 summary reports, site profile review reports,
6 for submission to the Board.
7 **MR. GRIFFON:** Right.
8 **DR. ZIEMER:** Right.
9 **MR. GRIFFON:** Right. So that -- yeah, that was
10 the original intent of the way we worked this
11 up. And I think one thing we'll have to deal
12 with in the subcommittee meeting is probably
13 part of it, at this point, is going to have to
14 be closed because we are going to be dealing
15 with the -- the case -- you know, the
16 individual cases and the Privacy -- you know,
17 the identifiable information. We might be able
18 to draft -- in that meeting I think we have to
19 try to draft a summary, and then maybe have a
20 second part of that meeting -- maybe it's only
21 an hour or so -- that -- that we reveal that
22 summary and go over that summary.
23 **DR. ZIEMER:** You're still seeing this as the
24 meeting that occurs the day before the full
25 Board, as opposed to somewhere back --

1 **MR. GRIFFON:** Either way. It could be back or
2 it could be the day before, right. So I'm -- I
3 guess -- I don't know, do -- I didn't know that
4 we had to make a motion to task the
5 subcommittee with something that's already
6 listed as a task.
7 **DR. ZIEMER:** It's already there.
8 **MR. GRIFFON:** Okay, that's what I was -- yeah.
9 **DR. ZIEMER:** It's already tasked.
10 **MR. ELLIOTT:** My point was just that the
11 subcommittee needs to have a general
12 understanding from the Board as to what it's
13 going to do at that meeting, that's all.
14 **MR. GRIFFON:** I agree. I agree.
15 **MR. ELLIOTT:** I mean which one of these things
16 -- you know, I think it's covered, but if what
17 we're talking about is rolling up reviews into
18 a general summary, that's number seven.
19 **MR. GRIFFON:** Right. Right. Right.
20 **DR. ZIEMER:** Okay? So no actual -- no
21 particular action is needed here. I mean it
22 basically is covered, but we have to do it.
23 **MR. GRIFFON:** Right. We have to schedule it.
24 We have to do it, yeah.
25 **DR. ZIEMER:** Have to schedule it.

1 **MR. GRIFFON:** Yeah.
2 **MR. ELLIOTT:** I'm sorry this is so complex, but
3 to -- one thing we have to be very careful with
4 is when you decide you need to close session,
5 we have to provide a determination to close,
6 and the only thing that can be discussed in
7 that closed session is what is announced as
8 being the purpose for the closed session.
9 **DR. ZIEMER:** Right.
10 **MR. GRIFFON:** So you're saying we can't lay out
11 a long-term schedule because we won't know
12 exactly what's going to be covered in --
13 **DR. DEHART:** Well, you don't need closed
14 session for that.
15 **MR. ELLIOTT:** No, I don't think I'm saying
16 that. I'm just saying that if you know you're
17 going -- your subcommittee is going to have a
18 closed session to do this type of work, then
19 that's the only thing that can be done in that
20 closed session.
21 **MR. GRIFFON:** Yeah.
22 **MR. ELLIOTT:** That's all I'm saying.
23 **DR. ZIEMER:** You would have to announce that
24 for each one.
25 **MR. ELLIOTT:** In the open session of the

1 subcommittee, you can take on any number of
2 these --
3 **MR. GRIFFON:** I gotcha.
4 **MR. ELLIOTT:** -- these charges.
5 **MR. GRIFFON:** I gotcha, okay.
6 **MR. ELLIOTT:** You know, as long as that Board
7 knows that's what the subcommittee's going to
8 do.
9 **MR. GRIFFON:** I gotcha, okay.
10 **MR. ELLIOTT:** But for the benefit of the
11 public's understanding and getting at this
12 issue of transparency --
13 **MR. GRIFFON:** This is what's going on.
14 **MR. ELLIOTT:** -- just the whole idea of going
15 into closed session just gets -- is a burr
16 under people's saddle. And we're required to
17 make sure that the determination to close
18 speaks specifically to why it's -- why the
19 meeting is being closed, and that's the only
20 conduct of business in that closed session.
21 **MR. GRIFFON:** No, right, I understand. I
22 agree, yeah.
23 **DR. ZIEMER:** Okay?
24 **MR. GRIFFON:** So I -- I think we're set -- I
25 mean the next meeting we have a subcommittee

1 meeting set up. Right?
2 **DR. ZIEMER:** Right.
3 **MR. GRIFFON:** And we have a closed session that
4 we're --
5 **DR. ZIEMER:** Right.
6 **MR. GRIFFON:** -- talking about. Have we
7 decided what the closed session item --
8 discussion item is? It's those 20-case roll-up
9 report that --
10 **DR. ZIEMER:** It's basically --
11 **MR. GRIFFON:** We're covered for the next --
12 **MR. ELLIOTT:** That's my understanding.
13 **DR. ZIEMER:** Yeah, right. And it's covered
14 under that.
15 **MR. GRIFFON:** Right.
16 **DR. ZIEMER:** Okay. Any other -- are there any
17 other items that we need to discuss today?
18 **MR. GRIFFON:** Just -- well, just related to
19 this whole thing. I mean the only other thing
20 is, in between -- in be-- I'm just trying to
21 think of the communica-- ongoing communication
22 questions. While SCA's working on these
23 obviously the subcommittee can't, as a body,
24 communicate or direct or -- so right now I
25 think what -- what's -- Paul, you've been

1 speaking on --

2 **DR. ZIEMER:** You're talking about the work

3 group or the --

4 **MR. GRIFFON:** No, no, I'm talking about ongoing

5 work by the subcontractor on site profiles, on

6 --

7 **DR. ZIEMER:** Oh.

8 **MR. GRIFFON:** -- case reviews --

9 **DR. ZIEMER:** Right.

10 **MR. GRIFFON:** -- whatever, if -- if there's --

11 there's a request to you for -- I -- I guess

12 all the direction for the subcontractor between

13 these meetings has to come from you at this

14 point. Right?

15 **DR. ZIEMER:** There will be some direction for

16 the subcontractor that actually will come from

17 Dr. Wade, who will --

18 **MR. GRIFFON:** Right.

19 **DR. ZIEMER:** -- and David Staudt, who will work

20 with them on establishing whatever incremental

21 cost increments are associated with what looks

22 like some additional work within the task, and

23 -- and we --

24 **MR. GRIFFON:** Okay.

25 **DR. ZIEMER:** -- basically authorized Mr. Wade

1 to proceed to do that on our behalf, so that --
2 that will occur, and I think he's already set
3 up some time to -- to work with them and define
4 what that will be, and identify the cost --
5 incremental costs associated with that.
6 Other than that, the contractor has its scopes
7 of -- scopes of work for the various tasks,
8 which it's following, I'm --
9 **MR. GRIFFON:** And if the -- I guess the things
10 I was thinking about is if -- if, down -- if it
11 becomes an issue of access to records at a
12 certain site or certain --
13 **DR. ZIEMER:** Oh --
14 **MR. GRIFFON:** -- other work they're doing --
15 **DR. ZIEMER:** -- when those things occur, what
16 actually happens is that John Mauro typically -
17 -
18 **MR. GRIFFON:** Notifies --
19 **DR. ZIEMER:** -- send -- or -- or one of his
20 staff, but usually it comes through John. I
21 get noted on it, Larry gets noted on it.
22 Usually the action involves NIOSH people in
23 assisting, for example, in getting these
24 clearances and so on, that -- that sort of
25 thing. But typically I'm notified as these

1 things occur. When these -- when these
2 contacts occur or there's access requested,
3 they're supposed to keep me notified on that so
4 we know what the contractor's doing relative to
5 --
6 **MR. GRIFFON:** I'm just trying to think through
7 things that --
8 **DR. ZIEMER:** Yeah.
9 **MR. GRIFFON:** -- that would unnecessarily hold
10 up, you know, their work or their progress, so
11 I -- but I think we're --
12 **DR. ZIEMER:** Yeah.
13 **MR. GRIFFON:** -- okay.
14 **DR. ZIEMER:** Okay. You may not really believe
15 it 'cause you're all tired, but we're actually
16 early. Anyone have some other things they want
17 to talk about for 20 more minutes?
18 If there's no further business to come before
19 us, we stand adjourned till next time.
20 (Whereupon, an adjournment was declared at 4:15
21 p.m.)
22
23

C E R T I F I C A T E

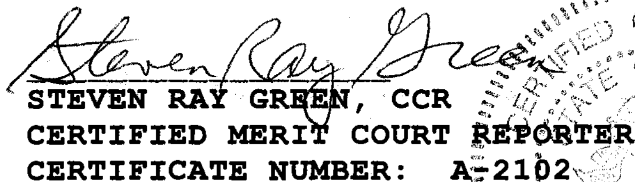
STATE OF GEORGIA :

COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 15th day of December, 2004; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 23rd day of January, 2005.



STEVEN RAY GREEN, CCR
CERTIFIED MERIT COURT REPORTER
CERTIFICATE NUMBER: A-2102