

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

convenes the

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

VOLUME I

The transcript of the Meeting of the
Advisory Board on Radiation and Worker Health
before Debbie G. Williams, Certified Court
Reporter and Notary Public; commencing at 8:30
a.m., Wednesday, February 5, 2003, at The
DoubleTree Guest Suites, 181 Church Street,
Charleston, South Carolina.

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MS. MARTHA DiMUZIO, NIOSH
MR. RUSH HENSHAW, NIOSH
DR. JAMES MELIUS
DR. SERGIO BUSTOS, SRSHEs Chair

STAFF/VENDORS

CORI HOMER, Committee Management Specialist, NIOSH
DR. JAMES NETON, NIOSH
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DEBBIE G. WILLIAMS, Certified Verbatim Court Reporter

1 DR. ANDRADE: So it --

2 MR. ELLIOTT: Does that answer your
3 question?

4 DR. ANDRADE: Once the Department of Labor
5 receives the -- is it the final?

6 MR. ELLIOTT: Once the Department of Labor
7 receives the final dose reconstruction from us and
8 the full administrative record, at that point they
9 will render a decision, a recommended decision. At
10 that point, on the recommended decision, the person
11 has a -- has an opportunity to contest that
12 decision, to appeal it.

13 DR. ANDRADE: Thank you.

14 DR. TOOHEY: Okay. If we move on --

15 DR. ZIEMER: Okay, Rich -- yeah, go ahead
16 then. You have another slide.

17 DR. TOOHEY: Well, I think it's just one
18 more. Okay. As I promised at the last meeting in
19 Cincinnati, our project web page is up. The URL is
20 www.oraucoc - Cincinnati Operational Center - .org.
21 The biographical sketches of the Health Physicists
22 performing dose reconstructions are posted on there.
23 There were two of them up yesterday morning; I'm
24 sure there are more now and we'll continue, even as
25 we speak. We're concentrating on the people who

1 for having those made available.

2 DR. TOOHEY: Okay.

3 DR. ZIEMER: Thank you.

4 DR. TOOHEY: We've got plenty of server
5 room.

6 DR. ZIEMER: Other comments? Mike Gibson.

7 MR. GIBSON: Just one concern for the
8 record, it's not really relevant to, you know, I
9 know that you're working on the conflict of interest
10 and everything else, but just running through the
11 list, I am somewhat concerned with this one -- of
12 this shallow pool of Health Physicists and internal
13 dosimetrists, there's going to be enough left at the
14 sites to do the current work to make it accurate to
15 -- to send forward to this dose reconstruction
16 process.

17 DR. TOOHEY: Yeah.

18 MR. GIBSON: I notice here there's six to
19 eight from Mound that left the site, and went to
20 work for ORAU, or one of their subs.

21 DR. TOOHEY: And of course, that's because
22 Mound is, as you know, closing down. We've picked
23 up refugees from Fernald. We're competing with
24 NIOSH for the same people, they're adding to their
25 staff, as so are we. And -- but actually, we think

1 we could include this type of information in
2 technical documentation, so I wanted to ask for
3 perhaps a little bit more clarification.

4 Larry, were you talking about technical
5 documentation such as the IREP, what do you call it,
6 Guide, or some other form of documentation?

7 MR. ELLIOTT: I was referring to the
8 technical documentation that supports the cancer
9 risk models in IREP, not this User's Guide that Russ
10 sent out to you by Fed-Ex last week, or you've seen
11 in the past. I think that we can simply put a new
12 section into that technical documentation titled
13 Administrative Policies, perhaps. And there we can
14 account for where science doesn't serve us well
15 anymore and we need to take a claimant-favorable
16 approach, and we can outline how that approach is
17 claimant favorable.

18 DR. ANDRADE: So what you're proposing is a
19 new --

20 MR. ELLIOTT: New section or -- or something
21 to the -- it's been a while since I've looked at the
22 technical documentation. I recall it being, you
23 know, it has different sections in it; it talks
24 about different cancer risk models; it talks about
25 the transfer issue from Japanese survivor experience

1 DR. ROESSLER: But have you done any work
2 then on the dose reconstruction for workers?

3 DR. BUSTOS: No, we have not.

4 DR. ROESSLER: Okay.

5 DR. BUSTOS: But it is a concern of the
6 Committee and theoretically, if the issue is brought
7 before us and we have people who have worked at the
8 Savannah River Site who appear before our Committee
9 relating their experience, and the ailments that
10 they have been affected with, naturally the -- the
11 doses that were established for the offsite
12 population will also apply in-site too.

13 MR. DeHART: Roy DeHart. Is there anyone
14 that's going to go over a little about the Savannah
15 River Site in terms of its operation to the degree
16 that it can be discussed around the table?

17 DR. ZIEMER: Physical description of the
18 site and the activities there?

19 MR. DeHART: Yes. He mentioned the size,
20 which is quite considerable. We have two --

21 DR. ZIEMER: I noticed there was --

22 MR. DeHART: We have two overheads.

23 DR. ZIEMER: -- was handouts. I'm not sure
24 of the source of those. Are these --

25 DR. BUSTOS: Yeah, I --

1 DR. ZIEMER: Can you talk a little more
2 about the --

3 DR. BUSTOS: -- I have provided two of
4 these. If we can put the -- if we can set up the
5 overhead projector.

6 Yeah, the -- the heart -- the heart of the
7 Savannah River Site is constituted by the -- by the
8 five reactors and the chemical separations. And
9 adjacent to it there was an area where the fuel
10 targets were prepared. And adjacent to the area
11 there was also heavy water -- heavy water plant.
12 This heavy water plant had the function of using the
13 Savannah River -- Savannah River water and
14 converting it to heavy water. That heavy water was
15 needed as a coolant in the reactors. Now, the heart
16 of the Savannah River Site is the five reactors,
17 R,P,L,C,K. And the Canyons, the H-Canyon, and the
18 F-Canyon that are the chemical -- where the chemical
19 separation is produced, and here (indicating) is the
20 heavy water plant that provides the coolant for the
21 -- for the reactors. By the way, all the -- all the
22 reactors are deactivated now, so -- and then the
23 chemical separation that takes place in the Canyons,
24 in the absence of a presence of humans, by the way,
25 there is waste, there is chemical waste and there is

1 radioactive waste that is generated. And this is
2 then taken -- or was taken to tank farms or to other
3 areas that are called seepage basins and the Z-area
4 with saltstone. So this is where the area, the
5 M-area where the reactor components, fuel and
6 target, were assembled, then they were taken to the
7 reactors. And the function of the reactors, during
8 the Cold War, and post-Cold War, was to produce
9 plutonium and tritium. That was the main. So
10 that's in a nutshell, that's a -- that's a lot, you
11 know, there would be a whole lecture to give on the
12 subject, but that would be SRS in a nutshell.

13 One of the activities of the Committee that
14 I neglected to -- was to tell you that when the face
15 tube, the analysis of the source term and the
16 emission of radionuclides was taking place, then the
17 Committee helped determining what area would be the
18 area that was going to be used for the sampling, for
19 the analysis. And that was an area larger than this
20 (indicating) one because this is the -- this is
21 simply the -- the area of the plant with the five
22 reactors, the C,K,L,P,R and the Canyons, the
23 F-Canyon and the H-area that where the chemical
24 separation was. And they are all strategically
25 positioned within this (indicating) circle; whereas

1 the -- the M- and A-areas, that was the fuel and
2 target fabrication areas, and the heavy water areas
3 were way apart. This (indicating) is 310 miles;
4 this (indicating) is the Savannah River Site; and
5 these are the streams that flow from the interior of
6 the Savannah River Site to the Savannah River.

7 Again, this is a very, very brief summary of
8 what could be said on it.

9 DR. ZIEMER: Thank you. Other questions?

10 MR. GIBSON: Doctor, you mentioned that you
11 guys went through the historical records in the
12 vaults and you looked back at how they performed
13 their analysis on some of their monitoring they had
14 done and stuff. How valuable do you think that was
15 to your research on --

16 DR. BUSTOS: Excuse me. I lost track on
17 that.

18 MR. GIBSON: Okay.

19 DR. BUSTOS: Would you start again?

20 MR. GIBSON: You mentioned that you had
21 looked through vaults and historical --

22 DR. BUSTOS: Vaults, yes.

23 MR. GIBSON: -- records --

24 DR. BUSTOS: Yes.

25 MR. GIBSON: -- and looked at how they had

1 done their analysis and --

2 DR. BUSTOS: Exactly.

3 MR. GIBSON: -- kind of recreated them.

4 DR. BUSTOS: Yes.

5 MR. GIBSON: How much value do you put on
6 that in ascertaining a dose that a population might
7 have got?

8 DR. BUSTOS: Oh, that was invaluable. It
9 was inventory, you know, when hydrochloric acid
10 came, nitric acid came, all the chemicals that came
11 to the plant. And then everything that was -- that
12 -- that was annotated was contained in there, so it
13 was a very -- that was a sine qua non starting
14 point.

15 MR. GIBSON: So did you find any anomalies
16 when you recreated these -- these analysis and had
17 other people look at them, or?

18 MR. BUSTOS: No -- no anomalies were found,
19 except that it was -- at one point there was a
20 closely kept inventory, and at other times there was
21 not as well kept as would have been desirable. But
22 that was -- that was corrected by interviewing the
23 people who were in charge of that, and were retired
24 people who were still around who volunteered to
25 provide information on precisely the missing parts.

1 MR. GIBSON: Thank you.

2 DR. BUSTOS: So -- so there was oral and
3 written history.

4 DR. ZIEMER: Has the research agenda of the
5 groups that you advise changed as a result of your
6 reviews? I noticed that you evaluate the adequacy
7 of their research activities. Has what you've done
8 caused them to change direction, change priorities,
9 change research designs?

10 DR. BUSTOS: Well, throughout the dose
11 reconstruction period, that took several years, the
12 scientists who were conducting this, chemists,
13 biochemists, nuclear scientists, etcetera, appeared
14 before the Committee and provided us with a step-by-
15 step detail of what they were doing. And they were
16 subjected to a question period, very, very intense,
17 that ranged from the scientific part to sometimes
18 the social aspects, the community aspects. So the
19 Committee was involved not only in being apprised of
20 the -- the rate of the project, but as of the
21 particulars, and they were asked in detail to
22 specify what -- what it meant, not -- you know,
23 because of the heterogeneity of the -- of the
24 Committee, some of the members did not have the --
25 the knowledge, but they had common sense and they

1 asked to be explained in terms that were very clear,
2 understandable, the meaning of what being said,
3 whether it was Owen Hoffman from SENES to John Teal,
4 everyone was required to explain in detail and very
5 clearly what had transpired. And because of that,
6 you know, at the end of the Dose Reconstruction
7 Project, then there was a summary, an account, of
8 what had been done that had to be understandable for
9 people who have very little knowledge, which was a
10 very difficult thing to do, by the way.

11 MR. ELLIOTT: I think one of the
12 accomplishments that you point to here in response
13 to Dr. Ziemer's question, the change in peer review
14 process that your Committee effected across the
15 three agencies, ATSDR, NCEH, and NIOSH, in my
16 opinion that was quite an accomplishment and it
17 effected some changes in how we, in the agencies
18 worked, and how we got peer review on our individual
19 research projects. Would you -- would you agree
20 that that -- I mean you highlighted it earlier, but
21 I think it's something that answers Dr. Ziemer's
22 question in a way.

23 DR. BUSTOS: Yes, exactly.

24 MR. ELLIOTT: Just so the Board understands,
25 there are four subcommittees, and as the Board goes

1 around having your meetings at different sites we
2 would intend to invite the other Chairs of the other
3 three. There's a subcommittee in Oak Ridge that was
4 just recently established within the last couple of
5 years, they don't have the tenure that Dr. Bustos
6 has. There's another -- that subcommittee is
7 sponsored and administered by the ATSDR, Agency for
8 Toxic Substances and Disease Registry. Dr. Bustos'
9 committee is sponsored and administered by the
10 National Center for Environmental Health. The
11 committee -- subcommittee at Hanford is sponsored
12 also by the ATSDR, and it's been in existence the
13 same time frame that yours started, I believe,
14 Dr. Bustos. Then the fourth committee is out of the
15 Idaho National Engineering Lab, and they were also
16 in existence from the very start when Dr. Bustos'
17 committee came on line, and it is also sponsored by
18 NCEH.

19 DR. BUSTOS: Any other questions or
20 comments?

21 DR. ZIEMER: Thank you, very much. That's
22 been very informative for us and we appreciate your
23 being with us today.

24 DR. BUSTOS: You are very welcome.

25 DR. ZIEMER: Our next Agenda item is one

1 that, in a sense, carries forward from the past, and
2 that is the area of the Board's review of dose
3 reconstructions. I want to refer you, first of all,
4 to the material under the tab called Discussion
5 Documents, which includes the current version -- or
6 versions of the various parts of the Request for
7 Contract that has been developed through our
8 workgroup. And then there's a summary of the slides
9 that were used this past -- was it in July --

10 DR. ROESSLER: Uh-huh (affirmative).

11 DR. ZIEMER: -- past July. And to begin our
12 -- well, let me make a few remarks, sort of
13 preliminary remarks, and then Larry, we'll let you
14 make some remarks and I want to call on Mark Griffon
15 as well. But you -- you recognize that we -- at our
16 last meeting we had the closed session dealing with
17 issues around the Request for Contract. I'm going
18 to ask Larry to give us an update on that process.
19 We also need to get some thought about how we need
20 to position ourselves as a Board, so that we're
21 ready to go at the point at which the Contract is
22 ready to go; what will our review process be; how
23 will we be structured as a Board to carry out and
24 conduct the reviews themselves with the assistance
25 of the contractor that is chosen.

1 But, Larry, why don't you give us a quick
2 update first on the -- the procurement process.

3 MR. ELLIOTT: Sure. First of all, let me
4 say that the document you have in your briefing
5 booklet under the tab that Dr. Ziemer pointed out to
6 you that says Draft 01/ -- whatever the date is on
7 there -- that is the document that we understood you
8 all to have reached consensus on and passed at your
9 last meeting in Cincinnati in January.

10 It is certainly -- you still have an
11 opportunity, this document has not gone forward into
12 the procurement process as of today. We need to
13 have from you some -- some clear direction at this
14 point on how you would want to proceed, and I will
15 get into that in a moment, but I'd like to say at
16 this point you still have an opportunity to make or
17 effect any further changes before this procurement
18 is initiated. This is your last opportunity to do
19 so. We -- and again, we have not put it into the
20 procurement process for this reason: We -- we left
21 the January meeting and having heard a few of the
22 Board members -- I didn't hear a consensus in this
23 regard, but I -- and I heard people speak to the
24 other side of this issue as well -- but that NIOSH
25 was in a situation here where there could be a

1 perceived conflict of interest with your audit of
2 our work being procured for technical consultation
3 to assist you in that being procured through NIOSH.
4 So I took that discussion to heart, I heard, you
5 know, I heard what certain Board members had to say
6 and what members of the public had to say in that
7 regard, and I went back to my principals and talked
8 about it and offered a suggestion to them that could
9 we not find a way to put some distance between NIOSH
10 and the effecting the award of this procurement, and
11 the administration of this procurement. I proposed
12 to -- to Dr. Howard that -- who is the Director of
13 NIOSH -- that perhaps, you know, we could seek
14 another agency to -- to handle this procurement for
15 the Board. I then approached and had some
16 discussions with Mr. Pete Turcic, and I think he's
17 in the audience. Pete's back there. He -- he's my
18 counterpart at the Department of Labor. He's the
19 Director of the -- of their Compensation Program on
20 this -- on this Act, and talked to Pete about
21 whether or not it made any sense for, in his mind,
22 for DOL to effect this procurement and make the
23 award, or whether there was another option. And we
24 -- we talked about that at length. We have pursued
25 other agencies as an option; we talked about the

1 General Services Administration. So what we boiled
2 down to is a decision for you all to make, and that
3 is whether you would prefer that the Department of
4 Labor effect the award of this Contract and
5 administer the Contract, or you'd just as soon see
6 NIOSH retain it and make the award, and monitor the
7 progress and make sure that, you know, we were
8 working in your best interests.

9 We've -- you know, in our deliberations we
10 identified that the other agency options were not a
11 viable option in that we could not make sure that
12 they would give due diligence in the processing of
13 this particular procurement, so that's where it
14 stands. It is not -- we've wrapped it all up, it is
15 in the form of a -- what we call an RFP, Request for
16 Proposals. I need to hear from you all what your
17 consensus is with regard to whether NIOSH should
18 effect this RFP and administer the award, or whether
19 you think that the Department of Labor makes more
20 sense to do so. So I would welcome your -- your
21 discussion in that regard, and your direction.

22 DR. ZIEMER: I wonder if it would be of any
23 value to the Board to also hear from Pete on this
24 issue from Labor's perspective. Maybe Pete will
25 tell us why it should go to NIOSH and NIOSH will

1 tell us why it should go to Labor.

2 Pete, if you're willing to come and address
3 the Board a little bit about how this would look
4 from your perspective and anything you think we
5 should know in terms --

6 MR. TURCIC: Okay.

7 DR. ZIEMER: -- of that issue.

8 MR. TURCIC: Sure. In my discussions with
9 Larry, the way we would envision that if DOL were
10 to, you know, handle the procurement and then the
11 ongoing coordination of the task orders, we would
12 basically do it in a manner where we were the
13 administrative arm of the Board for managing that
14 contract. We would have -- we envisioned that we
15 would have our office of the Assistant Secretary for
16 Administration and Management handle the procurement
17 in, you know, with naturally, you know, having
18 individuals on the procurement, on the evaluation
19 board, on the evaluation team, and then just
20 administratively carrying out that procurement. And
21 then following that, we would envision a system
22 where within the Department of Labor we would have a
23 liaison to coordinate -- any of the task orders
24 coordinate with the Board, so it wouldn't be that we
25 -- I guess the technical term would be the

1 contracting officer's technical representative, but
2 it really wouldn't be -- it would be more of a
3 administrative representative where the task orders
4 would come from the Board, then those task orders
5 would then be implemented and put into the system
6 and tracked, and from an administrative standpoint
7 DOL would merely be fulfilling a function of being
8 the administrative arm for providing that kind of
9 contractual services, you know, to the Board for
10 that process. From DOL's perspective, the -- it's
11 very important that the work of the Board in this
12 overview and function is very important to us in
13 maintaining the integrity of -- you know, we have to
14 adjudicate if -- if there are issues that come up,
15 that people raise issues concerning the dose
16 reconstruction process where that is adjudicated is
17 after the claimant gets a recommended decision; so
18 the, you know, from that perspective the quality
19 control function that the Board will be, you know,
20 carrying out in this process is extremely important
21 to DOL, and we would do whatever, you know, whatever
22 makes sense for administratively carrying this
23 function out.

24 DR. ZIEMER: Larry, do you have some
25 additional comments?

1 MR. ELLIOTT: Well, suffice it to say that
2 if -- if it was NIOSH carrying forward this
3 procurement and processing the procurement we would
4 do everything in due diligence and with the same
5 amount of interest and effort that Pete has just
6 described to you as well, so. We talked about
7 having a, you know, a technical liaison from NIOSH
8 work with whoever their technical project monitor
9 would be for the contracting officer. The Board
10 would create its task orders, and whether it was run
11 through the NIOSH procurement system or the Labor
12 procurement system, I don't think there's any
13 difference in the process, the sequence of events,
14 or the amount of effort that would be accorded to
15 this -- this whole procurement.

16 MR. TURCIC: Hey, Larry, in some of the
17 earlier discussions, one other piece of it, there
18 was a question came up about, you know, how DOL
19 would interact with the Board and with NIOSH, and
20 one way to address that would be a Memorandum of
21 Understanding specifically for, you know, for this
22 project.

23 DR. ZIEMER: Provided such Memorandum could
24 be developed at a more rapid fashion than others.

25 MR. ELLIOTT: I think we could do that.

1 DR. ZIEMER: Now, could either of you, or
2 others help me get a feel for the extent to which
3 conflict of interest could still be perceived? This
4 is also a Department of Labor program insofar as
5 they do make the final decision on adjudication of
6 the claims, so I'm trying to get a feel for what we
7 gain. It seems like you can gain certain things in
8 one direction and lose others, so can anybody speak
9 to that?

10 MR. ELLIOTT: Well, I'll attempt, and
11 certainly let Pete speak his mind on this too. I
12 think if the approach was to use the Department of
13 Labor's process, then the gain would be to NIOSH; we
14 would find ourselves somewhat distanced from -- from
15 this whole process. Certainly the perception of
16 conflict of interest exists for both agencies
17 because of our involvement in this program. And
18 that burden will just be shifted from NIOSH's --
19 from our agency to theirs. And Shelby Hallmark,
20 Pete's boss, knows this and we've talked about this,
21 so I don't know that it gains much, if at all,
22 whoever has this, either DOL or NIOSH, we will be
23 walking a tightrope and we will be doing the best
24 that we can to manage and control perceptions of
25 conflict and avoid any actual conflicts.

1 MR. TURCIC: I agree with the points Larry
2 made. One aspect of it would -- from DOL's
3 standpoint would be that -- in the way the process
4 works is that if an individual, they have, you know,
5 once -- once a recommended decision is made, then
6 the claimant can raise issues during the final
7 decision point, and then from there they can appeal
8 that to the District Court. So, from, you know,
9 from that standpoint it would just be which part of
10 the, you know, process and where the individual
11 claimant would have recourse.

12 DR. ZIEMER: Let's ask others. Jim has a
13 comment.

14 DR. MELIUS: Yeah. First of all, I'd like
15 to thank Larry and Pete for, no matter what we
16 decide or recommend here today, for making the
17 effort to sort of develop an alternative because I
18 think it's good for the credibility of the process
19 that we did consider an alternative to NIOSH doing
20 this procurement should NIOSH go ahead and the, you
21 know, reasonable alternative was, you know, a
22 practicable one was looked into. I personally have
23 trouble weighing the benefits versus the possible
24 risks of problems with moving it to DOL without sort
25 of thinking through the whole process, and I think

1 there are different points at which conflict can
2 arise or perceptions of conflict. There's also
3 different points at which, you know, scenarios where
4 certain problems may arise and, you know, which
5 agency is better or worse. And some of these -- as
6 with the conflict of interest, some of these
7 scenarios are unlikely to occur, but what if things
8 aren't going -- going well and at least to me, in
9 order to evaluate this, I'd like to sort of know
10 more details about the -- how the process should be
11 working, or how we plan the process to work for
12 actually get out these task orders and conducting
13 this review. And then think -- then almost work
14 back, which then, you know, how much do we gain from
15 the Department of -- of moving this to the
16 Department of Labor and how much would we lose from
17 the Department of Labor, you know, at least
18 potentially. And it's all going to be, I guess -- I
19 think, you know, realistically either agency could
20 do it fine. I mean that's -- and it's not a clear-
21 cut gain in perception either from either agency as
22 both Larry and -- and Pete have pointed out, but --
23 but I think the details are what are going to be to
24 some extent important and the procedures we set in
25 place. As I said, I'd almost rather work from --

1 let's work through the procedures; how are we going
2 to the procurement and so forth; then go back and
3 say can both agencies deal with this. And then --
4 then questions about which would be better, what
5 would be the delays involved in doing an MOU. We
6 don't have a great example up there historically to
7 work off of right now. And I want to go back
8 through my transcripts and count the number of times
9 Larry has said soon, or the next meeting. But --
10 but I mean I -- we do have to look at that
11 realistically, but it is the procedures that maybe
12 work -- I would prefer that we work on them and then
13 go back to this issue.

14 DR. ZIEMER: A good point, Jim. And there's
15 no reason we have to, for example, decide at the
16 front end, but we have to at least know that's a
17 decision that's part of the overall picture as we
18 proceed here today and tomorrow.

19 Roy, a comment.

20 MR. DeHART: Thank you. Clearly, NIOSH has
21 played a role in helping us prepare this document as
22 a procurement document to meet the Federal
23 Regulations, etcetera. I would ask the Department
24 of Labor who has reviewed or who all have reviewed
25 this document, so that they're comfortable with it

1 as -- as it currently is developed?

2 MR. TURCIC: The Division of Energy and
3 Employees Compensation, we've been -- we've reviewed
4 it and looked at it. And, you know, Jim made a good
5 point about the, you know, the process -- you know,
6 we have ideas of how, if it was administered by
7 Labor, how we would do that, and maybe what we need
8 to do is add some, you know, details to that.

9 DR. ZIEMER: But I think your question is:
10 Is this in a form that looks like they could handle
11 it readily without major --

12 MR. DeHART: And are the procedures in place
13 to do that, and I think we're being told that there
14 are planned procedures.

15 MR. TURCIC: Yeah, the procurement
16 procedures are all in place in order to do that.
17 Either NIOSH or DOL could pick up what has been done
18 and affect a procurement, you know, that's -- those
19 are government regulations imposed to, you know, HHS
20 or DOL, so yeah, those are in place and can be done
21 readily.

22 DR. ZIEMER: Jim.

23 DR. MELIUS: Just to clarify or reiterate on
24 Roy's comment. I think what's important, this
25 review is the Board's -- it's our function, we're

1 mandated to do this under The Act, and so the
2 process should serve our functions, what we need to
3 carry -- carry this out, and I think by -- we start
4 with what do we need to feel comfortable and have a
5 robust and solid scientifically based review
6 process. Then the questions will come up, you know,
7 I mean clearly just as Roy's question if DOL said
8 no, we'd have to start all over. Well, there's a
9 time issue or something. So I think it's
10 appropriate as we go along to ask whether or not
11 there would be a problem shifting to DOL. There's a
12 number of issues we really haven't, at least the
13 working group may have talked about with Larry and
14 his staff, but the whole Board hasn't, and I have
15 questions about a number of issues and procedures
16 that -- that I think are critical in terms of the
17 Board's carrying out its mandate that we need to
18 work through also.

19 DR. ZIEMER: Other comments, on this point
20 at least, on the issue of procurement?

21 (No response.)

22 DR. ZIEMER: Okay. If not, can we agree
23 that we'll proceed with the related issues and then
24 we'll have to return to this at some appropriate
25 point.

1 I want to give Mark an opportunity, if you
2 have any comments to add on the procurement
3 documents, the final versions, anything you need to
4 point out to us or highlight, Mark?

5 MR. GRIFFON: I don't -- I don't -- I guess
6 on the procurement documents, I don't think I have
7 anything to add at this point. I think the second
8 set of overheads are -- after those three documents
9 is a set of overheads from one of the earlier
10 workgroup presentations, and that sort of goes
11 through some of the other issues regarding procedure
12 I think came up in our discussions, such as
13 selection and sort of a process of how the Board is
14 going to be now faced with a contractor and with
15 NIOSH, so I don't know if people have had a chance
16 to look at that, but they may be more relevant to
17 the discussion that we went through.

18 DR. ZIEMER: Then, what we're faced with
19 then is the issue of, in a sense, mapping out the
20 process for how the Board will review dose
21 reconstructions; how the work will flow; do we need
22 a subcommittee, a permanent subcommittee that will,
23 for example, decide on the cases that -- that will
24 be reviewed; what -- what will the product of those
25 reviews be, those kinds of questions, so there's a

1 whole series of things beyond the procurement that
2 we need to consider. The ideal thing would be that
3 once the procurement is issued and a contractor is
4 selected, that we're ready to go knowing what we
5 will do, how we're structured to do it, and then we
6 simply move from there. And it may be that we won't
7 be able to close all the issues today and tomorrow,
8 but at least we want to identify what they are.

9 I -- I guess I'd be willing to have people
10 raise the issues now. I see Jim's already raring to
11 go, and Wanda is getting ready to go. Jim, go
12 ahead.

13 DR. MELIUS: No, no, actually no. Wanda had
14 hers up.

15 DR. ZIEMER: Wanda, do you want to go?
16 Okay.

17 MS. MUNN: I just had a question based on
18 your comments. Has -- have we then decided that we
19 are going to use a subcommittee rather than a
20 working group to do this? Has that decision been
21 made?

22 DR. ZIEMER: Let me answer it in the
23 following way. The difference in definition between
24 a Working Group and a Subcommittee has to do with
25 tasks and longevity. The Subcommittee has an

1 ongoing task and has a different set of rules by --
2 by which it operates, as compared to a Working
3 Group, which is pretty much Ad Hoc; it has a given
4 task, it's a pretty much short term, and it's over
5 with. So one of the decisions -- or one of the
6 issues the Board will have to decide is do we wish
7 to have a Subcommittee to kind of oversee this task
8 of dose reconstruction reviews because it's clearly
9 an ongoing task and -- and we would be subject to --
10 in fact, I think we have in the -- the -- we have
11 the Federal definitions of a --

12 MS. MUNN: Yes, we do.

13 DR. ZIEMER: -- Subcommittee and the *Federal*
14 *Register* requirements for that are in the packet
15 here to recognize the implications of that, and --

16 MS. MUNN: That was my concern.

17 DR. ZIEMER: -- we need to be careful that
18 we don't try to avoid that by saying well, we're
19 just going to have a --

20 MS. MUNN: No.

21 DR. ZIEMER: -- series of Ad Hoc Committees,
22 that's not going to --

23 MS. MUNN: No, that won't do.

24 DR. ZIEMER: -- do it.

25 MS. MUNN: No.

1 DR. ZIEMER: So it appears to me, at the
2 moment, that this is an ongoing task and either the
3 Board does it as a Committee as a whole, or we say
4 that we need a Subcommittee, or perhaps more than
5 one. But -- but we have not made a final decision
6 on that, but I think it appears right now that there
7 may be -- need to be some subset of this Board that
8 has that as a responsibility.

9 Does anyone want to speak to the issue of
10 requirements?

11 MR. ELLIOTT: I just wonder if it wouldn't
12 be beneficial if Cori spoke to the differences
13 between a Working Group and a Subcommittee. The
14 Subcommittee -- and she can explain this better than
15 I -- but, you know, a Subcommittee operates as, in a
16 public way; a Working Group doesn't have to. If you
17 have a Working Group, it has a life to itself that
18 once its mission is done, like this Working Group is
19 charged to find the options available to you to do
20 your review, and you're done. So now -- and that's
21 a finite, discrete task. A Subcommittee has a more
22 long-term involved Charter of Mission that's it been
23 given, so.

24 MS. HOMER: A Subcommittee must be federally
25 established, or formally established as well, which

1 I think there's some examples of how that might be
2 done. I believe the Board probably has a different
3 idea in mind of what their Subcommittees would be
4 formed as, or like, and because your tasks are
5 different, then a conventional Subcommittee would
6 be. But the general rules apply: the openness,
7 announcement in *Federal Registers*; availability to
8 public and anybody who wants to attend, either via
9 conference call, or in an open meeting. All of the
10 rules that apply to a full Board meeting apply to
11 Subcommittee meetings. Again, as Workgroups go,
12 very, very finite specific tasks, and then the
13 Workgroup is done, so.

14 DR. ZIEMER: Thank you, Cori. Now, keep in
15 mind that the Subcommittee is not necessarily doing
16 the reviews of individual dose reconstructions, they
17 are probably overseeing the flow of work, deciding
18 what percent or what numbers of different categories
19 of dose reconstructions will be reviewed, perhaps
20 assigning the tasks of the review process to Board
21 members and consultants, that kind of thing. As I
22 would see it, they're not actually the group that's
23 necessarily sitting there reviewing particular
24 projects, or dose reconstruction. Is that how you
25 saw it, Mark?

1 MR. GRIFFON: Yeah, that's similar to the
2 way we outlined it in some of our, you know, in some
3 of our earlier discussions, I mean we talked about
4 having a Subcommittee to do selection, and selection
5 of not only of individual dose reconstructions, but
6 site profiles to review, and things like that. And
7 then to have sort of rotating Board members working
8 with the contractor or contractors that are doing
9 dose reconstruction, so that we would sort of split
10 the share of the work on the actual reviews, so
11 that's certainly the way we constructed it, yeah.

12 MR. ELLIOTT: If I could add to that, kind
13 of the way I had envisioned what you've been talking
14 about in the Working Group --

15 WRITER/EDITOR: You're mike's not working.
16 I'm sorry.

17 MR. ELLIOTT: Now I'm on?

18 WRITER/EDITOR: Yes.

19 MR. ELLIOTT: Okay. It's magic. You could
20 have a panel of Board members working with your
21 contractor as Working Groups, you know, the finite
22 task there is work with the contractor, come up with
23 a review of a sample of dose reconstructions that
24 you have been given as a panel. The Subcommittee
25 itself could identify what dose reconstructions of a

1 representative sample would be reviewed, and how
2 those are brought to the Board; so you could
3 reconvene your panels as you need them -- or Working
4 Groups as you need them. That's one scenario as how
5 it might work.

6 DR. ZIEMER: Any other general comments?
7 Jim, did you have one?

8 DR. MELIUS: I don't know quite where we're
9 going, if we're going to discuss this
10 Subcommittee/Workgroup issue more, or do we need to
11 defer that for a while, or?

12 DR. ZIEMER: I think, again, we're trying to
13 get the issues on the floor --

14 DR. MELIUS: Yeah.

15 DR. ZIEMER: -- because none of them are
16 sort of made in isolation, and it may be helpful to
17 identify what -- what particular things have to be
18 done, and then try to put them together.

19 Do you have another comment?

20 MR. ESPINOSA: We're a small group -- we're
21 a small group as it is. Does a Subcommittee have to
22 be a majority of the members?

23 DR. ZIEMER: No.

24 MS. ESPINOSA: Okay.

25 DR. ZIEMER: No. I don't recall that there

1 are actually any size specificity to it.

2 MS. HOMER: There are no specific, no, you
3 can have it as two people if necessary.

4 MR. ESPINOSA: I was looking through it and
5 I couldn't find that there.

6 DR. MELIUS: And it can include
7 outside members?

8 DR. ZIEMER: I believe you can have outside
9 consultants.

10 MS. HOMER: Consultants, not members.

11 DR. MELIUS: Yeah, consultants, excuse me,
12 not members.

13 DR. ZIEMER: Roy?

14 MR. DeHART: I'm not trying to avoid the
15 formality of the Subcommittee, but I see it being
16 stifling in terms of flexibility and ability to move
17 quickly and be able to handle a lot of work. I
18 would think that we could do that in Working Groups,
19 still keeping the tasks very limited, very specific,
20 and move from one Working Group to another Working
21 Group, to another Working Group, different people,
22 and avoid the formality of a Subcommittee, and
23 that's what I'm going to be trying to think about as
24 we're going through.

25 DR. ZIEMER: Yeah. You may be suggesting a

1 scenario where the Board acts as the Committee as a
2 whole to determine the nature of the work. The part
3 that you just described sounds like the second part
4 of what Larry was talking about; these are the
5 subsets which work on -- it's like a Working Group
6 that has a task of reviewing this dose
7 reconstruction and then they're done, as opposed to
8 the coordinating function of deciding which sets of
9 -- of dose reconstructions are to be reviewed and
10 that sort of thing.

11 DR. MELIUS: Not disagreeing with that
12 sentiment, trying to avoid, you know, additional or
13 formal meetings and so forth, but I think one of the
14 criteria we need to think about with that is, is the
15 function so unwieldy or practical to do as a full
16 Board meeting, or that the waiting for full Board
17 meetings could delay that; but at the same time is a
18 function that there should be some transparency to,
19 that the public should have the opportunity to
20 comment and be aware of what was happening with the
21 Committee, there would be formal minutes and so
22 forth of that. So there may be functions that are
23 in between what a Workgroup should do -- could do
24 and there are -- I guess the third levels that are
25 sort of Workgroup reviewing it, you know, individual

1 case or something and going through all the
2 documents is not something that can necessarily be
3 done easily and in public, or should even be done in
4 public. But I think we have to be a little bit
5 careful about sort of setting up a series of Ad Hoc
6 Workgroups that sort of hide this from the public as
7 a way around that process. And that there could be
8 something in between also that where a -- for
9 example, a Subcommittee that would meet regularly by
10 conference call once a month to do this function may
11 be a way, you know, it could be announced in the
12 *Federal Register*, people could participate maybe one
13 way in between of dealing with certain -- certain
14 selected issues, selecting the, you know, the nature
15 of the cases to review, the process or whatever, to
16 do that. At the same time it's a little harder to
17 see where making assignments and so forth will be
18 easily done that -- that way either, and where that
19 would fit. But maybe if we work through what
20 exactly we would -- what the steps would be, that --
21 that we could then decide. But I do think we have
22 to keep in mind that it is a -- there should be some
23 -- the more transparency there is to this process,
24 the more credibility it will have.

25 MR. GRIFFON: Just one -- one more -- what

1 did he say, ad nauseam we comment. Anyway, just I
2 mean one more question on the Subcommittee. As I
3 understand the -- the -- looked into the FACA Rules
4 a little bit, and it says that if there's no further
5 deliberations on the Advisory Committee, then the
6 Subcommittees have to adhere to the public -- public
7 functions, that they have to be held publicly, but
8 if they -- if you read that backwards, then if they,
9 you know, the Subcommittee can act more like a
10 Working Group where we select cases, select the --
11 make the criteria, select cases, and bring them to
12 the full Board, and the Board deliberates over it
13 and agrees and puts that forward, I don't think, in
14 that case, it's really a Subcommittee that has to
15 adhere to the public requirements.

16 DR. ZIEMER: Well, we need some expert
17 opinion on that.

18 MS. HOMER: I would like to point out, which
19 I probably didn't make clear before, whether or not
20 it's a Workgroup or a Subcommittee, the decisions or
21 work done by Subcommittees or Workgroup has to be
22 brought to the full approval of the Board.

23 DR. ZIEMER: Well, yes, and the Workgroup in
24 -- in fact, brings its findings to the Board and at
25 which point they become public. It was just the

1 issue there that they can deliberate privately while
2 developing the work product that they bring to the
3 Board. In the case of the Subcommittee, that --
4 closed deliberations are also done in an open forum.

5 MR. GRIFFON: And the only reason I raised
6 that is not that I don't want it to be open, but
7 that the flexibility question that Roy raised, you
8 know, might be easier to conduct without that.

9 DR. ZIEMER: Now, this again is not an issue
10 we have to decide at the front end because it may be
11 driven more by what the process itself looks like,
12 how we're going to do the review. For example, we
13 may need to begin looking at how it is we're going
14 to conduct these reviews; what is it going to look
15 like in terms of consultants and Board members; are
16 we going to have a series of small panels or what.
17 And maybe we need to think about working from that
18 end and working back to see what the total picture
19 would look like. Are we going to have a number of
20 these subset groups working with the consultants, or
21 -- or having consultants do the work and then
22 meeting with them, or that kind of thing. We
23 haven't really decided how that's going to happen,
24 right? And then decide what that's going to mean in
25 terms of participation by this Board for example, is

1 everybody on the Board going to be involved in that,
2 or just certain ones. Again, that's -- the Board
3 can decide to do this anyway it wishes, I think at
4 this point. We're not bound by any particular
5 requirement.

6 So I'm going to suggest, and this may be a
7 good time to take a break because you may need to
8 collect your thoughts on that, but to determine what
9 the reviews are going to look like and what the
10 product of those reviews will be, and then back that
11 up. We have an idea, and I think we have an idea of
12 the numbers of reviews, we've talked about
13 percentages and so on.

14 Just before the break I want to remind
15 members of the general public if you do wish to
16 speak at the public comment period, please be sure
17 to sign up.

18 We'll take a 15-minute recess.

19 (Whereupon, a recess was taken.)

20 BY DR. ZIEMER: (Resuming)

21 Now, before we go further in discussing some
22 of the issues in the review process and so on, we
23 have an opportunity to learn a little more about the
24 Task Order Contract Award Processing and the length
25 of times involved. And Martha will walk us through

1 that. There is a handout that should be at your
2 place. It's a blue background that says Task Order
3 Contract Award Processing.

4 Martha, are you set to go on this?

5 MS. DiMUZIO: Yes. Larry asked that I just
6 provide you all with some information about how
7 exactly the task order process will work, so
8 obviously this is all after award of the contract.
9 But just to give everyone a little bit of
10 information about the timing on the contract, once
11 we're ready -- once we're -- well, at least for the
12 NIOSH process, obviously it needs to be determined
13 whether NIOSH or DOL is going to handle the
14 contract, but if it were to go through the NIOSH
15 process we would need to send it -- we're ready to
16 go basically now. The documents that -- it would
17 need to go to Atlanta for approval, that usually
18 takes again, about a week for processing, but for
19 actual, formal solicitation and everything, it has
20 to be out on the street for a minimum of 30 days and
21 it can be as much as 45, but we would be requesting
22 30 days with proposers given a minimum of 30 days to
23 respond. So then you would have the technical
24 evaluation panel meet and evaluate those proposals
25 and that's not really on this slide here

1 (indicating), I apologize. I thought I should --
2 this is sort of after award which is up on the
3 screen, but I realize no one knew the timing for
4 actually award of the contract, so after, you know,
5 the technical evaluation panel meets and so forth,
6 it could be, you know, a hundred and -- a minimum of
7 120 days from the time that NIOSH submits the
8 contract to the Procurement Office before an actual
9 award is made. So just some initial information
10 about the actual award of the contract and the
11 timing on that.

12 But what we have here is the contract has
13 already been awarded and we're ready to start
14 submitting task orders to the contract, so the
15 Advisory Board meets either as a Working Group or a
16 Subcommittee, develops the task order request, along
17 with the Independent Government Estimate and submits
18 it to NIOSH. So it will come to OCAS in Cincinnati,
19 and we'll prepare the necessary funding information,
20 and then that needs to be forwarded to Atlanta for
21 approval by both the NIOSH/AD Office and the CDC
22 Financial Management Office. And historically, that
23 takes approximately two weeks. Then -- then Atlanta
24 will forward the information on to the Procurement
25 Office, who will prepare the task order and submit

1 it to the contractor proposal; again, about a week.
2 The contractor will prepare the response to the
3 Board's proposal, and according to the contract,
4 they have up to 14 days to submit their proposal.
5 That's then -- we receive the proposal back, that is
6 then reviewed by the Advisory Board; if they accept
7 it, it can be awarded; and I will say approximately
8 another week. If the Board requests revisions to
9 that proposal, the contractor has an additional week
10 to respond to any revisions. So basically what will
11 happen is, you know, on average, once the Board
12 submits a task to NIOSH, it will take approximately
13 seven to eight weeks for that task to be assigned to
14 the contractor to start work.

15 DR. ZIEMER: Okay. Everybody understands
16 this is after the procurement?

17 MS. DiMUZIO: This here is after the
18 procurement.

19 DR. ZIEMER: This is two months, sort of
20 minimum, if a procurement is completed and we have a
21 contract.

22 MS. DiMUZIO: Right.

23 DR. ZIEMER: Now, remind us again how long
24 under optimal conditions will the main procurement
25 take? I don't know --

1 MS. DiMUZIO: Under optimal conditions --

2 DR. ZIEMER: Optimal conditions.

3 MS. DiMUZIO: Under optimal conditions the
4 proposal would be out on the street in the *Commerce*
5 *Business Daily* for 30 days --

6 DR. ZIEMER: Right.

7 MS. DiMUZIO: -- so the bidders would have
8 30 days to respond -- it would be out as an
9 announcement for 30 days, and then during that time
10 frame they have the -- the bidders will propose
11 their thing; then the Technical Evaluation Panel is
12 established, and they review the proposals that have
13 been submitted. That -- depending on the quality of
14 the proposals that are submitted, and if you need to
15 go back and forth and do best and final and so
16 forth, that could be an additional two to three
17 months, depending on the number of bids and so
18 forth. And then after the Advisory -- after the
19 Technical Evaluation Panel has selected the -- the
20 best proposal, from there it usually takes about
21 another two to three weeks for the actual award.

22 DR. ZIEMER: So it would appear that
23 somewhere in the range of three to four months are
24 required to bring the procurement to closure, and a
25 couple of more months to get the first task order in

1 place. So I'm just trying to make sure the Board
2 has a feel for timing here, that you're ready to go
3 on the first task order, if you started today with
4 the procurement, that it would be somewhere
5 approaching six months from now before you're ready
6 to go with the first task order. Is that -- am I
7 correct on that?

8 MS. DiMUZIO: Yes.

9 DR. ZIEMER: It might be slightly better
10 than that?

11 MS. DiMUZIO: It could be slightly better,
12 but --

13 DR. ZIEMER: But not -- not very much
14 better, and it could be a whole lot worse.

15 Jim?

16 DR. MELIUS: Yeah. I have a question. This
17 is related to that Working Group/Subcommittee issue,
18 and it's really the first bullet up there. The
19 Advisory Board would submit a task order request,
20 along with the Independent Government Estimate.
21 That's a new Independent Government Estimate, which
22 means that that has to have -- well, that whole
23 procedure really requires a meeting in person, and
24 then a closed session, and you know, announcements
25 and so forth, and I mean I think we have to factor

1 that into this decision on how to -- how to operate
2 it. And so much of that depends on what the detail
3 is of the task order; do we want to do a detailed --
4 I mean there's lots of ways we could do it, but --
5 but we do the elements of the task order through a
6 Working Group or something, then the Independent
7 Government Estimate is part of an actual Committee
8 meeting. But if we're going to be doing a lot of
9 task orders between meetings, it depends on the
10 frequency of the task orders, then I almost would
11 argue for a Subcommittee, which would allow you --
12 which would have to meet in person, but would be
13 allowed to do the Independent Government Estimate.
14 Is that -- that's my question.

15 DR. ZIEMER: Martha, you were going to talk
16 to us a little bit, were you, about that Independent
17 Estimate right now?

18 MS. DiMUZIO: Yes. I did just --

19 DR. ZIEMER: Give an example?

20 MS. DiMUZIO: But -- but Dr. Melius is
21 correct, you would have to have some type of an
22 Executive Session in order to develop that
23 Government Estimate, whether it's a Subcommittee, or
24 the full Board, or whatever, so --

25 DR. MELIUS: But -- but it can be done by a

1 Subcommittee?

2 MS. DiMUZIO: It could be done by a
3 Subcommittee because the Subcommittee can act on
4 behalf of the Board, correct, Cori?

5 MS. HOMER: They cannot act on behalf of the
6 Board. Everything that is discussed has to be
7 decided by the full Board, not the Subcommittee.

8 MS. DiMUZIO: Okay.

9 DR. MELIUS: That's what I -- that's what I
10 want to make sure of.

11 MS. DiMUZIO: So basically it would be
12 Independent Government Estimate associated with an
13 individual task. What I did for, just for the sake
14 of this meeting, is I just took the sample task,
15 Attachment D, from the -- from the current proposal
16 that we have and developed an Independent Government
17 Estimate, you know, and --

18 DR. ZIEMER: This is a sample only.

19 MS. DiMUZIO: Yeah, obviously it's a sample
20 only because I'm sure a Health Physicist --

21 DR. ZIEMER: Nobody should take the \$2 an
22 hour rate for a Health Physicist very seriously.

23 MS. DiMUZIO: That's right. So we just
24 wanted the Board to see what type of information
25 that needed to be included in -- in the Estimate as

1 it goes forward, so this is, you know, this is the
2 type of information that would be required, so --
3 I'm sorry we don't have this on a slide -- but you
4 would -- initially you would have -- the staff would
5 be identified, and normally when you -- once the
6 contract is awarded, the staff is usually
7 identified, so you -- you may possibly be listing
8 staff here by name. And then, obviously you would
9 know what their hourly rates are and so forth; so,
10 you know, you would total their salaries and their
11 benefits to come up with the personnel costs; if
12 travel is necessary, you know, we would add in those
13 costs, you know, as required; any miscellaneous, you
14 know, and that's postage, mailings, you know,
15 anything like that; then the overhead costs that the
16 contractor is charging, a subtotal, and then any
17 fee, award fee, that the contractor is entitled to,
18 to come up with the Independent Estimate and which
19 would then be submitted to the -- along with the
20 task order, to the Procurement Office for
21 processing.

22 MR. ELLIOTT: Martha, I think I'm correct in
23 this, but help me out. There would be a need to
24 have two executive sessions on any individual task
25 order, would there not? One to prepare in advance

1 the task order and the Independent Government Cost
2 Estimate to be submitted to the contractor, then
3 once you get the proposal back on that task from the
4 contractor, it would require another Executive
5 Session of whoever, the Subcommittee or the Board,
6 to examine that proposal, deliberate upon the
7 Independent Cost Estimate -- or the proposal cost
8 estimate --

9 MS. DiMUZIO: Cost proposal versus --

10 MR. ELLIOTT: -- matching against
11 Independent --

12 MS. DiMUZIO: -- Independent Government.

13 MR. ELLIOTT: -- and provide any negotiation
14 points back to the contracting officer.

15 MR. DiMUZIO: I would -- I would give a
16 qualified yes to that, only from the standpoint that
17 it's possible that once you've received a proposal
18 back from the contractor, you could say in a meeting
19 that the -- the estimate was -- if you don't have a
20 problem with the estimate, I don't believe you would
21 need to go into Executive Session --

22 MR. ELLIOTT: Okay.

23 MS. DiMUZIO: -- to discuss the estimate.

24 MR. ELLIOTT: So the Board -- the Board or
25 the Subcommittee of the Board could -- could specify

1 to the contracting officer that if the proposer's
2 cost proposal is within or lower than the
3 Independent Cost Estimate --

4 MS. DiMUZIO: Yeah, so --

5 MR. ELLIOTT: -- they don't have to have
6 that yet.

7 MS. DiMUZIO: Right, so at a meeting of the
8 full Board you could just say we -- you know, we
9 accept the proposal, the cost proposal as submitted
10 by the contractor, and you wouldn't have to go into
11 what the Independent Government Estimate was.

12 DR. MELIUS: The second -- the potential
13 second Executive Session, does that have to be the
14 full Board or can it be a Subcommittee of the Board?

15 DR. ZIEMER: I think that's the same
16 question, is it not, Cori?

17 MS. HOMER: Yes.

18 DR. ZIEMER: Decisions must be made --

19 MS. HOMER: Anything can be discussed by a
20 Subcommittee as a full committee, or as you can a
21 full committee, but anything that a Subcommittee
22 does has to brought to the full Board for discussion
23 and determination.

24 DR. MELIUS: So that would -- that means
25 this process then, you just, the Board, we meet once

1 every six weeks, you're talking about a six week --

2 MS. MUNN: Hiatus.

3 DR. MELIUS: -- another you can add to this
4 task order processing, what, at least another four
5 weeks, I think, but, you know, on average if it has
6 to be the whole Committee.

7 MS. DiMUZIO: Could you do that as a
8 conference call?

9 DR. MELIUS: If it doesn't involve an
10 Independent Government Estimate.

11 DR. ZIEMER: I think we already determined
12 that a conference call for an Executive Session
13 probably doesn't work, right?

14 MS. HOMER: It must be a secured call.

15 MR. ELLIOTT: It wouldn't -- a conference
16 call wouldn't work if you had to have an Executive
17 Session, but if you got around that, you didn't have
18 to have an Executive Session to discuss independent
19 -- discuss the proposer's cost estimate you could do
20 everything you need to do by -- by teleconference.

21 DR. MELIUS: But you wouldn't necessarily
22 know that until it was submitted.

23 MR. ELLIOTT: That's right.

24 MS. DiMUZIO: But I mean particularly in the
25 beginning when the contract is first awarded, I mean

1 if it's possible that we have a series of task
2 orders ready for when the contract is awarded, I
3 mean you could have sort of one session where you
4 reviewed several tasks at least to get the process
5 started.

6 DR. MELIUS: I -- I think that makes --
7 obviously makes sense, but I'm just trying to figure
8 out the alternative, and whether there is any other
9 way of -- on that.

10 DR. ZIEMER: Which perhaps emphasizes the
11 need to have some tasks ready to go at the front end
12 of the process then.

13 DR. MELIUS: We'll have to agree to accept
14 this rate of \$2 an hour for a Health Physicist.

15 DR. ZIEMER: Okay. Any other questions for
16 Martha on this issue?

17 Okay. Thank you, Martha, that helps frame
18 out the time constraints or lack thereof that we
19 have with this process.

20 DR. ZIEMER: Cori, do you have a comment?

21 MS. HOMER: Conference calls for closed
22 sessions have been conducted by CDC conference call
23 bridge, and that is considered secure. We'd have to
24 double check and have absolute certainty, but I know
25 that it has been done in the past and if others have

1 considered it secure, then it may be secure enough
2 for our purposes as well.

3 DR. ZIEMER: Okay. Thank you.

4 Now, let's -- let's focus back now on the
5 tasks before us. I'm -- I'm trying to develop a
6 feel for how to go about this, and I'm not smart
7 enough to have figured it out yet. It seemed to me
8 that it might be helpful to look at the -- I'm
9 trying to see which document it is -- the Statement
10 of Work and the various types of reviews we have to
11 do, or that we say that we would like to do, and try
12 to get some ideas on the floor as to how we would
13 carry those out as far as this Board.

14 MR. GRIFFON: Attachment C.

15 DR. ZIEMER: Attachment C, right.
16 Attachment C of Draft 1/31/03, Request for Contract,
17 and beginning on page 15 we have the Individual Dose
18 Reconstruction Review; and then we have the Advanced
19 Review; we have the Blind Dose Reconstructions; then
20 we have the section on Site Profiles and so on.

21 It seemed to me sort of intuitively that if
22 we could begin to address these maybe section by
23 section, Individual Dose Reconstruction Review,
24 let's take that as the simplest case. How are these
25 to be carried out? That's not simply a rhetorical

1 question. I mean it is rhetorical at this point,
2 but I think we now need to come to grips with that.
3 And I -- I think it might be helpful, and I'm going
4 to -- Mark, I'm going to put you on the spot and say
5 okay, the Working Group sort of had a model in mind,
6 and if you can remind us of that, and then let's
7 take off from there and flesh it out a bit.

8 Well, the Chair always has the prerogative
9 of getting other people to come up with the good
10 ideas, right?

11 MR. GRIFFON: Yeah, I'm not sure. I think,
12 Paul, what you're asking for is -- is assuming that
13 we've selected the cases already, or do you want to
14 back up and go into how we're selecting the cases?

15 DR. ZIEMER: I think we have to -- have to
16 talk about that as well.

17 MR. GRIFFON: Okay. Okay. I mean --

18 DR. ZIEMER: In order to define the scope of
19 what it is this Board is going to be doing because
20 we're going to have to have task orders for all of
21 this. Unless we can put it -- unless we can --

22 MR. GRIFFON: Right.

23 DR. ZIEMER: -- delineate it we can't write
24 a task order.

25 MR. GRIFFON: Yeah, I think one clear place

1 we have to start is the selection process, and I
2 think it might be -- we threw out some parameters in
3 past discussions on how we would look at selection.
4 We know a percentage of cases that we're going to
5 consider. I think we also have to look at case
6 availability, so this is hard to do without looking
7 at the actual data base to know, you know, what
8 cases are available for us to review -- you know, if
9 you have a certain selection criteria, but there's
10 no cases that fit into that realm in the first round
11 of cases that are done by the contractor, then we're
12 kind of sitting --

13 DR. ZIEMER: But see, you've defined the
14 first step. Somebody is going to have to review the
15 available cases, I mean maybe that's step one,
16 right? And then we would say, and who is going to
17 do that, is that the full Board or is that a subset.

18 DR. ANDRADE: Paul --

19 DR. ZIEMER: That's what I'm -- I'm trying
20 to call out these issues. Okay.

21 DR. ANDRADE: I think this is a critical
22 point for everybody to keep in mind as we go through
23 this discussion, and that is that we have to all be
24 clear, and be on the same page of music, by the way,
25 on whether -- what you mean by availability are

1 cases that have been at least taken to the level of
2 being sent back after the -- after the final dose
3 reconstruction. Okay. Realize that all the
4 language that's written here in the Statement of
5 Work is in the past tense, and I think, in my own
6 opinion, it was perhaps fortuitous that it was done
7 this way, perhaps we just got lucky, that if -- if
8 we recall and remind ourselves that it is done in
9 the past tense, and we really will be developing a
10 quality review process, we're going to be second
11 guessing the dose assessors as they're doing the
12 work then I think we will then be overstepping the
13 boundaries or the intent.

14 DR. ZIEMER: I -- I believe, and others can
15 correct me, it was certainly my understanding that
16 this is an audit that's after the fact.

17 DR. ANDRADE: Okay.

18 DR. ZIEMER: It's completed dose
19 reconstructions. Is that not everybody's
20 understanding?

21 DR. MELIUS: Yeah.

22 DR. ANDRADE: Okay. Very good. I think
23 that -- that helps.

24 DR. MELIUS: But I'm just saying, agreeing
25 -- fully agreeing with that, but I think for the

1 purposes of this task or this selection we're going
2 to have to be projecting out because of the time --
3 because of where we are now in the process because
4 of the time frame going out, we're going to have to
5 be able to project out numbers. We're not going to
6 be actually doing selection, but --

7 DR. ZIEMER: But knowing what cases are
8 coming down the line and some numbers of future
9 cases will be selected.

10 DR. ANDRADE: If that's what you mean by
11 availability then --

12 DR. MELIUS: That's -- that's -- yeah.

13 MR. GRIFFON: Yes.

14 DR. ZIEMER: But it's completed cases that
15 are looked at.

16 DR. MELIUS: But -- but, and we are going to
17 have some estimate of availability, but then when
18 the actual selection takes place it will only be
19 from the completed cases --

20 MS. MUNN: The available pool.

21 DR. MELIUS: -- the available pool, and do
22 that, and we're going to have to probably recognize
23 that our projections are not always going to be good
24 because, you know, things get delayed or whatever,
25 particularly as we get into some of the finer points

1 of types of cases from different sites and things
2 like that, that's going to be maybe hard to fill.
3 And we're going to have to have some flexibility in
4 how these cases are chosen -- will be chosen at the
5 time for review.

6 DR. ANDRADE: Absolutely. I think then
7 almost by default we have solved, or probably come
8 to a conclusion here about one of the bigger
9 problems that was laid out even earlier, and that is
10 the issue of conflict of interest between the
11 administrative handling of this process by NIOSH
12 and/or the Department of Labor. If this is -- is
13 this is to be done after the fact, then there is no
14 conflict of interest with the Department of Labor.

15 DR. ZIEMER: Are you saying the case would
16 have already been adjudicated?

17 DR. ANDRADE: Absolutely.

18 DR. ZIEMER: Let me ask a question now,
19 Mark. When you said identify available cases, you
20 are suggesting these be identified generically by
21 type, location, or what? In other words, I'm asking
22 you is this something that could be done as you're
23 saying, in open session, we're not identifying
24 individuals; you may identify sites, types of cases,
25 numbers of cases, something that --

1 MR. GRIFFON: Yeah, I think --

2 DR. ZIEMER: -- can be done by the full
3 Board --

4 MR. GRIFFON: Right. I think --

5 DR. ZIEMER: -- in open session that we say
6 okay, at this meeting we've set aside some time -- I
7 mean I could see at each Board meeting having some
8 time set aside where we do this.

9 MR. GRIFFON: Yeah, generally I think so. I
10 think we can discuss some, we've already discussed
11 some potential parameters, you know, but we -- we
12 didn't get more specific than that. I guess the
13 question I was running through my head was -- and it
14 depends on how we lay out this task order -- but if
15 you have a task order to be completed in one or two
16 years or whatever, you estimate a budget for the
17 first year, and based on our sampling scheme there's
18 no cases completed that meet those criteria, then
19 we, you know, we failed. So we've got to project
20 and that might have, you know, we'd have to work
21 with NIOSH to see, you know, maybe by -- by finding
22 out what they have in the hopper, what they're
23 working on, you know, the -- you know, just as an
24 example, if they were doing all Hanford cases first,
25 I know they're not, but if, you know, they were

1 doing all Hanford first, then, you know, our
2 criteria is, you know, we're not meeting all our
3 sampling criteria, so just projecting like Jim said,
4 the numbers.

5 DR. MELIUS: My thinking, that would be a
6 task for a workgroup to do, and come back to the
7 Board with sort of the parameters of that, you know,
8 the task, based on where we see NIOSH is, and what
9 NIOSH is projecting, a number of other, some of
10 these (inaudible) -- there will be so many cases
11 available for, you know, completed cases available
12 within this time period for review. And that to me
13 would be something that could be probably better
14 done by a workgroup talking to NIOSH. Then maybe an
15 affirmation of that, or even the final selection be
16 done by the, or which could be done and I think sort
17 of very easily and naturally as part of this task
18 order development.

19 DR. ZIEMER: We're just getting ideas on the
20 floor now.

21 DR. MELIUS: Yeah, yeah.

22 DR. ZIEMER: We have not approved
23 workgroups.

24 Tony.

25 DR. ANDRADE: Okay. Then I have a question

1 of Jim. Jim, to the best of your knowledge, in the
2 cases that have been reviewed, some preliminary dose
3 reconstruction done, or perhaps even finals, even
4 though you describe your work as having attacked
5 those cases that are quote, low-hanging fruit at
6 this particular point in time, do you believe that
7 you have a good representative sampling of a wide
8 variety of cases?

9 DR. NETON: With a sample size of 18, I'd
10 say no. Eighteen out of 10,000, so. But we do have
11 a couple of different approaches that one could look
12 at, but obviously there's -- there's a number of
13 things like AWE's and such that would not be
14 included.

15 DR. ZIEMER: Keeping in mind that this
16 process may be six months off before it gets
17 underway and looking what's in the pipeline, I think
18 the sense of the question is how representative and
19 what -- what we have now that's coming onscreen in
20 the next six to eight months, how representative is
21 that?

22 DR. NETON: I think -- I think Mark Griffon
23 hit it -- hit it on the head. The Board needs to
24 work with us and the ORAU contractor to determine
25 what the plan of attack is for the upcoming six

1 months to a year, and then develop a sampling
2 schedule based on that. I'm not convinced with the
3 task order you really need to identify specific
4 types of review. I mean you're really just talking
5 about numbers of reviews period, and you don't
6 really need to get that specific I don't think.

7 MR. GRIFFON: Yeah, the only thing I was
8 thinking, Jim, is that if we do specify a number of
9 reviews and then given the criteria we've laid
10 out --

11 DR. NETON: Yeah.

12 MR. GRIFFON: -- we're overwhelmed with one
13 type of case --

14 DR. NETON: Right.

15 MR. GRIFFON: -- but we don't have any of
16 the others, then we, you know.

17 DR. NETON: But I think there were complete
18 -- wasn't it just like advanced versus basic. I
19 mean it didn't break it down into compensable versus
20 noncompensable.

21 MS. ROESSLER: No.

22 DR. NETON: So I think you could, you know,
23 the sampling strategy is you're going to take a
24 certain percentage of those and do an advance
25 review, so if we predict that there's going to be a

1 thousand cases --

2 MR. GRIFFON: But you're -- you're also
3 looking at the types of review versus the parameters
4 by which to select cases, and those are two
5 different things.

6 DR. NETON: Yeah, and I've forgotten what
7 those were.

8 MR. GRIFFON: I mean the -- the parameters
9 we were thinking about were -- were site,
10 complexity, the -- the --

11 DR. NETON: And I think we're far enough
12 along where we could work with ORAU and develop a
13 sampling strategy for the -- the sites that may be
14 coming through, but based on the -- it's really now
15 being driven by the completion of the site profiles,
16 that's sort of the limiting factor at this point.
17 Once you have a full set of data on someone and they
18 appear to be noncompensable, if you don't have the
19 complete site profile in place, it can't move
20 forward, so as those site profiles become completed
21 at least for certain blocks of years, we can give
22 you an indication of which cases will be moving
23 forward in fairly large chunks.

24 DR. MELIUS: Two things; one is just a
25 follow-up to that. I think you said you were doing

1 a first-come-first serve, you know, in the order
2 that they were received, so, you know, from taking
3 into account these other parameters like site and
4 profile, I think you could, with some time and
5 effort, sort of figure out how to do it. And I
6 think that would be a way, and then you're just
7 going to be estimating what's going to be a complete
8 case, available case at some point down the road or
9 within a certain time period. I also think, though,
10 we have to be careful that we may have a general
11 sort of task order in terms of -- it wouldn't
12 specify the cases, but we also have to work out a
13 procedure for how those actual cases will be
14 selected. I mean we don't want to put us in the
15 position of having -- or put NIOSH in the
16 position --

17 MR. ELLIOTT: We're not going to select
18 them.

19 DR. MELIUS: Yeah, you're not going to want
20 to be in the position of making the selections, so.

21 DR. NETON: If I could point out, just make
22 -- Martha can correct me if I'm wrong, but I think
23 if you write a task order for a certain volume of
24 work or it ends up being adopted, you can always
25 extend it. If you don't complete that work in that

1 given contract year I think we have the option to
2 just say okay, we'll carry this over in subsequent
3 years.

4 MS. DiMUZIO: Right. What I was going to
5 say is that, you know, you can say that --

6 WRITER/EDITOR: You need to use the mike.

7 MS. DiMUZIO: The task order can say that
8 you're going to review the cases; you want the
9 contractor to review 70 cases over the year. That
10 doesn't mean you have to have those 70 cases
11 identified at the start of the task order. You
12 could, you know, you could look at the matrix or,
13 you know, give NIOSH some type of guidance on what
14 your matrix, you know, of what you'd like to look
15 at, and we can see how the matrix is and what type
16 of numbers that you're looking at. So you don't
17 really have to, when you assign the task order, at
18 that point in time, know exactly what the cases are.
19 You know that you want the contractor to review 70;
20 you could give him 10 now, you know; 50 in three
21 months, you know, cause you're going to give them,
22 you know, however long; you want 70 cases in a year,
23 so you would probably do a task for one year for
24 those 70 cases. So you really don't have to know
25 upfront prior to award of that particular task

1 exactly what those tasks are.

2 DR. NETON: We could always add or --

3 MS. DiMUZIO: And we could always modify.

4 Yes, we could add time to the task if we realized we
5 didn't get the right matrixes that we wanted or
6 reduce time and reduce the number, and then, you
7 know, reduce cost or something like that, so.

8 DR. ZIEMER: Just one second. I want to
9 capture a thought because I think, Jim, your comment
10 moved us to the next item after availability, but I
11 can't remember what you said.

12 DR. MELIUS: On the case selection.

13 DR. ZIEMER: Case selection.

14 DR. MELIUS: Yeah, and if I can --

15 MR. PRESLEY: Go ahead because that was what
16 I was going to talk --

17 DR. MELIUS: Well, my -- it was this
18 workgroup -- if we did this sort of workgroup, it
19 could also be not only work on the parameters of
20 this task order, but also a case selection, specific
21 case selection process; how are we going to select
22 cases and meet these parameters, and what's an easy
23 way of doing it without having to, you know, wait
24 until the cases are through the process.

25 MR. GRIFFON: Yeah, how --

1 DR. ZIEMER: Well, by case selection you're
2 identifying them by sort of generic features, not
3 by --

4 DR. MELIUS: And then we'd also --

5 MR. GRIFFON: We're talking stratified
6 sampling, I guess, yeah.

7 DR. ZIEMER: Yes.

8 DR. MELIUS: Then how will the actual cases,
9 a process for how the actual cases will be selected
10 once they --

11 DR. ZIEMER: Right. I'm just going to jot
12 down as another case selection process is the issue.
13 Okay. Now, Robert.

14 MR. PRESLEY: Well, when we started the
15 working group we started talking about a percentage,
16 and then we went off and talked about looking at the
17 highest number of cases from a given area being the
18 highest that we would do, and then go back and look
19 at the AWE areas, maybe the AWE areas where we were
20 having the most trouble, and try to pull some of
21 those out to see if everything was according to all
22 there. And that's some of the things that we have
23 talked about in the past is maybe taking a
24 percentage --

25 DR. ZIEMER: And again, that probably is

1 part of the case selection process.

2 MR. PRESLEY: Right. And that will be part
3 of the case selection process also, to intertwine.

4 DR. ZIEMER: Right.

5 MR. GRIFFON: You know, just for your
6 information in those overheads there is -- there is
7 page 4 -- yeah, the July overheads behind the three
8 contract parts. Page 4 has a couple of overheads on
9 case selection and stuff that we had talked about in
10 the working group preliminary stuff. And I think
11 what we're talking about as far as stratification is
12 the -- the second bullet of the first overhead
13 there, it talks about some stratifications we were
14 considering. I'm not sure that's all of the
15 appropriate ones, but that's what came out at the
16 time.

17 DR. ZIEMER: Very good. Okay. Who's next?
18 Case selection process as you have it here gives
19 some of the parameters: the site; the exposure
20 type; cancer type; and so on. It gives the
21 percentage of cases, but I assume, Jim, that you
22 were talking about a little more specificity beyond
23 this --

24 DR. MELIUS: Oh, sure.

25 DR. ZIEMER: -- even the actual process now.

1 DR. MELIUS: I think there are like three
2 levels to this. One is an estimate of numbers that
3 would be appropriate for the task order, given our
4 overall sampling scheme, whatever we want to call
5 it, for case review. Secondly is a way the group
6 could work out how would the cases be selected, a
7 procedure given the data base, given how things are
8 being processed and so forth, a way for -- a method
9 for case selection. And the third thing is the
10 actual procedure, the actual selection of the cases.
11 Now, that may be a separate, because that's after
12 the task order is awarded and we have to decide is
13 that something that the Committee does, is that
14 something the Committee has to do, which many of
15 these things seem to be, or can that be done by --
16 will we have another workgroup that would do -- be
17 tasked just to do that, and is that appropriate.

18 DR. ZIEMER: And that, in fact, is one of
19 the issues that we have --

20 DR. MELIUS: Yeah.

21 DR. ZIEMER: -- to decide.

22 DR. MELIUS: Right.

23 DR. ZIEMER: Well, given that we're going to
24 do 37 cases of something or other, how are you going
25 to actually choose them?

1 DR. MELIUS: Yeah. Right. A procedure for
2 doing that, and then third, just actually
3 implementing that at the time when it needs to be
4 implemented. And I don't think that is something
5 that's easy to -- that we should be, in fact,
6 delegating to NIOSH or whoever is doing the
7 contract, or do they want to be involved in that
8 part of it.

9 DR. ZIEMER: No, that's -- that's a Board
10 activity purely under this particular task.

11 DR. MELIUS: Yeah.

12 DR. ZIEMER: Once the -- once the cases are
13 selected, and we have identified the cases available
14 and we have a process in place we've agreed to,
15 that's sort of a one-time thing, but it can be
16 tweaked as you go along. We have a procedure for
17 the selection of cases, and now you have before you
18 X number of cases, now what happens?

19 MR. GRIFFON: Now --

20 DR. ZIEMER: Okay. I mean we know
21 conceptually what happens, I want to know what
22 really happens.

23 MR. GRIFFON: Oh, what really happens, I
24 mean it does depend on the type of review I guess,
25 but if you had a pile of Basic Reviews --

1 DR. ZIEMER: Let's start with Basic Reviews.

2 MR. GRIFFON: Right. Well, I think first,
3 you know, there's the question of how this material
4 can be delivered to the auditor; whether it has to
5 be D-identified and I believe it has to be
6 D-identified, so whatever cases we select are
7 D-identified, and then for the Basic Review I think
8 we're only looking at the -- I'd have to go back to
9 all these detailed, all of our parts of the Basic
10 Review, but I think one's first step would be that
11 the auditing contractor would get a disk copy, or
12 whatever form, from NIOSH of the D-identified
13 version of that case, the entire administrative
14 record, along with, I guess, the final decision for
15 the Basic Review because they're not going to --
16 it's not a Blind Review, they're going to see the --
17 that's one starting point I can think of is that
18 they're going to get that.

19 DR. ZIEMER: And Jim, if -- Jim Neton, if
20 you have comments to add to this, jump in, but I'm
21 trying to get at questions like: Is this delivered
22 to an individual who is the contractor? Is this
23 delivered to a Board member, through them, in
24 consultation with the contractor does something -- I
25 mean at some point we've got to get very specific

1 what happens. And we're not going to solve this all
2 today, but I want to get these questions before us,
3 so we -- we have some direction as we go forward.
4 We may not even be able to finish this tomorrow, but
5 we need to start framing out the process, and try to
6 identify -- and we may have to have a working group
7 actually step through this and make some block
8 diagrams. But it's almost like a paper flow thing.

9 MS. MUNN: Yeah, it is. Yeah.

10 DR. MELIUS: I also think that some of us,
11 because I think the question comes up as to what
12 this whole (inaudible) Board members are involved in
13 each individual review.

14 DR. ZIEMER: That's exactly what the
15 question is. We can't just -- we've got --

16 DR. MELIUS: But -- but --

17 DR. ZIEMER: -- that's floating around here.
18 We need to --

19 DR. MELIUS: But that's also going to be
20 dependent on what the flow of cases is, the task and
21 the issues we've just been talking about, that if
22 there's a large number of cases early on -- for
23 example, I could see where we set up the process so
24 that Board members would be more involved early on,
25 so that we get more familiar with the process, and

1 so -- and then as the reviews go along the Board
2 members might want to be less involved. But all of
3 that is going to float or, you know, involve how
4 many cases there are, how much work there is, and to
5 do with --

6 DR. ZIEMER: Obviously we can modify this as
7 we gain experience. We're going to be operating
8 sort of like Jim has been, as we gained experience
9 we'd start modifying. But you have to have a
10 starting procedure, so you have to have something to
11 modify.

12 MR. GRIFFON: I guess the initial scheme was
13 to have Board members working with the contractor,
14 some sort of panel, and how that's constructed, you
15 know, if we had designated assigned panels, I'm not
16 sure that's going to work for people's availability
17 and things like that.

18 DR. ZIEMER: And we have to think about --

19 MR. GRIFFON: Right, yeah.

20 DR. ZIEMER: -- availability, and where is
21 this going to occur physically --

22 MR. GRIFFON: Right.

23 MS. ROESSLER: Yes.

24 MR. GRIFFON: Right.

25 DR. ZIEMER: -- are people traveling

1 somewhere, or --

2 MR. GRIFFON: Right. Now the model we had
3 discussed we had discussed in the working group --
4 in the previous working group was to have the -- the
5 idea was to have the panel -- actually, I think I
6 put it in some of the estimates and stuff we talked
7 about. The Board members that were on the panel
8 assigned to those reviews would -- would plan on
9 coming to the Advisory Board meeting a day early or
10 something like that where they could meet with the
11 subcontractor and work through and see -- and we're
12 really relying on the subcontractor to do a lot of
13 the detail work. I would think as far as
14 documentation though, like the administrative record
15 or whatever for cases that are being reviewed my
16 notion would be that these things could be mailed.
17 I think that's -- that would be legal, so I could
18 see CDs going out to the contractor and to the panel
19 members for that -- that were responsible for that
20 case. And maybe some process has to be worked out
21 that they be returned back to NIOSH at the end of
22 those case reviews, I don't know what the rules
23 would be there, but, you know, I don't see that you
24 have to physically come to -- everybody would have
25 to physically travel to NIOSH to get these cases and

1 sit and review them all at once. They could have
2 them back at their offices and collect it at a --
3 and come back to a meeting to collect it, especially
4 for the Basic Review, which is the lower level
5 review.

6 DR. ZIEMER: Robert?

7 MR. PRESLEY: If everybody got a CD, the
8 two-person, three-person, four-person, five-person,
9 whatever the panel is; we had talked about coming in
10 a day early, the panel, taking the instruction from
11 the contractor, and if everybody said that was fine,
12 then we would come in front of the Board, the full
13 Board and say, this panel recommends that this dose
14 reconstruction either be accepted or rejected at
15 that time. And if it's -- I see it as accepted, it
16 goes; if it's rejected, then we've got a problem.

17 MR. GRIFFON: And what I could -- the way I
18 saw that panel working there is that if the
19 contractor came back in and we try to do it
20 sufficiently so that we could have maybe, you know,
21 five, ten, whatever number of cases that we can look
22 at at one time, not just one case at a time; you
23 look at five cases and maybe you say well, four of
24 these we're in agreement with you, we're going to
25 present that to the Board, the overall Board, and

1 the Board can rule on it. But one, we'd like you --
2 we have these questions, and we told the contractor
3 to give us some more information and, you know, do
4 some further work on this one and report back to us
5 at the next meeting, you know, something like that
6 might evolve, that way the panel is digging into the
7 cases a little deeper than the overall Board, so
8 that's kind of how I envision that working.

9 DR. ZIEMER: Other comments at this point?

10 DR. MELIUS: Also, I think you have this
11 process sort of practically that maybe it's a series
12 of there's a workgroup appointed that's panel one;
13 panel one meets between -- before meeting one;
14 reports back -- we're not going to have, you know, I
15 don't think four panels meeting before each meeting,
16 so it's going to be done sequentially. Now, panel
17 one, if we follow Mark's sort of protocol here,
18 panel one may have some leftover cases that aren't
19 resolved by -- by meeting one, so those would be
20 deferred to meeting two, and panel -- you know, and
21 I -- and those are hypothetical, I think we still
22 have to work out the logistics of -- of how that
23 would actually occur. And then also, these type of
24 reports get, you know, what are we accepting at
25 meeting one, or do we really have to have panel one

1 meet before the meeting -- before meeting one, so
2 that there's really time for a report because I
3 think we need to be accepting a report on the -- I
4 mean the full Board has to approve a report on
5 accepting a report on this. And then have some way
6 of summarizing that, I think, of that review process
7 which is really an overall Board function. I would
8 presume we would do that with the help from the
9 contractor, but.

10 MR. GRIFFON: What Jim just said was -- it
11 sort of summarized our conversations where we talked
12 about these rotating panels, and I think that does
13 make sort of sense that at each next meeting we
14 might want to then say okay, we've got these cases
15 up and running and we need a panel to work -- for
16 the next meeting to work with the contractor on
17 these certain cases. I think we might have to do it
18 like that because then -- then Board members could
19 decide, you know, who is available; secondly, there
20 might be conflict of interest issues where we can't
21 review certain cases because of our personal
22 backgrounds, so we could assign panels sort of at
23 each meeting, sort of ad hoc selection of those
24 panels moving forward.

25 DR. ZIEMER: When you say rotating panels,

1 there wouldn't be a certain panel that's always made
2 up of the same combination of Board members, it may
3 be some --

4 MR. GRIFFON: That's sort of the way I
5 would, yeah.

6 DR. ZIEMER: Roy.

7 MR. DeHART: I think we had talked about in
8 the group a panel of three basically trying to meet
9 together, but that could be changed of course. What
10 I would like to see us flesh out a bit is -- is
11 what's happening with the panel when it meets with
12 the contractor and what, as Jim has implied, what is
13 the report. I had not envisioned a great report
14 coming out -- out of that. The effort was to look
15 at the work that had been done by the contractor and
16 if there is agreement, that's it. And if there is
17 issues, then it's back to the contractor to rework
18 until there is agreement, and then presented to the
19 Board. But from what Jim was saying it implied some
20 report of depth might be coming out of that.

21 DR. ZIEMER: Well, part of what you're
22 raising, actually the question: What is the nature
23 of the report that comes out of the panel? I think
24 that's a very important part of the audit. It's not
25 necessarily the issue of should compensation have

1 been paid or not, it may be the issue of -- and the
2 bottom line might have been correct, but if we start
3 to see things like incorrect assumptions are being
4 made, or unsupported assumptions are being made, or
5 something like that, then you start looking for
6 patterns. So it seems to me the report has to be
7 dealing with the nature of what's being done and how
8 well that is being done. Certainly part of the
9 bottom line is, is the correct decision made. But
10 we're not sending things back for redoing of the
11 decision, we are looking for -- and you might
12 actually, I guess, conceivably have a case where you
13 say, you know, this person should have been paid off
14 and they weren't, in which case you might actually
15 have a way to reopen it, but that's a separate
16 issue, but if -- if your finding some flaws in the
17 methodology, I guess is what you're looking for.
18 And so we may have a series of things, and I'm
19 trying to remember if you addressed this. Is the
20 report -- or was the dose reconstruction, were the
21 assumptions valid --

22 MR. GRIFFON: Yeah. Yeah, we have it in
23 there.

24 DR. ZIEMER: -- was the site information
25 data properly used -- weren't there --

1 MR. GRIFFON: Yeah. Oh, yeah, they're all
2 -- they're all in there.

3 DR. ZIEMER: They're in there.

4 MR. GRIFFON: I -- I guess I envisioned this
5 report as being --

6 DR. ZIEMER: Well, that would be the basis
7 of the report, would it not?

8 MR. GRIFFON: Yeah, I guess I envisioned
9 this report being fully developed when the
10 contractor came to these panel meetings. And the
11 notion of the panel at all, I mean you could say
12 well, why have the panel. I thought the intent of
13 having the panel was that they would get the CDs
14 ahead of time with all this data that the contractor
15 is reviewing, and would have access to the
16 contractor doing that review via phone, most likely.
17 But they could have access by e-mail or phone, you
18 know, to ask questions are you looking into this, or
19 whatever. Then when the contractor comes to meet
20 with the panel the day before the Advisory meeting,
21 they'd go through their entire report, and if I'm on
22 the panel I can say well, you know, wait a second, I
23 was looking at the administrative record and, you
24 know, these pages, you know, I don't see you really
25 addressing this issue in your report at all, you

1 know, so the panel members have had -- have had more
2 time to review the specific cases, and then they can
3 -- they can, you know, they don't replace the
4 Board's vote, but they'd have more time, you know,
5 and the Board -- it was just to alleviate from
6 having every Board member review every case,
7 you know, so.

8 MR. DeHART: Let me give you an example of
9 how a review might happen. We deal with medical
10 records; we have a checklist basically that we just
11 go down and make sure that you know there's a name,
12 and there is a diagnosis, and evaluations, and a
13 proper treatment appears to be made; boom, boom,
14 boom, we'd check it off and if that's it, then this
15 one would be completed in terms of its review and
16 recommended to the Board. But if there's problems,
17 we would address those and ask the contractor to try
18 to make those changes.

19 DR. ZIEMER: Thank you. Tony, and then Jim.

20 DR. ANDRADE: Given what's in the definition
21 of Basic, Advanced, and Blind Review Requirements, I
22 believe that answering the questions or addressing
23 each and every specific item there, even in a view
24 graph, would comprise a report. But if we have a
25 panel to check the quality of the auditors who are

1 checking the quality of the contractors, then I
2 think we're going to be duplicating efforts and
3 wasting time, so if the panel convenes to insure
4 that these things have been done in a checklist
5 method, then I think that would really be all that
6 is necessary and probably minimize people sitting on
7 a panel's time and effort.

8 DR. ZIEMER: Jim. And then were you going
9 to respond to that, Mark?

10 DR. MELIUS: If you want to go ahead, you
11 can.

12 MR. GRIFFON: No, go ahead.

13 DR. ZIEMER: Jim.

14 DR. MELIUS: Yeah, I would see this working
15 off of form and I -- and I think it would behoove us
16 as a Committee, so perhaps we develop the form so we
17 can -- cause we have to give that at the time these
18 task orders go in place, and we don't want to make
19 that the first task order or we delay the whole
20 process, so we can't let the contractor do that, so
21 that's one. And I think the issue only comes up --
22 there's an issue that would come up, it may not
23 always come up, but would come up if we find a
24 problem or a potential problem. That's when there's
25 the issue of the report and maybe it's also when the

1 Advisory Board member would sort of get more -- we'd
2 have to judge how serious this is; is it a pattern,
3 and then there would be a need to be some report
4 from the panel that would say we have reviewed 10
5 cases, whatever it is, that we found problem A, and
6 we'd have to have some way of putting all those
7 panel reports together, you know. And it may be
8 that the kind of problem that may be found may be
9 only serious if it's a pattern or, you know, there's
10 lots of different ways to characterize that. But I
11 don't see us doing large reports or long reports on
12 each case or anything. It would -- it ought to work
13 off of form, and I think we have to spend the time
14 developing a comprehensive or a complete form that
15 we're satisfied with.

16 DR. ZIEMER: Thank you. Mark, you were
17 going to respond to Roy's comment, or Tony's.

18 MR. GRIFFON: I was.

19 DR. ZIEMER: You were.

20 MR. GRIFFON: I guess that's why I let Jim
21 go first because I was pausing on this one, but I --
22 you know, I don't -- the intent of the panel,
23 certainly the reason we're looking for a contractor
24 for this Advisory Board is to pull expertise into
25 this Board to actually do these reviews. On the

1 other hand, it is the Board's responsibility to do
2 this -- this oversight task, so we are responsible
3 for these findings, so I'm listening to the
4 checklist comment and, you know, I'm thinking of the
5 model on NIOSH's side, which is that, from what I
6 understand NIOSH has -- ORAU is doing the bulk of
7 the dose reconstructions; NIOSH is reviewing every
8 single one. I think that we're having a contractor
9 do all the dose reconstructions. I don't -- and it
10 wouldn't be as extensive of a review, but I think --
11 maybe a checklist is enough -- but I think there's
12 got to be some sort of review by the panel just to
13 make sure that the Board is comfortable with the
14 final product.

15 MR. PRESLEY: Mark, isn't that what we're
16 going to do on the Blind ones?

17 MR. GRIFFON: Yeah, I haven't got that far.

18 DR. ZIEMER: On the general review,
19 certainly it was my understanding that we're not
20 recalculating, we, the Board, we're not doing dose
21 reconstructions.

22 MR. GRIFFON: Right. But I mean I -- I
23 guess I just envisioned it as being -- the panel
24 members involved in it as being more than our -- the
25 Board's contractor comes back and we have a

1 checklist that says they looked at basic review
2 items A-1, check; A-2, check. I mean I think the
3 panel should -- should look at their report and --
4 and make some kind of determination as to whether
5 they -- the contractor addressed it adequately for
6 -- for the Board to make their final decision as to
7 whether the whole case was reviewed appropriately,
8 you know. That doesn't mean that they start from
9 scratch and do all the work the contractor did, but.

10 DR. ZIEMER: Okay. We have a comment from
11 Mike, and then we'll get back to Tony.

12 MR. GIBSON: I guess Mark was kind of
13 addressing what I was thinking, is, you know, if we
14 have rotating Board members for different cases,
15 each one of us will probably have a different idea
16 of what's an acceptable site profile; what's
17 acceptable default parameters; so it looks like to
18 me it could keep us from being consistent if we just
19 have a basic, generic form that we check off unless
20 we really define, as a Board, what adequate site
21 profile, you know, which gets us into another level
22 of the work, so.

23 DR. ZIEMER: Keep in mind we're -- we're
24 really not asking quite the question of what's an
25 adequate site profile, we're more asking something

1 along the line: Did the dose reconstructor use the
2 information properly in reconstructing the dose?
3 Many of these site profiles may indeed be inadequate
4 from one point of view, but may be adequate for
5 doing a particular dose reconstruction, so some of
6 these -- some of these questions, you know, have to
7 be answered in the context of particular cases so
8 that if there's -- if there's an issue with a case,
9 then you raise it and say, you know, they made some
10 assumptions here that you can't make based on what's
11 available. And I think you're quite right, Mike,
12 that you may have a better feel in some cases for
13 whether that's the right, and I think the Board does
14 bring its view to the -- to the process. It's very
15 interesting, just -- I just talk generically, you
16 know, Boards nowadays are getting a lot of scrutiny,
17 particular those that have audit functions. I'm on
18 a -- I'm on a different Board right now that is
19 setting up an audit committee to audit the auditors,
20 and you know why that's come about. But there are
21 Federal Regulations now that Boards have to audit
22 their auditors, and it's -- the auditing function of
23 a Board Audit Committee is not one of doing the
24 audit. They are looking to certify that the
25 auditors followed the proper audit procedures that

1 they say they're following. There is a point at
2 which you have to take people's word when they say I
3 did this, and they show you how they did it, you
4 know, somebody can still fool you, but since the
5 Arthur Anderson case has come about, you know,
6 there's -- people are checking the auditors. Now,
7 Boards even have to determine whether their auditing
8 committee is properly auditing the auditors, so it
9 keeps moving back a level. But I think there is a
10 sense in which we have to take the responsibility as
11 a Board to do this function. We -- we are -- we are
12 doing an audit, and it's not our contractors, they
13 are helping us do the audit, but you're quite right,
14 it's our responsibility; ultimately if there's a
15 problem, it falls back on us.

16 I'm off my soap box, and who is next? I
17 think Tony was next, and then Jim.

18 DR. ANDRADE: Again, I envision the report,
19 or a report to a panel, whatever body, to be -- to
20 include statements and/or groups of statements that
21 address the various elements that the contractor was
22 assigned to do; whether it's basic, advanced, or
23 blind. So it's fairly simple insofar as what
24 content should be -- should be there. If the --
25 okay, let me -- let me digress to an example and go

1 back to the example that Mike used that we may be
2 uncomfortable, or one of the panelists may be
3 uncomfortable about the adequacy of a site profile.
4 Well, the nice thing about the way the system is
5 functioning is that inadequacies usually lead to
6 greater uncertainties in dose reconstructions;
7 therefore, inherently the system self-corrects. In
8 other words, it becomes more user friendly as the
9 uncertainty grows, and that can be pointed out; that
10 can be information that's fed back to the -- to the
11 associate universities, etcetera, so I think that's
12 a self-correcting sort of issue. I just wanted to
13 mention again these contractors here are
14 incentivised through the contracting process itself.
15 In other words, they're being paid to find mistakes,
16 to find errors, to find shortcomings. That's where
17 -- you've got to keep that in mind as well.

18 DR. ZIEMER: I'm not sure we pay any bonuses
19 if they find one.

20 DR. ANDRADE: No, but -- but there are
21 reasons why these people are bidding, okay, and so
22 let's not forget that.

23 DR. ZIEMER: Thank you. Jim, you had
24 another comment.

25 DR. MELIUS: Yes.

1 DR. ZIEMER: Then we're going to close it
2 off for now.

3 DR. MELIUS: Okay. I think we could develop
4 a form based to some extent on what we've already
5 written here that would be used by the contractor in
6 doing the review, used by the panel in meeting and
7 discussing that review would capture that
8 information, and something that I do agree with Tony
9 that we're going to -- they are going to be finding
10 things, and I think the part of the panel function
11 is going to be sort of determining how serious that
12 is, understanding that -- that, and then making some
13 sort of assessment out of it, and then we have to,
14 as a panel or a Board make an overall assessment of
15 that. But I think if we get into forms that we're
16 all comfortable with, I think that we can make the
17 process work without, you know, generating a lot of
18 paper that's not useful or putting too much of a
19 burden on us to do the actual dose review. And it
20 is quality assurance, and so it will actually, I
21 think, tend to find problems or potential problems.

22 DR. ZIEMER: Thank you. With that comment
23 we're going to end the discussion on this topic
24 today. We will be back to this topic again
25 tomorrow.

1 We do have on our Agenda a Public Comment
2 Period. We have several individuals who have
3 requested their time to comment. We will begin with
4 -- let me see if I can pronounce these right: Is it
5 Hans Behling, S. Cohen & Associates. Hans, did I
6 pronounce your last name correctly?

7 MR. BEHLING: Yes.

8 DR. ZIEMER: Thank you. Please come and
9 address the group.

10 MR. BEHLING: I really don't have as much of
11 a comment as a question, and the question -- there's
12 two questions that somewhat relate to each other and
13 they do involve a NIOSH/IREP dose model, and perhaps
14 somebody here in the Advisory Board can answer the
15 question.

16 When you talk about internal exposure from,
17 let's say a rem of 31, the issue in the scientific
18 literature has been based regarding the efficacy for
19 a unidose of internal radiation to include thyroid
20 cancer as opposed to external radiation. In other
21 words, a rad is a not a rad, it is not the findings
22 in the external or internal, and the ratio between
23 the efficacy of internal to external has been in the
24 scientific literature defined as being a part, it's
25 a part of 10 to 1 or -- or essentially 1 to 1. Does

1 the particular IREP model address that issue of
2 efficacy once the dose for internal and external
3 exposures to the thyroid has been added to each
4 other? That's my first question.

5 DR. ZIEMER: We can probably have Jim Neton
6 answer that. Go ahead with your second -- or Jim go
7 ahead and.

8 DR. NETON: I'm not sure I really understand
9 the question. You're talking about external
10 exposure in a gamma radiation field added to some
11 internal exposure from like the data radiation that
12 one might receive, something like that?

13 MR. BEHLING: In terms of the PC
14 calculation, if one say had external, whole-body
15 exposure that includes the thyroid, let's say if 10
16 rads or rem, and then from an internal exposure to
17 ion like 31, you also have 10 rems --

18 DR. NETON: Okay. Yeah.

19 MR. BEHLING: -- and how are they added to
20 each other, and what is the efficacy assigned to
21 internal in terms of risk coefficient for the
22 private citizen?

23 DR. NETON: Okay. The answer to the first
24 part of that question is they are treated totally
25 independently; IREP allows for input for both an

1 internal dose component and an external dose
2 component; it's on an annual basis. I don't know
3 the exact value for the risk coefficient for
4 internal versus external, but the external was
5 modeled after the Hiroshima-Nagasaki survivors. The
6 internal risk coefficient is also modeled after the
7 Hiroshima/Nagasaki, but the dose calculation is not.
8 I mean that's done separately using the ICRP models,
9 so the answer is we do account for both internal and
10 external. The efficacy model though, the risk
11 coefficients though, once the dose is calculated is
12 based on an external -- well, that's not true --
13 there is -- there is some medical studies, or a few
14 medical studies that were incorporated into
15 developing that risk coefficient, and I guess I'm
16 not sure exactly how much weight was given that.
17 I'd have to look into that to get back to you.

18 MR. BEHLING: The second question is also an
19 important one related to iodine and the potential
20 thyroid exposure. We all know that the uptake
21 fraction, that is the transfer from blood to thyroid
22 for iodine is heavily dependent on a dietary intake
23 of cold iodine. In other words, a person, you have
24 two people; one takes a dietary iodine intake of
25 let's say 300 micrograms per day, and the other

1 person only 100 micrograms; expose those same two
2 individuals with all other parameters being equal to
3 an airborne environment or ingestion; the person who
4 has a lower dietary intake has a higher FS-2 or
5 uptake fraction, and as opposed to the person with
6 the 300 micrograms. Now, we do know, and I've done
7 a lot of work on this area, that the dietary intake
8 of iodine has shifted over the years since the
9 introduction of iodized salt. Also, there are
10 geographical differences that separate East Coast,
11 West Coast. The most recent data I've seen is that
12 West Coast people, on the average, may be consuming
13 up to 700 micrograms of iodine a day, which will
14 certainly impact the -- the FS-2 fraction for
15 thyroid doses. And so we have a variation here over
16 time and space that deal with the dietary iodine
17 intake that has a pronounced effect on the actual
18 dose calculation. What is the issue that will be
19 addressed on that level?

20 DR. NETON: That's a difficult question, but
21 the answer to that is that we use the standard
22 default ICLP metabolic values for -- for uptake of
23 iodine. I guess in just quickly thinking about your
24 comment, those that were rich with the iodine --
25 diets were rich in iodine we would be actually

1 overestimating their dose. Those that were
2 deficient, we would be underestimating, but I don't
3 think that we really have any way of reconstructing
4 -- a good way of reconstructing their iodine intake
5 at the time of the occupational exposure. This is
6 the non-environmental exposures, so the answer -- we
7 don't address it, we use the standard default;
8 however, models do allow for us to incorporate
9 uncertainty into the dose calculation itself. To my
10 knowledge, we have not done an iodine exposure dose
11 calculation yet, but we certainly could incorporate
12 that into the uncertainty in the dose dosimetry.

13 DR. ZIEMER: But keep in mind also, in the
14 case of occupational workers you -- you may actually
15 have thyroid uptake measurements, which give you the
16 actual burden of iodine in the thyroid, so you --
17 you don't have to depend on any metabolic models for
18 those. And many of the facilities using iodine
19 would have that. I'm not sure about the older
20 cases, but --

21 DR. NETON: That's a very good point. If --
22 if the exposure got to the point where there was a
23 significant dose of thyroid, a person, not more than
24 likely, but probably could have been -- would have
25 been monitored and we would have the exact value of

1 a good approximation of the iodine in their thyroid.
2 For those lesser cases, we tend to be very
3 conservative or claimant favorable in our approach,
4 and we'd certainly more than likely overestimate the
5 amount of dose to the thyroid.

6 DR. ZIEMER: Thank you. Any of the Board
7 members have questions on this issue?

8 Okay. Next we will hear from Denise Brock
9 with United Nuclear Weapons Workers of the St. Louis
10 region.

11 Ms. Brock.

12 MS. BROCK: Hi. I'm Denise Brock, and I'm
13 going to read from this because I'm extremely
14 nervous.

15 I am from St. Louis, Missouri, and my father
16 was Christopher Davis. He was an employee of
17 Mallinckrodt Downtown Destrehan Plant for 16 years.
18 In 1967, he was diagnosed with lung cancer and after
19 a complete pneumectomy, and years of suffering, he
20 passed away.

21 My mom, Evelyn Coffelt, is 70 years old.
22 She is a claimant and she filed two years ago. Up
23 until about a month ago my mom worked full-time just
24 to make ends meet, but due to failing health she has
25 been forced to quit her job.

1 My mother is living barely above poverty
2 level, and I was hoping that her claim would be
3 handled expeditiously, and that she would be
4 compensated. I am here on her behalf and on behalf
5 of all of the Missouri claimants.

6 Prior to coming here I had called two
7 meetings; the first consisted of about 60 people,
8 which kind of surprised me, I thought I'd end up
9 with about 15 or 20; and the second, I actually had
10 over 300 people, including Congressional staffers
11 and Federal Officials. And one of those Federal
12 Officials is here today; Dr. Jim Neton, and I would
13 like to thank him publicly, now, for attending; as
14 well as stating that since listening to the
15 discussion today I feel confident in going home
16 knowing that there's an honest effort being put
17 forth by this Board to wade through all of this. It
18 seems to be kind of public opinion from the
19 claimants that maybe they're not going to get paid,
20 and I think sitting here listening to this just
21 shows me that everybody is putting an effort forth
22 and that it's -- there's a lot of intricacies in
23 this.

24 I would also like to commend the Paducah
25 Resource Center; they have been a lifeline for

1 myself and the claimants.

2 Since my second meeting, I have been
3 contacted in excess of over 600 people, and that's
4 not including members of the press, the media, and
5 even Erin Brockavich's office. Throughout the
6 contacts of the claimants though, I've noticed that
7 we have all similar statements, concerns, and
8 questions, and in reference to that I have some
9 issues that I'd like to raise with the Board, all of
10 which have really been touched upon today.

11 Number one would be the quality of the --
12 and I say transcripts, but I'm understanding that
13 would be drafts pertaining to the phone interview.
14 For example, my mother had her phone interview on
15 December 12th, and I did record this. It's my
16 understanding that the phone interview is a very
17 integral part of this program, especially dose
18 reconstruction. Knowing this, I have done a
19 tremendous amount of research concerning the
20 facilities. At the beginning of the interview the
21 interviewer's computer went down; she was very nice
22 and very polite, but she did assure me that she
23 could write as fast as she could type, so I
24 continued, and as I said before, I had quite an
25 enormous amount of information about these sites.

1 This time, because it was about my father, I was
2 talking about the Destrehan site, and they worked
3 with Belgian Congo pitchblende. This African ore
4 was so hot that the workers were exposed to not just
5 U238 and it's daughters, but U235, which I
6 understand is rarely found in nature, and all of its
7 daughters; thorium, all three types of radon gas,
8 three types of radium; and I kind of went through
9 all of this with her, even in reference to like the
10 work environment. As I continued, the interviewer
11 conveyed that the Health Physicists were aware of
12 all that the plant consisted of, and felt confident
13 in summarizing. And typically, one might be
14 comfortable with that, but I have heard repeatedly
15 from claimants and other sources that the data is
16 still being recaptured, and that there might not
17 have even been a site profile done yet. My question
18 is: Was she correct -- is the interviewer correct,
19 would it -- has there been a site profile done, and
20 do they know everything they need to know, or on the
21 flip side, maybe would that be incorrect, and maybe
22 she would be remiss in taking -- not taking down
23 everything that I had stated to her?

24 DR. ZIEMER: I'm wondering if any of the
25 NIOSH staff are able to answer that, and if not

1 right now, they will certainly be able to shortly.

2 DR. NETON: Yeah, I think I can address that
3 partially anyways.

4 It sounds like -- let's go back. The
5 interview is really to try to elicit the information
6 that's specific to the claimant that may not be
7 known about their exposure scenario, you know, where
8 they worked in the plant, what type of material the
9 claimant worked with individually, so that's really
10 one of the -- one of the main intents of the -- of
11 the interview itself. If a claimant does have site-
12 specific information they developed on their own
13 that is somewhat voluminous in nature, that should
14 be provided to us; it could easily be provided to us
15 under separate cover, but it really is not the
16 intent of the interviewer at that point to go over
17 and develop site profiles during the interview. So
18 I think maybe we have a little bit of
19 misinterpretation of what the interview is actually
20 accomplishing. Do we have site profile for
21 Mallinckrodt done? No. I mean we're working on it,
22 there's a lot of information we have, but there's a
23 lot we don't have. Anything that you would have or
24 a claimant, related to the Mallinckrodt site, we
25 would encourage that to be submitted, and that's

1 more than likely what the interviewer should have
2 said, is, please, you know, submit that under
3 separate cover, when it's a volume, if it's not
4 meant to be taken down on the telephone. Anything
5 that is specific though to the claim itself, it
6 could help elucidate the actual dose to your father
7 would have been of value, and it --

8 MS. BROCK: He had three separate job
9 titles --

10 WRITER/EDITOR: Use the mike, please.

11 MS. BROCK: He had three separate job
12 titles, so I'm assuming, and I actually had which
13 plant he was in like 4, 6, and 7, those different
14 areas, so if I was being specific with what were in
15 those areas, would that have been something the
16 interviewer would take down? I mean I'm just
17 confused, or do I send that in with my hard copy?

18 DR. NETON: No. If you knew specific job
19 titles, and locations, and type of materials, which
20 are actually part of the interview. I mean that is
21 the script the person should repetitively go
22 through, and that's why we computerize it; what's
23 the job title; what type of radioactive material;
24 what plant; what type of radioactive materials; that
25 should have been captured in the interview, so if it

1 wasn't, then, you know, maybe we need to revisit
2 that.

3 MS. BROCK: And I can send that in.

4 DR. NETON: Oh, sure. Absolutely. Or we
5 could arrange for another follow-up interview if you
6 have additional information to add.

7 MS. BROCK: And, let's see, that brings me
8 to my -- to my second one, would actually be the
9 issue of dose reconstruction. I have a letter with
10 me to one of the claimants from the Department of
11 Labor stating that dose reconstruction could take
12 months, even years. And I'm assuming that's
13 accurate, and I just would like to say that that is
14 very disheartening because these claimants do not
15 have months or years; they are dying daily. Even
16 though I do understand there's a process that one
17 must go through, and especially after being here
18 today, you know, I can see that NIOSH is actually
19 making great efforts in this. And I can empathize
20 with all sides, but when it's obvious that workers
21 were endangered, and they were, that's a given, and
22 when you know that they were exposed to some of the
23 most hazardous materials known to mankind -- and I'd
24 like to make reference to an exit interview of
25 Merril Eisenbud conducted January 26, 1995, by

1 Thomas J. Fischer and where Mr. Eisenbud states that
2 Mallinckrodt was to be -- is one of the two most
3 worst facilities. And I also had a concern about,
4 if like in my father's case, if the Department of
5 Energy, it's my understanding, could not find
6 specific things in reference to my father, then when
7 you dose reconstruct that, I'm assuming you use
8 coworker data. And that kind of gives me grave
9 concerns because, as I said, he had numerous job
10 titles, and I'm wondering at that point if that's
11 possible to even -- even do that if they worked
12 seven days a week, 14-hour shifts, and maybe he was
13 in, you know, different areas, is that possible to
14 even do that. And then I wonder when does dose
15 reconstruction not become feasible because my
16 ultimate goal would be -- again, I think I've talked
17 to several people -- to make Mallinckrodt a special
18 exposure cohort, so I mean is there --

19 DR. NETON: The use of coworker data may not
20 be possible. Clearly, if we can't identify
21 coworkers for your father in the facility, and then
22 we would go back one level, which is in our Rule,
23 and revert to the exposure models essentially, which
24 we would try to generate from the type of materials
25 that were there, and their concentration data we may

1 have, that sort of thing. Once we develop an
2 exposure model of that type, if the claimant, in
3 this case it might be your father, could be placed
4 in the environs of what that exposure model covers,
5 and that would be the basis for his dose
6 reconstruction. We're working on approaches like
7 that at other facilities, you know, I can't fill in
8 much more detail on that other than sometimes
9 coworker data may not be possible. And if we don't
10 the source term at all, you're right, at some point
11 we would say it can't be done. We haven't done that
12 yet, but it is a distinct possibility and it's
13 provided for in our regulations.

14 MS. BROCK: So then is it possible then like
15 after a phone interview like my mother had, if
16 perhaps you can't find all of that, and you can't --
17 is it possible to dose reconstruct without that
18 Mallinckrodt model? I mean is that possible, or is
19 it something she's going to have to wait for?

20 DR. NETON: That sort of gets to the issue
21 of how long it takes to do a dose reconstruction.
22 And we need to get sufficient information, obtain
23 sufficient information to develop some type of a
24 model. Once we do that, then we have to make the
25 decision is the model sufficient to -- to calculate

1 doses for people in the areas in plants that maybe
2 your father had been, so we'll just have to wait and
3 see. I guess I can't fill in any more details on
4 that. I apologize, but I can't give you any more
5 specifics at this time.

6 MS. BROCK: My last issue is really a policy
7 issue. And if I might use a hypothetical -- and
8 bear with me. Say you have -- and I know we've
9 addressed this -- or you've addressed this with the
10 smoking. If you have two workers with the same
11 exposure, and I don't know, maybe say 60 rem or
12 whatever would be compensable, both have lung
13 cancer, and one is a smoker and one is a nonsmoker,
14 how is it equitable to have that smoker at an
15 automatic disadvantage if they're exposed to the
16 same thing, same amount of time, and they both have
17 lung cancer?

18 DR. ZIEMER: Russ Henshaw is going to
19 volunteer to answer that.

20 DR. NETON: No, I don't want to take a shot
21 at this.

22 MR. HENSHAW: Well, that's a question that
23 does come up from time to time, and I'm not sure how
24 best to explain the theory behind that in IREP.
25 This may be -- somebody please yank me away if I get

1 too wordy here. But just to go back to the
2 beginning, we have the Japanese cohort that the
3 base-line rates are taken from and the excess
4 relative risk of smoking for lung cancer. That
5 Japanese cohort consisted of, on average, moderate
6 smokers. So now we have a cohort of people for whom
7 our excess relative risk for lung cancer is based on
8 of moderate smokers, and we have claimants who --
9 some who were smokers and some who were nonsmokers
10 -- some were smokers and some were not smokers. The
11 probability of causation -- and further we're
12 mandated by the legislation to calculate the
13 probability of causation that a worker's cancer was
14 caused by his or her radiation exposure, so now you
15 have the case of two individuals with similar
16 exposures; one's a smoker, one's a nonsmoker. And
17 the hypothetical scenario you present is where under
18 those circumstances one is compensated and one is
19 not, even though they were exposed to the same
20 amount. Well, this gets back to the way the
21 legislation reads, is: Was the worker's cancer as
22 likely as not caused by radiation exposure? And
23 what probability of causation does is calculate the
24 contribution in a probabilistic (sic) way. The
25 contribution of the radiation exposure to the

1 cancer, the likelihood that that radiation exposure
2 in and of itself caused the cancer. Well, with the
3 nonsmoker there is not -- the smoking is not
4 contributing to that effect, which is -- which is
5 lung cancer; therefore, the probability of causation
6 is higher. For a smoker, we have two contributing
7 factors; one the radiation exposure, one the
8 smoking. So in that case the -- the estimated
9 contribution of the radiation exposure is less. Now
10 getting back to that Japanese cohort -- this
11 probably is making things a lot more confusing,
12 so. But getting back to the Japanese cohort, that
13 was a cohort of moderate smokers, so when we adjust
14 for smoking in our lung cancer model, it does two
15 things: It has the effect of decreasing the
16 probability of causation for smokers, and that
17 varies with the category of smoking, but it also has
18 the effect of increasing the probability of
19 causation result for nonsmokers. So now you plug
20 these two hypothetical claimants into the IREP
21 software; on the one hand you have a factor that
22 increases the probability of causation, on the other
23 hand you have a factor that decreases the
24 probability of causation. So in a nutshell, that's
25 how one person could be compensated and the other

1 one not. Now the issue you're raising is how is it
2 equitable, how is that fair. I think -- I mean I
3 think that sort of goes beyond the science issue and
4 into an issue of policy, but as of right now we're,
5 you know, we're using the science as best we can for
6 the IREP modeling, and it just so happens that
7 there's probably no more substantiated cause of
8 cancer than smoking, that smoking is a cause of lung
9 cancer. So the data is, you know, unequivocal and
10 indisputable about that, and that's why we adjust
11 for it in the IREP model -- you know, at some point,
12 you know, that might change as, you know, that
13 adjustment may change, we may, you know, tinker with
14 the categories if science or new data suggest that,
15 or there could be some other influences that could
16 cause a policy change, but for right now that's --

17 MS. BROCK: I know you said it's legislated
18 or mandated through legislation. Is it mandated or
19 is it just to be considered? Is it mandated?

20 MR. HENSHAW: It's not mandated that we --
21 that we adjust for -- we adjust lung cancer claims
22 for smoking. I'm sorry if I --

23 MS. BROCK: Maybe I misunderstood.

24 MR. HENSHAW: Yeah, it's mandated that we
25 use -- we use the best science available to estimate

1 most accurately the probability of causation for any
2 cancer model. And for lung cancer, you know,
3 tobacco smoking is the greatest cause of lung
4 cancer, I don't think anybody would seriously
5 dispute that. I mean I understand the issue you
6 raise, I'm not trying to discount that at all, no
7 one here would. I think it's, I guess, an anomaly
8 of the adjustment, if you will, but I don't know.

9 MS. BROCK: Well, thank you. And the only
10 other thing -- can you hear me -- the only other
11 thing that I'd like to add is just a request to have
12 the next meeting, or the special exposure cohort
13 meeting in St. Louis. It would just be really
14 helpful for the claimants there to see what I've
15 seen today. I mean I just think it would make a big
16 difference. I'm telling you, it's impressed me and
17 I'd like to say thank you.

18 DR. ZIEMER: Thank you, very much. Let me
19 ask the Board if anyone has any questions for
20 Ms. Brock?

21 DR. MELIUS: Just in a quick follow-up, I
22 think. The issues you raised I think were very
23 good, and certainly two of them, the smoking issue
24 is one that the Board voted on today to put under
25 further review and scrutiny, and I think we'll be

1 dealing with that in later meetings. Secondly, the
2 issue of what happens when there's not adequate dose
3 information will be dealt with through the special
4 exposure cohort regulations, and the Board was not
5 pleased with the first edition of those, and
6 particularly in this issue of when is there not
7 adequate information available, so hopefully that
8 issue will get addressed also. Hopefully when NIOSH
9 gets these next set of regulations out for review.

10 MS. BROCK: Thank you.

11 DR. ZIEMER: Well, the next one appears to
12 be Richard Miller, whose handwriting -- Richard, did
13 you sign up?

14 MR. MILLER: Yes, I did.

15 DR. ZIEMER: Okay. Then, you're on.

16 MR. MILLER: Good afternoon, and welcome to
17 Charleston. I keep seeing you in these hotel rooms.
18 The hotel rooms, with the exception of New Mexico,
19 all look alike. And as Camille said, I wish we were
20 having it at Aiken, so we would have lots of
21 Savannah River workers here. Otherwise, the hotels
22 are kind of boring, you know, we could just do these
23 in Cincinnati, right, Larry?

24 MR. ELLIOTT: That's right.

25 MR. MILLER: But I had a couple of series of

1 questions for the Board, and the first has to do
2 with sort of leading, I guess, to what happens to
3 the product that the Board generates after it does
4 its review, your audit, or whatever you want to call
5 this. The review contractor shows up and you all
6 develop whatever product it is, your checklist, your
7 evaluation, your audit of your auditor, or whatever
8 the appropriate line is that you're drawing, and
9 then let's just take a hypothetical -- Larry's sort
10 of reading my mind. Do you want to ask this
11 question, Larry?

12 And -- and -- and the -- and the question
13 would be: Let's just say for example, you all look
14 at a case and you find either unsupported
15 assumptions, questionable assumptions, you didn't
16 look at the, you know, your assumptions on particle
17 size are all wrong, and therefore your committed
18 dose is wrong, and therefore, not only does that
19 affect an individual's case, but it might affect a
20 clache of cases that go back. Say you've handled a
21 site profile, and so you've got a whole of clache of
22 those. When NIOSH gets that, you have a set choice
23 points, I guess. One is you can decode the Blind
24 cases that was brought to the Board, which wouldn't
25 know who it was, but you would -- you would probably

1 have a way to decode it, presumably. And I guess
2 then the question is: Would you have, either
3 yourselves, or ORAU rework it? I guess that's
4 question one, and question two behind it is: Or
5 would you simply say look, we're not going to do it,
6 this is an adjudicated claim, the case is closed,
7 noted; we're moving on with life, we've got 10,500
8 piled up and more are like airplanes on the runway
9 waiting to come in, and just say we're going to
10 rework our procedures going forward. And then third
11 sort of choice, perhaps, is you have to go back and
12 review all of those in that clache, which would be a
13 function -- and then how would you know whether to
14 even accept the advice. In other words, you could
15 say professionally, you know, with all due respect
16 Advisory Board, fly a kite. So that's the question.

17 DR. NETON: I'd like to just address
18 maybe one portion of this, and then leave
19 the policy decisions about what we do up to
20 Larry.

21 But I think one thing I would like to point
22 out with your question is that we expect that there
23 are going to be differences in dose reconstructions.
24 I mean we have a unique process, we apply it as
25 efficiency process, and we take it only as far as we

1 need to so that Labor can make a decision. So in
2 your example of particle size for instance, if the
3 contractor, the oversight contractor, the task order
4 contractor that the Board hires comes back with a
5 dose reconstruction that differs by a factor of two
6 because they chose different particle size, but that
7 factor of two might make a difference between one
8 percent and two percent probability of causation, I
9 don't view that as a substantive issue. The issue
10 to the oversight contractor is: Did NIOSH, in my
11 mind, make the correct -- draw the bar on the right
12 side of the line for Labor to make the final
13 decision? So we need to remember that when we're
14 looking at these things. This is not -- these are
15 not exact, accurate dose reconstructions. And I'll
16 stop at that and then Larry maybe address what we're
17 going to do with it if there are substantive issue
18 where maybe a person should have been compensated.

19 MR. ELLIOTT: I love Richard's three-part,
20 four-part questions, you know, he always fires those
21 and then, you know, expects me to remember each and
22 every significant nuance of -- of what question,
23 which order, but let me just start.

24 The Department of Labor's regulations, and
25 our regulations both have a clause which allows us

1 to revisit dose reconstructions that have been
2 completed. That's the clause for DOL or us that we
3 would use to reexamine a dose reconstruction that
4 may have been found to be inadequate or of poor
5 quality. Okay.

6 Now whether or not -- I think the second
7 question Jim answered, perhaps. The third question
8 is: Would we just take it and would we ignore it?
9 And certainly, you know, the -- the Department's
10 position is this Advisory Board advises the
11 Secretary, and by that fact, gives us advice too on
12 how we do our work. We're going to consider that
13 duly, and depending upon what it is, you know, I
14 can't predict how we're going to go, but --

15 MR. MILLER: Well, let me give you the
16 hypothetical with the word "material" associated
17 with it, so that we're dealing with a material
18 issue. I'm not dealing with a question of trivia
19 here, so that at the end of the day let's assume
20 that you got the solubility wrong, so that you
21 really have a question of whether it's compensable
22 or not, even though it's not your job or your
23 contractor's job to be sitting around running IREP
24 all day on the dose models as they flow through.
25 Right? At least that's what you tell us. But --

1 but if that's true, and let's just say you got the
2 solubility wrong for whatever reason, and that's a
3 hypothetical, or a series of factors; the energy
4 level of the neutrons, just got it wrong for
5 whatever reason. That set of assumptions or
6 uncertainties are so wide that you, at the end of
7 the day, if you got a case and you get it back and
8 it was material, would you decode that case, decode
9 the Blind case and rework it and send it back
10 through because the claimant would never know that
11 there case was being audited cause they're blind as
12 well, unless they're getting a phone call under that
13 disputed procedure.

14 MR. ELLIOTT: Well, the answer to your
15 question is yes, of course.

16 MR. MILLER: Okay. I didn't know that.

17 MR. ELLIOTT: Of course, we --

18 MR. MILLER: I didn't hear that.

19 MR. ELLIOTT: -- would. We're going to -- I
20 -- I don't see any way out of it. We're going to
21 have to help the Board identify what cases are
22 available, and we're going to have to be the ones to
23 help redact the information as provided in whatever
24 form or shape this actually takes, so we're going to
25 know who's behind each case. We're going to also be

1 able to track other cases that have the same
2 similarity, the same issue, and they get revisited
3 back through the clause that says rework a dose
4 reconstruction.

5 DR. NETON: I would like to just add a
6 proviso though, that we -- we would reserve the
7 right to evaluate those comments and respond to them
8 if we don't believe that they are correct. Merely
9 because a person states that the material could have
10 been fast solubility class may or may not be true, I
11 mean we need to evaluate that, and that would sort
12 of be more claimant friendly for, you know, kidney
13 or something like that; so, you know, we would look
14 at it and if there was credible evidence provided by
15 the review that we screwed up, of course we would
16 address that and fix it.

17 MR. MILLER: I just -- I hadn't heard that
18 before. The authorities I knew existed, but I
19 hadn't heard you actually state on the record that
20 -- that when these Blind cases got brought to you
21 and you could go do that. That's great. That's
22 terrific. That's very -- that's a good answer.

23 MR. ELLIOTT: Hey, Richard, you could talk a
24 little bit more about the good things we're doing,
25 you know, get some of that on the public record too

1 -- you know, when you force me to make comment on
2 the public record I'm going to give you an honest
3 response, but I'd appreciate hearing some things
4 from you about some of the good things we're doing,
5 some of the claimant favorable things we're doing.

6 MR. MILLER: As soon as we move pass the
7 initial Chapter 14, I can't wait.

8 The -- the -- this is a, to the DOL
9 question. There were a number of policy issues that
10 got raised today regarding whether DOL, or NIOSH, or
11 perhaps even other choices are available as a
12 contracting authority. And I just sort of wanted to
13 float a couple of ideas on that area. I think one
14 of the concerns that was playing out, at least as I
15 sensed at the last Board meeting, was -- the
16 question of whether the Board was really comfortable
17 having NIOSH select, and other others have said it,
18 whether NIOSH should be selecting the audit
19 contractor for you all, so then there was a
20 discussion about how many Board members would
21 participate, who else -- how you would select the
22 auditor so it wasn't seen as NIOSH auditing itself,
23 in effect, and -- and -- or at least selecting its
24 auditor. And then it seemed to me that was sort of
25 one point of clearance, which, if it's resolved -- I

1 don't know if it is or not -- but if it's resolved,
2 then it seems to me the question is: What are the
3 conflict issues that are raised by having it in
4 OCAS; what are the conflict issues that are raised
5 by having it, perhaps elsewhere in NIOSH, meaning
6 the contracting authority; or in CDC, or jumping
7 completely out of the agency, and in this case, into
8 DOL, and what are the advantages? And a couple of
9 things, at least, come to mind. I guess -- and it
10 has to do with how will it work in the real world if
11 you took it outside of either the NIOSH or CDC
12 world. One of the questions is: If you've got it
13 -- if you've got DOL as your contracting entity --
14 this is what I was having a hard time getting my
15 head around today -- if DOL is the contracting
16 entity and they say, "Say, we really want to do
17 these telephone interviews that NIOSH doesn't want
18 to do." Okay. It's an issue of disagreement about
19 the scope. How does -- how does that get resolved?
20 I mean cause it's an agency now that has the
21 contracting, and it gets the appropriations too, so
22 they get the money first, and they also have --
23 they're supposedly going to respond to what the
24 Board wants, although it's not clear what the legal
25 authority is that the Board has to drive what DOL

1 does. That's not in a statute, so you'd have to
2 create some legal authority. But assuming that
3 legal authority existed, for the sake of this
4 hypothetical question, you know, how -- how would
5 those issues be resolved, which leads to another
6 sort of real-world question, which is -- and I don't
7 even know what the boundaries are that you've all
8 thought about is -- would the auditor have access
9 only to you and your records, this audit contractor,
10 or would they also have access to your contractor,
11 meaning ORAU -- you know, and -- and -- and
12 depending on what your answer is, or depending on
13 the terms and conditions of that, you all may find
14 yourself, you know, in this interesting situation
15 where, you know, you're going to have to start
16 resolving these interagency disagreements about how
17 to work this through. And so I just -- I wanted to
18 see some sort of real-world examples about how this
19 is going to -- is this really going to work
20 smoothly, I guess is the question.

21 DR. ZIEMER: Richard, I don't think any of
22 us have a good answer for you. We were raising
23 those kinds of questions in different forms as we
24 debated this -- this very issue. We indicated
25 earlier today that while there may be some pros of

1 using DOL, there are also some cons, and vice-versa.
2 I'm not sure the hypothetical things that you raise
3 here now are even answerable at this point to any of
4 us, unless Larry has prepared the answer, but -- but
5 I'm going to take those more as rhetorical
6 questions. I --

7 MR. MILLER: Yeah.

8 DR. ZIEMER: You're raising issues that we
9 can think about as we --

10 MR. MILLER: I'm raising those questions to
11 think about it would operationalize. (sic) And I
12 guess to lead to a second part, which is how long is
13 it going to take us to -- you all, NIOSH staff,
14 whomever, makes the decision or advice, how long is
15 it going to take you to figure this out? In other
16 words, do you have to go to your next Advisory Board
17 meeting in Knoxville, St. Louis, wherever, before
18 you decide who is even going to be the contracting
19 entity before you put the RFP on the street because
20 there's a lot -- the devils may be in the details
21 here, I don't know.

22 DR. ZIEMER: Well, come back tomorrow and
23 find out.

24 MR. MILLER: Oh, you think you're going to
25 decide tomorrow?

1 DR. ZIEMER: I would hope -- I would hope we
2 can make a decision by tomorrow, but in any event --

3 MR. MILLER: Yeah.

4 DR. ZIEMER: -- you know, I clearly -- and
5 let me just say that I'd be a little nervous about
6 -- we have a certain mandate under law and under the
7 Executive Memorandum in terms of the responsibility
8 of this Board and how it's set forth and so on. And
9 it's not clear to me at all that we could even, as I
10 said, legally move this procurement to another
11 agency, at least the way things are set up now.

12 MR. ELLIOTT: Let me talk to that because
13 that -- we don't believe there's any legal authority
14 issues here. It's one procurement, whether it's run
15 through a -- a HHS Procurement Office, or it's run
16 through a DOL Procurement Office. The Board advises
17 the Secretary of HHS. Whether it's NIOSH effecting
18 and awarding and administering the procurement, or
19 it's DOL, any issues that come up through the
20 deliberation of the Board in development of task
21 orders is going to be transparent to the public.
22 The Board will report to the Secretary if they've
23 got problems with whoever is effecting, you know,
24 the -- the issue at hand for that given point. I
25 don't know what to say beyond that, I mean that's --

1 DR. ZIEMER: That answers your question then
2 on what the Department of Labor could impose or not
3 impose on the Board.

4 MR. MILLER: Well, you'd have to formalize
5 that, right, in some respect, wouldn't you?

6 MR. ELLIOTT: The Department of Labor is not
7 -- not -- all they would be doing is taking on the
8 administration of the contract. There's no --
9 there's no necessity to have a legal authority or
10 formality about that.

11 MR. MILLER: Except that Dan takes direction
12 from this Board. Wouldn't they, I mean wouldn't you
13 all, if you come up with a task order and say do
14 this.

15 MR. ELLIOTT: They -- they're just
16 administering the procurement, the contract. That's
17 all they're doing. They don't -- you know, if the
18 Board comes up with a task order, the -- the only
19 bounds that would be on this would be the same for
20 DOL or NIOSH, and that's to stay within the FAR,
21 Federal Acquisitions Regulation. Okay. So if a
22 task order comes surfacing up through the Board that
23 steps out of bounds in that regard, then whoever
24 administers it in the government is going to say
25 whoa, you can't do that.

1 MR. MILLER: So if -- so I guess then the
2 question is: If the DOL is merely carrying out what
3 sounds to me to be a kind of a pure administrative
4 function, not quite administerial because it's
5 probably more deliverable than that, but not a whole
6 lot more, than an administerial function, what's the
7 big upside in terms of -- I mean what is the upside
8 of -- of -- of moving the DOL versus using either
9 some part of NIOSH or -- I mean I -- I -- I could
10 see where you don't want to have the people who are
11 -- who are administering dose -- who are overseeing
12 dose reconstruction also overseeing their own audit.
13 I mean there's something intuitively reasonable
14 about that, but I mean you -- you can get -- get
15 around that pretty quickly, you know, just by how
16 you, you know, use your administrative boxes within
17 CDC. And -- and the only reason I'm posing it is
18 just because every time we look at another set of
19 interagency relationships, and I'm not talking about
20 the really tedious ones that you have to deal with,
21 but -- and -- and -- and -- and -- and -- and for
22 which we think you're doing a good job. Noted. But
23 what is the upside? I mean what is the real upside
24 because at the end of the day the Labor Department
25 has a set of interests in this thing.

1 MR. ELLIOTT: Sure. Sure.

2 MR. MILLER: They are not completely
3 neutral. They need to go to court someday and
4 defend when somebody comes along that says we
5 contest; we don't like the way you did dose
6 reconstruction; we challenge your assumptions, or we
7 don't even like ICRP, you know, we want you to use
8 some other model, whatever it happens to be they
9 want to go to court over; at the end of the day,
10 right, they go roaring into court and DOL is going
11 to have something to hold up and say geez, you know,
12 this thing's been audited. Look at these smart
13 people on this Advisory Board, and look at this
14 smart auditor they brought in, and look at these
15 smart audit reports, and this thing is not hand
16 leading, this is like the real, you know, this is
17 the Real McCoy, so they need this audit function,
18 but do they need this audit function in such a way
19 that it's going to -- that it's their contracted
20 authority versus yours?

21 MR. ELLIOTT: I don't know if you were in
22 the room earlier when Pete Turcic and I were talking
23 to this point. The only advantage that it brings to
24 NIOSH/CDC/HHS is it removes this perceived conflict
25 to DOL, if DOL administers the contract. We -- you

1 know, the only -- the only aspect of the
2 relationship if DOL run it that we talked about
3 earlier, Pete mentioned that we would probably need
4 a Memorandum of Understanding. Our relationship
5 with DOL has been exceptionally good over the course
6 of this -- this program's history, unlike that with
7 another agency that we've had. So, you know, we've
8 -- we've even talked about, you know, how quickly an
9 MOU could be put in place and all the principals in
10 both sides, both departments are -- are
11 knowledgeable of this and ready to that if that's
12 what it takes, so.

13 MR. MILLER: Okay. All right. I mean I
14 just -- it -- it sort of popped up. This is the
15 first time it was sort of discussed probably, and,
16 you know, at least from my perspective I just sort
17 of thought, you know, if you want to move it out,
18 you know, you can move it to another part of NIOSH,
19 I mean you don't have to move it all the way over to
20 DOL, you can move it over to another part of CDC. I
21 mean, you know, I wasn't quite sure the rationale
22 for that versus, or, you know --

23 MR. ELLIOTT: Let me be clear.

24 MR. MILLER: -- OCAS and put it in --

25 MR. ELLIOTT: NIOSH is NIOSH. Okay. I am

1 NIOSH. I report -- I report to the Director of
2 NIOSH, so it's not OCAS. When we do a procurement,
3 it's done through NIOSH's Procurement Office.

4 MS. DiMUZIO: It's done by the CDC.

5 MR. MILLER: Right.

6 MR. ELLIOTT: Which is CDC's.

7 MR. MILLER: Right. That's the point, the
8 CDC.

9 MR. ELLIOTT: So -- so if it's CDC's, it's
10 CDC's. It's all -- it's all in the semantics. If
11 you want to call it NIOSH; you want to call it OCAS;
12 you want to call it CDC --

13 MR. MILLER: Okay.

14 MR. ELLIOTT: -- we're all in the same boat.

15 MR. MILLER: Okay. All right. Thank you.

16 DR. ZIEMER: That concludes our session for
17 today. I'd like to ask, Cori, are there any
18 housekeeping informational items we need to pass
19 along this evening? I'm not aware of any.

20 MS. HOMER: I would suggest that if you have
21 anything requiring security, please remove it from
22 the room.

23 DR. ZIEMER: Okay.

24 MS. HOMER: Laptops, any kind of equipment.

25 DR. ZIEMER: Okay.

1 MS. HOMER: Because I can't guarantee that
2 the room will be locked.

3 DR. ZIEMER: Okay. Thank you. So noted.

4 We begin tomorrow morning at 8:00 a.m. with
5 the sort of casual half-hour, and the Board is
6 recessed.

7 (Whereupon, the above-entitled proceedings
8 were recessed at 5:05 o'clock p.m., to be reconvened
9 Thursday, February 6, 2003, at 8:00 o'clock a.m.)

10 o0o

C E R T I F I C A T E

STATE OF GEORGIA)
 COUNTY OF FORSYTH)

I, Debbie G. Williams, Certified Court Reporter in and for the State of Georgia, do hereby certify that the foregoing proceedings were taken down by me; that the foregoing proceedings were reduced to print by me; that the foregoing VOLUME I, consisting of pages 1 through 262 represent a true, correct and complete transcript of the proceedings; that I am not a relative, employee, attorney or counsel of any of the parties; that I am not a relative or employee of attorney or counsel for any of said parties; nor am I financially interested in the outcome of the action.

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This, the 22nd day of February, 2003.

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

convenes the

ADVISORY BOARD ON
RADIATION AND WORKER HEALTH

VOLUME II

The transcript of the Meeting of the
Advisory Board on Radiation and Worker Health
before Debbie G. Williams, Certified Court
Reporter and Notary Public; commencing at 8:30
a.m., Thursday, February 6, 2003, at The
DoubleTree Guest Suites, 181 Church Street,
Charleston, South Carolina.

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I N D E X

VOLUME II
February 6, 2003

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P R O C E E D I N G S

8:30 a.m.

1
2
3 DR. ZIEMER: Good morning, everyone. We
4 want to also welcome Henry Anderson to our group
5 this morning. We're glad to have you here, Henry.
6 We got all the good stuff done yesterday.

7 DR. ANDERSON: Yeah, that's what I figured.

8 DR. ZIEMER: We'll tell you about your
9 assignments a little later.

10 I want to remind all of the Board members
11 and others who are here today to register today,
12 even if you registered yesterday, we ask you to
13 register each day, so please do that in the
14 registration book if you haven't already.

15 Also, the members of the public who wish to
16 comment during the Public Comment Period, we ask you
17 to sign up for that. I do want to give members of
18 the public a kind of heads-up that it's quite
19 possible that we will complete our work schedule
20 earlier than the original Agenda shows, in which
21 case we would move the Public Comment Period up a
22 little bit toward closer to midday, so if you will
23 make note of that. I don't have a specific time at
24 this point because it's going to depend on how hard
25 and long I'm able to keep the Board working.

1 We're going to begin this morning with the
2 Minutes of the last Open Meeting, that is the
3 Meeting Number 10. That meeting was the January 7th
4 and 8th meeting. I'd ask the Board members to get
5 their copies of that, and what we will do on the
6 Minutes, I ask you that if you have typos and minor
7 grammatical changes, that you simply pass those
8 along to Cori separately. As we approve the Minutes
9 we want to take action on specific things that may
10 be conceptually or factually wrong, so when I ask
11 for corrections, or additions, or deletions, we'll
12 focus on those kinds of things. So let's -- let me
13 call attention first to the Executive Summary
14 section of the Minutes. I might say
15 parenthetically, I had an initial review myself of
16 these Minutes and I shortened the Executive Summary
17 by several pages. It was nearly as long as the
18 Meeting Minutes, and it still seems a little long to
19 me, but because there were a number of bullet points
20 that I ended up leaving in that I was going to
21 delete. I was planning to delete nearly all of the
22 bullet points and just let it stand, but I decided,
23 for example, to leave the Public Comment Summary,
24 all of those bullet points in, rather than simply
25 say we had a Public Comment Period, so the Executive

1 Summary is a little longer than perhaps it should
2 be, but nonetheless, that's it.

3 Let me ask if anyone has any corrections,
4 additions, or deletions for the Executive Summary?
5 It's pages 1, slash, 8 to 8, slash, 8.

6 MR. NAMON: Dr. Ziemer, on page seven --

7 DR. ZIEMER: You need to identify for the
8 court reporter.

9 MR. NAMON: Yes, David Namon, Department of
10 Health and Human Services.

11 On page 7 under Board Housekeeping, the
12 description of the possible need for a conference
13 call on February 19th and 20th is not accurate, and
14 not the way it was actually said at the meeting, and
15 I would suggest that we delete everything after the
16 -- where it says February 19 or 20 to the end of
17 that sentence.

18 DR. ZIEMER: "The likely need for a
19 conference call on February 19 or 20, for two to
20 three hours to discuss SEC rulemaking to be issued
21 on" -- I'm sorry. What are you -- what are you
22 saying?

23 MR. NAMON: I'm saying that -- that
24 everything after the word "rulemaking" is -- is not
25 accurate, and is not what was said at the meeting.

1 And so, obviously the rulemaking was not -- there
2 was not a rulemaking issued on January 20th. That's
3 also not what was said at the meeting that there
4 would be, so I would suggest that we would remove
5 everything in that phrase.

6 DR. ZIEMER: Okay. Let me make two comments
7 first. The fact that it didn't occur is immaterial
8 to the minutes.

9 MR. NAMON: Agreed.

10 DR. ZIEMER: So it's what was stated at the
11 meeting which you said was incorrect?

12 MR. NAMON: Right.

13 DR. ZIEMER: What was stated then? Because
14 this is based on what the recorder recorded.

15 MR. NAMON: What stated at the meeting was
16 that it was possible that something could be issued
17 during that time frame, I think during the month of
18 January.

19 I think the clearest way to deal with it
20 would be to delete everything after the word
21 "rulemaking", if -- or to delete everything after
22 the number 20; but in any event, it was not --
23 obviously nobody said, including you, Mr. Chairman,
24 nobody said that there would be something issued on
25 a particular date.

1 DR. ZIEMER: Oh, as opposed to an expected.

2 DR. MELIUS: I think what --

3 DR. ZIEMER: It was the expectation that
4 somebody -- something would be issued on or about
5 that date.

6 DR. MELIUS: Well, if it were issued on
7 that, that was maybe the -- the week it might be
8 issued, in which case, then we needed to be able to
9 have our conference call within the 30-day period
10 that we needed it to complete the Board's review, so
11 the date came from an estimate of -- I'm trying to
12 figure out what was the correct timing for those
13 conference calls. And the particular dates were
14 discussed. I mean it is there, but I think what's
15 not accurate is the -- I don't think, Larry, or
16 whoever was speaking at that time said that it would
17 be issued on the 20th.

18 DR. ZIEMER: I have a -- Tony, you have a
19 possible solution. I think -- I think we want to
20 capture the idea of why we were going to have this
21 meeting, and it was based on an expectation; the
22 fact that it didn't occur is not a part of the
23 minutes, but we do want to correctly express what
24 did occur at the meeting.

25 DR. ANDRADE: Thank you. I do recall that

1 the SEC rulemaking was, in fact, discussed, and we
2 talked about the possibility of the SEC Rule to be
3 issued on or about a date, so I would propose that
4 the solution is to simply include the word possibly
5 between "to" and "be" on that particular sentence.
6 In other words, two to three hours to discuss the
7 SEC rulemaking --

8 DR. ZIEMER: How about an expected SEC
9 rulemaking?

10 DR. ANDRADE: Okay. Discuss the expected
11 SEC rulemaking, possibly to be issued on January
12 20th.

13 But I do recall that that was the essence of
14 our conversation.

15 DR. ZIEMER: Well, the expectation was that
16 we would be discussing the rulemaking at this
17 meeting and then finalize it.

18 DR. ANDRADE: Right.

19 DR. ZIEMER: Yes, go ahead.

20 MR. NAMON: I have the transcript in front
21 of me, and it was indicated that we were hoping that
22 something would be published during that week of the
23 20th, but again, no one suggested that a particular
24 date that it was expected.

25 DR. ZIEMER: Based on that, let me suggest:

1 The expected SEC rulemaking that -- that possibly
2 would be published the week of January 20.

3 MS. ROESSLER: Or "if it is in January."

4 DR. ZIEMER: An expected SEC rulemaking if
5 it is issued the week of January 20.

6 MS. ROESSLER: Uh-huh (affirmative).

7 DR. ZIEMER: Would that solve it?

8 DR. MELIUS: Yeah.

9 DR. ZIEMER: We're not trying to --

10 DR. MELIUS: That's fine.

11 DR. ZIEMER: To discuss the expected SEC
12 rulemaking if it is issued on the week of January
13 20th.

14 So that would capture what we did based on
15 some expectations without pinning down a date. Does
16 that fix it, I suppose. There's no question we
17 discussed it while we were doing the meetings.
18 We're not trying to pin down NIOSH as having
19 committed to that.

20 MR. ELLIOTT: I'm even more gun shy to say
21 anything.

22 MR. NAMON: Now, when you get to the main
23 minutes there's a similar change necessary.

24 DR. ZIEMER: Oh, yeah. Hold on for that.
25 Okay. Anything else on the Executive

1 Summary? Wanda.

2 MS. MUNN: I haven't seen the transcript,
3 but my memory of the meeting dates that we discussed
4 -- actually, what I wrote on my calendar was that
5 April 28th, 29th, was a potential, and we still,
6 that May 1st and 2nd were the probables. I -- I
7 don't know whether that's -- whether my notes are
8 incorrect. Of course, we're not going to get around
9 to discussing that until this afternoon, but I had
10 potential April 28th, 29th, and probable on May 1,
11 2.

12 DR. ZIEMER: Anyone else comment? I have
13 both blocked off without any change.

14 MR. DeHART: I believe that was for the
15 forthcoming meeting, the next meeting, not to be a
16 phone call.

17 DR. ZIEMER: Right. Right.

18 MS. MUNN: Yes, that's correct, but I'm
19 talking about the next meeting.

20 DR. ZIEMER: She's asking whether -- whether
21 we indicated a preference of one over the other.

22 MR. DeHART: The 28th and 29th I'm not
23 available.

24 MR. PRESLEY: My recollection on that was
25 that we marked them both, and Cori was supposed to

1 go back and see which one she was able to get a date
2 on.

3 DR. ZIEMER: Apparently, all of these were
4 indicated as being available to members of the
5 Board. I don't believe this says one or the other
6 is preferred at this point.

7 MS. MUNN: Okay. My notes may be wrong.

8 DR. ZIEMER: Okay. Thank you. Any other
9 corrections or additions on the Executive Summary?

10 Now, let's go to the main Minutes, and we
11 can handle the same change that we just noted on
12 Board Housekeeping.

13 David, what page are we looking at that?

14 MR. NAMON: It's page 21. It's the second
15 paragraph under Board Housekeeping. I think if you
16 changed the word "will" to "may".

17 DR. ZIEMER: Yes. So, "will be" to "may be
18 issued", a conference call may be needed. That will
19 solve that. Thank you. Without an objection, we'll
20 make that change.

21 Other comments, other corrections, or
22 additions?

23 There's no additional corrections or
24 additions. The Chair will accept a Motion to
25 Approve the Executive Summary and the Minutes as

1 noted with the changes.

2 MR. PRESLEY: So moved.

3 DR. ZIEMER: Seconded?

4 MR. DeHART: Second.

5 DR. ZIEMER: Further discussion?

6 All in favor, aye.

7 (Ayes respond.)

8 DR. ZIEMER: Any opposed, no.

9 (No responses.)

10 DR. ZIEMER: Abstentions?

11 (No responses.)

12 DR. ZIEMER: The Motion carries, the Minutes
13 then are approved with those changes as made.

14 Now, let me give you kind of an outline of
15 where I see us headed on our Work Session here.
16 There's several items that we need to address. One
17 of those will be the decision as to who will be the
18 -- let me just say the agency that will let the
19 contract on behalf of the Board. And we currently
20 have two options that we're considering; one is the
21 Department of Labor, the other is NIOSH or CDC; we
22 view that as one entity, NIOSH/CDC. We don't have
23 to decide that at the front end here, but I would
24 like us to come to closure on that if possible
25 today, so that we can proceed and have whatever time

1 we gain by moving forward achieved. So that
2 decision is before us.

3 We also need to come to some sort of
4 agreement on exactly what will be covered in
5 procedures for the review process; that is, the
6 review of completed dose reconstructions, the audit
7 process, if you will.

8 Now, I'm going to propose certain things
9 here as we proceed. Number one, I have some
10 overheads or slides where I hope I've captured what
11 we kind of delineated yesterday. This will help us
12 and maybe also help the recorders to figure out what
13 it was we agreed to.

14 I also have a kind of a strawman procedure
15 to give us some feel for what a procedure might look
16 like. But in preparing the strawman -- this is just
17 something for us to shoot at -- in preparing this,
18 it became pretty clear to me that to really do the
19 procedures, I don't think we can sit here in Board
20 session and develop that; in fact, it seems to me
21 that we are going to have to do a mockup; we're
22 going to have a workgroup maybe go to NIOSH and
23 actually go through some dummy reviews -- dummy
24 reviews might not be a good word for it, but reviews
25 for dummies, maybe that's what it is -- maybe one or

1 two of each kind and start stepping through it and
2 say okay, what do we do first. We look at the site
3 profile; is it complete, and start -- sit there and
4 really work through the procedures. We may also
5 need to take a look at some of NIOSH's and ORAU's
6 procedures to see how they're going about looking at
7 these things. I mean step wise because we can't --
8 I don't think we can proceed beyond that today, but
9 -- but we can at least identify what the complements
10 of those procedures are with these, so that's what I
11 propose we do today, and make sure we're all on the
12 same page in terms of sort of the overall scheme of
13 things; what needs to be covered, maybe what does --
14 what do the final products look like, and what would
15 be the content, what procedures we need to cover.
16 But I'm not sure we can go beyond that today, and we
17 may need a workgroup then to follow up on it.

18 Okay. So we have those two things relating
19 to the completed dose reconstruction review process.

20 We also have the issue of the special
21 exposure approval legislation, which we know will
22 not be available January 20th, or even the week of
23 January 20th, but may -- but may be published
24 sometime in the near future.

25 Now, our next meeting, if it's the end of

1 April or in to May is nearly three months away; all
2 of February, all of March, most of April, and if
3 that hits the street before April 1st, then our next
4 meeting will be too late to react to that proposed
5 rulemaking. So I think we will probably need to
6 identify another meeting time before then. So when
7 we get to the Board work schedule later this
8 morning, that will be one of the items we'll need to
9 address. And there is some possibility we may have
10 something close to an estimate of when that might --

11 MR. ELLIOTT: We're hoping to hear something
12 this morning so that we can inform the Board to help
13 make the schedule happen.

14 DR. MELIUS: 2003. Pin it down. We've got
15 to pin it down.

16 DR. ZIEMER: In any event, that's what we
17 have before us, I think, today. And in thinking
18 about that and perhaps the extent to which we can do
19 some of that work, it occurred to me last night that
20 we might very well finish by midday, depending on
21 how things go.

22 Now, let me just pause, and if anyone wants
23 to react to anything I said, or comments, or shall
24 we proceed? I'm open to -- always open to better
25 ideas.

1 Henry, you can't move to dismiss now.

2 MR. ELLIOTT: Two things I would suggest
3 that you consider and you perhaps want to put these
4 into the future, but this concept of having a task
5 order prepared so that it's on the table so that, I
6 mean when the contract is awarded I don't think you
7 want to have a delay of developing a task order; you
8 want to be able to present that within the first
9 week of the award to get these folks started. The
10 second thing that I think you should consider is
11 something I mentioned to Mark yesterday afternoon,
12 and I think Richard Miller also brought it up in his
13 public comment, is what's -- what's your product at
14 the end of this, you know, what are you going to
15 deliver to the Secretary. I think you need to think
16 a little bit about that and through that. I don't
17 think you're going to want to provide a
18 recommendation on every review that you do, every
19 dose reconstruction review that you do, but I think
20 you need to figure out, you know, what's the
21 appropriate communication to make.

22 DR. ZIEMER: Right. And in fact, that's the
23 nature of one of the key questions I will ask this
24 morning as we proceed.

25 Other general comments before we move on?

1 Okay. Let's see, do I need to work that
2 clicker from the front or can I work it from here?

3 DR. NETON: We'll have to check and see. I
4 guess so, maybe it will work from there. Why don't
5 you just try it once and see if it will move
6 forward?

7 DR. ZIEMER: Okay.

8 So this is what we -- this is what we were
9 discussing yesterday, and what I've done here is
10 broken this into several points that we were talking
11 about. The first was that we said we had to have --
12 had to identify the available cases to review. This
13 is not necessarily just those completed, but as we
14 look forward, so I've -- all I'm doing here is
15 raising some questions, and I want to make sure in
16 these questions that we've covered content wise what
17 it is we're trying to do. For example, who should
18 do this, is it the full Board, is it a Workgroup, is
19 it a Subcommittee, when should it be done, and
20 what's the nature of the product; that is, whoever
21 identifies these cases, do they come back to the
22 Board with a report and say these are the cases we
23 believe should be reviewed, or do they just proceed?
24 Are these the right questions; are there additional
25 questions; and to what extent can we answer these

1 right now.

2 I just would like to capture this if we can
3 and get the Board's ideas, and then we'll move on to
4 the next item, which is the case selection process.
5 Okay. Again, we talked about each of these a little
6 bit yesterday, so I'm feeding back to you what we
7 talked about. We talked about some of these
8 questions yesterday, but I want to make sure we're
9 on the same page on it, so.

10 Okay. Roy.

11 MR. DeHART: When we're talking about who
12 should do it, certainly at the initial stage I think
13 the Board as a whole needs to be involved, but that
14 doesn't mean it needs to be the Board going through.
15 A workgroup could come out with suggestions using
16 the model we had on the percentage that we had
17 developed before. So I would suggest that we have a
18 workgroup that would go through the available 60,
19 70, 80, whatever it happens to be at the time, and
20 make the selections against a matrix, and then
21 present those to the Board for final approval, so
22 the Board would know exactly what the process is.

23 DR. ZIEMER: Okay. Let's get some other
24 feedback. Jim.

25 DR. MELIUS: Yeah, I -- I think we need a

1 workgroup to do this, but I think it's got to be
2 sort of a step-wise process throughout this, and
3 maybe it's more than one workgroup or different
4 workgroups, but as I understand what's required by
5 the FACA regulations is that we -- the Board would
6 have to approve a lot of the steps along the way.
7 So I would see it as a workgroup that would put
8 together, you know, do some of the -- the work,
9 looking as they develop new forms, whatever would be
10 involved, then would come back to the Board probably
11 at each meeting with a certain, you know, things for
12 approval, and is this going to apply to -- some of
13 this would be the task order development because
14 that's really an important part of this process, and
15 I think actually the first thing that we should try
16 to work out, and maybe it's having the workgroup do
17 it, is a schedule for this step wise because we have
18 a number of issues that are going to need some time
19 to work on.

20 Larry, you've already mentioned the idea
21 that we need to get these task orders ready at the
22 -- hopefully at the time that the -- or around the
23 time that the contract is awarded. We also have
24 this OMB question hanging out there about the -- the
25 interview issue. And so I think the sooner we can

1 get that prepared, the better in terms of getting
2 approval for that. So I think the only way it can
3 be done is through a workgroup, but a workgroup that
4 serves discrete functions or tasks that would then
5 report back to the Board at each meeting, and then
6 we would go on and then do something else at the
7 next meeting and so forth.

8 DR. ZIEMER: And keep in mind, we can always
9 change the process at any time, but I've kind of
10 looked at this as the first time through, and, you
11 know, once we've sort of developed the procedures
12 and get -- get the process rolling, we may want to
13 alter how it's done, but I'm really looking at
14 getting under way, and I've heard a couple of
15 suggestions about the workgroup.

16 Henry?

17 DR. ANDERSON: Yeah, I think a workgroup,
18 but it would seem to me if -- if this is basically
19 an algorithm, I mean we've said which cases we want
20 to review, then basically it's you pick a cutoff
21 date and then everything before that you then
22 classify them into our various categories, and then
23 you'd have a random, you know, selection process.
24 So it would seem to me if you pick various dates,
25 whatever's, you know, prior to that date would be

1 eligible, and then, you know, each time we meet
2 perhaps we could have -- or you could set the date
3 of cutoff a certain number of weeks or whatever
4 prior or completed cases, however we're going to do
5 it, prior to the next meeting, so that at the
6 meeting we could say the process was done, and here
7 are 6, 10, 100 cases ready to go, so that it would
8 it be a -- once we decide how it's going to be done
9 it would be -- at least the selection process would
10 be more automatic than having a group necessarily
11 have to get together to review that data, and then
12 say yes, do the selection process. I mean I -- for
13 the early on I think the more we can kind of
14 automate it and it's transparent because we've set
15 out the criteria for how to do it, it then just has
16 to be, you know, so that the records actually are
17 completed and available and all back wherever they
18 need to be for the review to start, and that's kind
19 of a NIOSH, you don't want to set a date so that
20 we'll have some cases come in that aren't yet really
21 fully completed. So that's how I would do it and if
22 -- if it's setting up those, translating our
23 guidelines as we've put together into an algorithm,
24 that certainly could be done by a workgroup, but I
25 would not want to have a workgroup have to meet

1 every time to say here they are, and then shuffle
2 them into groups. I think if we select the criteria
3 that are already in NIOSH's data base, that can all
4 be done electronically.

5 DR. ZIEMER: Other comments? Wanda.

6 MS. MUNN: Yes. I think that Jim and Henry
7 both have captured most of my thinking, which very
8 clearly indicates in my mind that we need two
9 separate workgroups approaching this initial issue;
10 one of them to identify how the NIOSH matrix is
11 going to be able to present the information to us,
12 and identify how we can use that matrix to resolve
13 our issues of percentages in terms of how we're
14 going to cross-cut the reviews that we do; and
15 another to actually put together the kind of
16 checklist that we were talking about to work with
17 NIOSH to see what their checklist covers; is it
18 adequate for our purposes.

19 DR. ZIEMER: Right. I don't want to get you
20 ahead of the headlights here. Those are separate
21 issues. Right now it's the issue of saying what's
22 out there. NIOSH will have completed a certain
23 number of cases. And we talked about some extremes,
24 suppose they were all Savannah River cases, then
25 what do we do.

1 MS. MUNN: Yeah.

2 DR. ZIEMER: Or do we say okay, we're going
3 to sample a certain amount of those and then wait
4 for a certain number of these. So this process, the
5 identification of available cases, is kind of
6 looking ahead at -- at what NIOSH is doing and
7 saying what parts of these are we going to look at.

8 DR. ANDERSON: Yeah.

9 DR. ZIEMER: That's all it is, and so we'll
10 say who's going to do that; how soon do we do that;
11 do we have to do that right away, like within the
12 next month, or can we wait till, you know, after the
13 contract is let. I'm trying to pin this down
14 because a lot of what we've done so far is fuzzy.
15 We're going to do this, but who is going to do it,
16 and when are they going to do it, and what is it
17 they are going to do. That's sort of what we're
18 asking here. And that's what I would like to get
19 the Board -- and I don't know the answer to those
20 things; it's hard enough to know the questions to
21 ask, let alone the answers, so there may be some
22 other questions. And then what is this group, are
23 they going to come back to the Board and say okay,
24 we have a certain number of cases available from
25 here, here, and here, we're going to -- or what.

1 So Wanda, and then Tony.

2 MS. MUNN: So what I'm suggesting is that we
3 form a workgroup immediately to go sit down with
4 NIOSH and do essentially three things: Identify
5 what their matrix is going to cover; identify what
6 they have now; and then bring back to this Board a
7 suggestion as to how we will proceed down the line
8 because obviously, it's anticipated that the number
9 of cases are going to ramp up quickly. And since
10 that's the case, then our first -- first set of
11 cases may not really and truly have much to do with
12 what we're going to do long term.

13 DR. ZIEMER: Okay. Thank you. Tony.

14 DR. ANDRADE: Wanda articulated a bit of
15 what I was going to suggest. I also believe that we
16 should form a workgroup, a representative workgroup
17 of this body, in other words, representing all view
18 points, that will come up with a draft of selection
19 criteria, a schedule for -- or a draft of number
20 one, selection criteria; number two is a draft set
21 of task orders; and number three is a draft
22 schedule. And I think that working from the
23 products that Mark has put together, the draft
24 schedule may not be all that tough. Who should do
25 it, and if we can appoint a working group, and I

1 would suggest that we refrain from appointing
2 multiple working groups and that we keep maximum
3 flexibility by allowing, as time goes on, people to
4 rotate in and out such that those folks with time
5 available during a particular period of time can
6 continue to work. When should it be done? I think
7 the first report back on those specific products
8 that I mentioned should be available by the next
9 meeting, so the workgroup should be meeting in
10 between time. And the nature -- I've already
11 mentioned what the products would be here.

12 DR. ZIEMER: Very good. And we'll -- we'll
13 sort of keep those suggestions on hold until we hear
14 from everybody, and then when we formalize anything,
15 we can. And you weren't making a specific motion,
16 right then?

17 DR. ANDRADE: (Shakes head negatively.)

18 DR. ZIEMER: Okay. Mark.

19 MR. GRIFFON: I actually agree with most of
20 what's been said. Building on what Wanda and Tony
21 said, I guess I, when we talked about this
22 yesterday, and how I formulated this in my head is
23 that really the selection criteria I think should be
24 developed first. And then the -- when we look at
25 the -- and I know I brought this issue up yesterday,

1 so it's my issue, but when we look at the cases, I
2 think the cases and how they meet -- looking at our
3 selection criteria and looking at what's available,
4 that's going to build our schedule. That's going to
5 help us to build a schedule going forward and that's
6 sort of how I conceptualized this, but I -- I agree
7 also with what Tony said, that the, you know, the
8 selection criteria, the review of the available
9 cases, and building the schedule, along with the
10 task orders, procedures, and some kind of draft
11 format for the final report form should be developed
12 by some sort of working group, and, you know, the
13 structure of that right now I think is up for grabs.

14 DR. ZIEMER: Other comments? Robert.

15 MR. PRESLEY: Can we not come up with a
16 simple formula? We're going to do 150 of these a
17 year, is that correct? That comes out to
18 approximately 12 a month. Can we not come up with
19 some type of a simple formula that we can give HHS
20 and say okay, you know, we want 12. Now, where
21 those 12 lie, it may be 12 out of 50, it may be 12
22 out of 250. We ought to be able to come up with
23 some type of formula that you pick -- this month you
24 pick 1, 6, 8, and 10; next month you pick 30, 40,
25 and 50; and then we do the checking on whether we

1 want to do a Blind out of those 12, or what we want
2 to do. And if it gets to where that one month all
3 of them are Savannah River, then -- then the next
4 month we tell whoever it is that we -- the next
5 month, you know, we've done Savannah River, we want
6 some different ones.

7 DR. ZIEMER: Larry.

8 MR. ELLIOTT: Those of you who were on the
9 workgroup that Mark headed up, I think -- and I
10 think several others may have seen our tracking
11 system, so you know what it's like; you know we can
12 query it. What I want to take exception to here is
13 that I've heard a couple of people comment that give
14 this to HHS, have the matrix, you know, tell, have
15 them select. We're not going to select, okay. I'm
16 going to tell you that right now. You guys are
17 going to have to select. You can come in, we will
18 set you up in front of the screen, you're going to
19 do the tracking, you're going to do the inquiry
20 there, and then you guys need to select.

21 MR. GRIFFON: Yeah, and I think, Bob, I
22 agree with you. I just -- in that, the example you
23 just gave with the Savannah River, I mean that's my
24 idea of having the selection sought ahead of time so
25 that we know, okay, over the year we expect these

1 cases to come through at some point. Month by month
2 we start filling in those boxes and we see, okay,
3 we've completed all of our Savannah River
4 requirements, we've got to find cases in these other
5 categories, and we -- and we track it as we go on,
6 so, you know, that's consistent with what I think
7 we've been talking about.

8 DR. ZIEMER: Tony.

9 DR. ANDRADE: I just wanted to mention that
10 clearly we can't anticipate any -- any or all of the
11 problems we may have in finding cases that meet our
12 criteria. That's why I wanted to emphasize -- at
13 least at this point in time that's why I wanted to
14 emphasize the word "draft". This working group
15 should come back with a draft of selection criteria;
16 a draft of a procedure on how to go about working
17 with those cases, a draft task order list, and
18 schedule, because as we go along we may dearly want
19 to address one issue or one particular type of
20 cancer, or something like that; however, the cases
21 may just not be available. So I'd say let's give
22 ourselves maximum flexibility, understand that this
23 is going to be a living sort of piece of work, if
24 you will, and that we will only really begin to be
25 able to focus on all of the issues that this Board

1 is interested in as time goes on when there are
2 several cases available that -- that are of interest
3 to us.

4 DR. ZIEMER: It appears so far that there is
5 a pretty strong sentiment to having a working group
6 do this task of identification of available cases;
7 that it probably should be done fairly soon; and the
8 answer to the third question will depend on what
9 they find, but they would come back to the Board
10 presumably, at least the product will be some sort
11 of report back to the Board.

12 Is that all fair so far? I'm not trying to
13 lock us into anything, but we need to keep that
14 coming back in mind.

15 Let's go on to the next item, which is the
16 Case Selection Process. And here again, these are
17 items that you all identified yesterday: Case
18 Selection Process; what's the process. We've kind
19 of answered some of this already. Who should do it?
20 It already sounds like that's the working group, at
21 least to start with. When should that be done?
22 That's probably locked in with -- or linked in, at
23 least, with the first item, if I am fairly
24 summarizing what's already been said.

25 I think the third bullet is fairly obvious,

1 we agree that the Board is going to need to approve
2 whatever is done by the workgroup.

3 What's the nature of the product here. And
4 I'm not sure what form this ends up taking. It's
5 clear that we're not asking NIOSH to do the
6 selection, but we are asking for availability of the
7 case information. Now, I'm going to ask Larry a
8 question, so I'm going to pause just a minute.

9 DR. MELIUS: If I may comment. It wasn't
10 clear to me yesterday, and I think we're going to
11 need to get it clarified, this whole issue of the
12 Board having to approve sort of every step. And at
13 least based on my recollection of the discussions
14 yesterday, was there how we do the -- for the Board
15 to do the case selection, you know, I mean can we
16 have a workgroup do that, the actual case selection?
17 Is that -- can we -- I think that it would make more
18 sense if we would approve the procedure for the
19 workgroup --

20 DR. ZIEMER: I think that was the
21 understanding that we would say that the
22 recommendation might be that we will review a
23 certain number of cases of this type, and this type,
24 and this type, not that it's this person, this
25 person, and this person. And requesting the Board

1 -- request by the Board to NIOSH/ORAU to provide the
2 case files with certain characteristics, I'm not
3 sure what that means except in -- and I'm not sure
4 that you know what that means yet in terms of the
5 extent to which the identification of the individual
6 claims has to be done. So we would need to work
7 with NIOSH and ORAU on this in terms of privacy
8 issues because in principle we are trying to review
9 this process independent of who the claimant is;
10 obviously, you would know from the site from which
11 the claimant came because we would still want to
12 make sure that we don't have conflicts of interest
13 in the review process. But those issues remain, so
14 I'm not sure what we mean exactly by requesting this
15 of NIOSH. Clearly, we're not going to ask you to
16 pick the cases.

17 MS. MUNN: No.

18 DR. ZIEMER: But to make available
19 something, a product that can be reviewed in
20 whatever form. So comments on this.

21 DR. ANDRADE: Again, to maintain
22 flexibility, we may have selection criteria that
23 might -- that if we're hard and fast on them we may
24 not be able to meet them the first or second time
25 through; therefore, we, the working group can come

1 up with a selection criteria. It can also come up
2 with the cases, given what NIOSH tells us -- yeah,
3 NIOSH tells us is available, and we can work on one
4 criteria, rather than another.

5 I envision this working group, again, if we
6 have rotating membership, to provide different
7 products at different periods of time. For example,
8 if we commission a working group today, then I
9 believe that the first product, if you will, will be
10 nothing more than administrative procedures, as Jim
11 alluded to, okay. And those can be reviewed by the
12 Board during our next meeting; however, once the
13 contract is let, then the product, the nature of the
14 product is going to change dramatically. What I
15 would envision is general comments on how well the
16 Associated Universities is doing their job, and
17 also, perhaps findings, if any, on -- or questions
18 that may come up about how they are doing dose
19 reconstruction, whether they might pick out a couple
20 of areas that we might want -- we might be
21 interested in reviewing. So I think that that is
22 the direction in which the type of product will go
23 as time goes on, but we should give the working
24 group -- again, if it is a representative working
25 group, representative of view points across the

1 Board -- as much flexibility to come up with the
2 cases, the selection criteria, maybe change control
3 processing insofar as changing the -- the criteria,
4 the selection criteria, depending on what is
5 available from NIOSH. So I think -- I think that
6 pretty much sums up the -- the way I feel that we
7 can get our arms around this fuzzy issue.

8 DR. ZIEMER: Thank you. Jim.

9 DR. MELIUS: One thing that we talked about
10 yesterday that I think will be important for the
11 workgroup early on is we're going to need to be able
12 to project the number of cases that will be
13 available over time. If we set up selection
14 criteria that are very specific, we may -- we could
15 easily end up with a situation where nothing would
16 be, those kinds of cases wouldn't be available for
17 five years or something, I mean, you know, something
18 sort of like that, and so I think we need to have a
19 feel for what will be the schedule of case --
20 availability of cases, given the criteria and how
21 that can sort of fit into this process also.

22 DR. ZIEMER: And clearly we would need to
23 work with NIOSH and ORAU on that.

24 MR. GRIFFON: Yeah, and Jim, I think that's
25 consistent with what I said. The only thing I

1 didn't want to see happen is that the availability
2 of cases drive the selection criteria. I think we
3 should, you know, think of that.

4 DR. MELIUS: Drive the schedule.

5 MR. GRIFFON: Drive the schedule, right.

6 DR. ZIEMER: Roy DeHart.

7 MR. DeHART: What we have really discussed,
8 I think, for the working group was working
9 initially, was a matrix. And a matrix can be filled
10 in at any time, so all you do is whatever you have
11 available that you fill -- put the squares where you
12 need to, and over time you fill them in.

13 MR. GRIFFON: Well, I think Jim's point is
14 that we don't want the matrix to be empty for the
15 first three years, right?

16 DR. MELIUS: Yeah.

17 DR. ZIEMER: Do you want to move on to the
18 next item at this point? And if I could summarize,
19 it appears that this work could be done in
20 conjunction with the other, that is the same
21 workgroup initially address these issues together.
22 Okay.

23 Henry?

24 DR. ANDERSON: Yes, since we -- since
25 there's a considerable backlog now of cases that are

1 in the system I guess the question would be to
2 NIOSH, what is the -- you know, are they going
3 through the cases in numeric order, the first-in,
4 first-out --

5 MS. MUNN: Yes.

6 DR. ANDERSON: -- or how they're doing it
7 because it could be that if we set up some criteria,
8 if it isn't first-in, first-out, then they could, in
9 fact, over a year set up their review schedule that
10 would be -- would assure that some of the cases were
11 interested and go through the system. Now, that is
12 innately unfair -- unfair perhaps, but that's
13 what --

14 DR. ZIEMER: We heard yesterday that some of
15 the --

16 DR. ANDERSON: First-in, first-out.

17 DR. ZIEMER: -- first-ins are still waiting,
18 yeah, in the long queue because of unavailability so
19 far of the -- or lack of information.

20 DR. ANDERSON: Yeah, I understand, but if
21 it's first-in, first-out, then we ought to know --
22 we ought to know where they're coming, you know, to
23 be able to look at them.

24 MR. ELLIOTT: We are working first-come,
25 first-served, but that doesn't mean that you reap

1 the fruit of that in those -- in the sequence.

2 DR. ANDERSON: Yeah, I understand. Yeah.

3 MR. ELLIOTT: So, for example, on, you know,
4 Bethlehem Steel site profile may knock out 300
5 claims for Bethlehem Steel in one fell swoop, but
6 those 300 claims, you know, there's probably a few
7 of them were in the 1,000, and, you know, the next,
8 they just sprinkle across, you know, in sequence.

9 DR. ANDERSON: Right. Yeah.

10 MR. ELLIOTT: And so it's very hard for us
11 to predict when a particular claim in sequence is
12 going to come to final closure, so.

13 DR. MELIUS: And I think there's also a
14 potential problem in that some of the more difficult
15 -- some of the cases for which it's more difficult
16 to find information, to get adequate information,
17 are going to back up in the queue, and wait for a
18 site profile information, and that in some ways
19 could bias the selection process if we, when we pick
20 from the first 1,000 or whatever the number would
21 be, so I think there's some details that really have
22 to be looked into to make sure there's a fair
23 selection of cases.

24 DR. ZIEMER: Mark.

25 MR. GRIFFON: Yeah, and that was my point

1 about -- about not letting the availability of cases
2 drive the selection criteria because I think that,
3 you know, some of those more difficult cases are
4 going to be the ones we're more interested in
5 reviewing also, so.

6 DR. ZIEMER: A good point.

7 The third item we talked about was the
8 actual procedure for the selection of -- this is the
9 process, but the actual procedure for the selection
10 of cases. You see I'm asking some of the same
11 questions here. And they start to overlap,
12 obviously, but I've separated them out. I think it
13 appears now, based on the discussion, that some of
14 these answers are rhetoric, again, working group,
15 and we need to get underway with this. Keep in mind
16 that the actual procedure is different from the
17 process. The procedure is -- well, look at the end
18 there: What does a procedure look like? I've asked
19 that question. What does the selection procedure
20 look like? And if -- if we move toward having a
21 workgroup work on these things, then we would charge
22 them with doing that, tell us what -- and come back
23 to the Board and show us. That's not something I
24 think we can do here. In fact -- well, we'll get to
25 it in a moment. Let me solicit any other comments

1 on this. This is the procedure for selection of
2 cases. It includes like you just mentioned, Mark,
3 what about the difficult cases which are down the
4 road; how do we assure that our procedure is
5 cognizant of those, so that as we instruct in the
6 selection of the cases that we allow for that, how
7 do we take care of this matrix, so.

8 Any other input on this item? Again, these
9 topics are all ones that were brought up by the
10 Board yesterday. I just want to make sure we're on
11 the same page as we go forward.

12 We're okay? Okay, let's move on.

13 Procedures for the review of the cases.
14 This is having done the selection, when we actually
15 get cases to review. We need a review procedure,
16 and this question: Who is going to develop the
17 procedure, when should that be done, does the full
18 Board approve the procedure, and what would that
19 look like?

20 After asking those questions I thought about
21 this further, and have bounced this idea off a
22 couple of people this morning. It seems to me that
23 to answer this, what would a procedure look like, we
24 need to do one or two, or more, mock -- I call them
25 mock reviews, and actually have maybe it's the same

1 workgroup sit down with some cases and start through
2 what would look like a, say a Basic Review. Now,
3 the first time through there's no procedures to even
4 do this. And you have to sit there and say okay,
5 what is the first thing we do, you know, do we ask
6 is the site profile adequate, or maybe step one is:
7 Is there a site profile? Is it adequate? So you
8 start looking at procedures, but it seemed to me
9 that we're going to have to have a group hammer this
10 through and develop the procedures. And maybe look
11 at NIOSH procedures as to how they do a review,
12 their own, you know, the dose reconstruction; maybe
13 look at ORAU's, and gain some clues as to what it is
14 that needs to be done if you're reviewing. I think
15 of it as an auditor. An auditor uses some of the
16 same procedures in auditing as the accountants use
17 in accounting, they have to go through some similar
18 steps.

19 Now, Tony.

20 DR. ANDRADE: In my mind I really see this
21 as kind of Phase II of the working group's charter,
22 if you will. Once we have established --

23 DR. ZIEMER: So that has to do with when it
24 should be done, then?

25 DR. ANDRADE: No.

1 DR. ZIEMER: No?

2 DR. ANDRADE: But really this should be put
3 in the context of what is the product that we
4 eventually want from the contractor on board. Okay.
5 I really believe that that is what drives -- what
6 would drive this kind of procedure.

7 DR. ZIEMER: Uh-huh (affirmative). Because
8 the last question, there may be a report on an
9 individual review, but what you do with all of those
10 reports --

11 DR. ANDRADE: Right.

12 DR. ZIEMER: -- and compiling them into an
13 overall.

14 DR. ANDRADE: Exactly. And so I think that
15 this would be the work of the working group. It
16 could be a whole new set of members, it could be
17 some members that continue on, but this would be the
18 working group after we've met the next time to look
19 at the administrative part of selecting cases, case
20 availability, case number projection, and that sort
21 of thing. Then the working group would go on to
22 define the work to be done in these particular
23 arenas, and which is basically a task order. And I
24 have -- my own personal gut feeling is that it
25 would be driven very much by what is listed in the

1 Basic, Advanced, and Blind Review steps that -- that
2 have already been deliberated to a certain extent.

3 DR. ZIEMER: Roy.

4 MR. DeHART: Actually, what we'll be doing
5 is primarily overlooking our contractor to assure
6 that they're doing what we're wanting, so in fact,
7 much of this may be feeding back into the task order
8 issues, as well as the basic contract that we're
9 just about ready to approve to go on the street.

10 DR. ZIEMER: Yes, but I want to make sure,
11 at this point I think it's useful for us to think of
12 our contractor in a sense part of us. Let's keep --
13 we're not reviewing our contractor at this point.
14 Our contractor is helping us do this review, so
15 let's -- it seems to me it might be helpful for us
16 to think of this in terms of suppose we were doing
17 this with no contractor, we're just doing it, it's
18 us. We really aren't having a contractor help us do
19 some tasks that we can't otherwise do either for
20 lack of time, or in some cases, lack of ability. I
21 -- and I say that in a nice way. We are not dose
22 reconstructionists, okay.

23 I think Jim was next, and then Mark.

24 DR. MELIUS: Yeah. Just to follow up on
25 that point. I think that this is going to be part

1 of developing the task order. We're going to need
2 to have this done before we can do a task order, and
3 I think it needs to start relatively soon because
4 given the schedule that came out, given this OMB
5 issue that will be part of some of these reviews,
6 that we need to get this process underway relatively
7 rapid, and I don't think we can wait for this part,
8 for example, until after the April meeting. I don't
9 think that's what Tony was suggesting, but I don't
10 think we should do it too sequentially because I
11 think if we can get some of this started because if
12 -- if not, we're going to back up the whole process.

13 DR. ZIEMER: Mark.

14 MR. GRIFFON: That echoes my concern. I
15 mean I think it's -- I think in developing the
16 procedures I think our task order is going to be
17 more fleshed out, it's going to be kind of a
18 parallel process. And also just -- I was also maybe
19 worried about the sequential because I think either
20 we can put a lot of pressure on the Board to meet
21 sooner again to review these things step wise, and
22 that might, like Jim said, slow down things. We
23 need to get these things rolling.

24 DR. ZIEMER: Gen.

25 MS. ROESSLER: And along with that, I think

1 that this workgroup needs to, whether it's a mock
2 review or whatever it is, needs to go to NIOSH,
3 needs to work with those people, needs to see what
4 they're doing because otherwise, it's sort of like
5 working in a vacuum; you really don't know what
6 their process is until you actually see it.

7 DR. ZIEMER: Gen, I certainly, in my mind
8 when we were talking about developing these
9 procedures, in my mind the working group has to be
10 there in Cincinnati and -- and I think that's what
11 you're suggesting. And maybe have some sample cases
12 -- real cases where they can step through and say
13 what -- what will a review actually involve,
14 procedurally what do we have to do step wise, and
15 then develop an itemized kind of checklist that
16 makes sure that items are not overlooked, that we're
17 examining the issues that we think are important.

18 Wanda.

19 MS. MUNN: This is what I had in mind
20 earlier when I said I see this as a two-step
21 process, and as a two-workgroup process because I
22 don't see the workload being such that the same
23 workgroup could be addressing these procedures as
24 are addressing case selection and the items we were
25 discussing earlier.

1 DR. ZIEMER: Tony.

2 DR. ANDRADE: I could see it both ways;
3 however, I think in the -- in the interest of
4 efficiency and in saving time that indeed it
5 probably would be best to proceed in parallel, and
6 so I would suggest -- I'm not pushing anybody here
7 -- but I would strongly suggest that the people who
8 came up with this -- with the Statement of Work, in
9 other words, Mike's, Mark's working group or some
10 members thereof perhaps follow through on working on
11 this. They are the most familiar with the elements
12 of what it is that we are going to want from the
13 contractor, so maybe that's a place to start. I
14 don't know you feel about that, Mark.

15 MR. GRIFFON: Very enthusiastic. I mean I
16 do want to be involved, even though I know it's
17 going to be quite a bit of work going forward. And
18 I think we have -- have met at a lot of meetings on
19 these issues and we did go to NIOSH, so we have a
20 jump-start on the whole process, so I would
21 certainly be willing to participate in that.

22 DR. ZIEMER: Who else was on that workgroup?
23 I'm looking to see what our representation was. A
24 fairly good representation cross-section wise in
25 some of the areas of disciplines in the Board we

1 got. Well, we'll come back to that and ask about
2 these folks' availability and see how their
3 availability, and time, and so on. But thank you,
4 for that suggestion, that helps the Chair,
5 certainly.

6 Other comments on this? Shall we proceed?

7 The Basic Report, or what is the product.

8 And I think about these in two ways; one is
9 individually because as I envision it, and again,
10 I'm -- I'm throwing some ideas out and you can shoot
11 them down and tell me they're -- I'm thinking wrong
12 and you have a better idea, or we'll go from there,
13 but we -- there will be individual reports that
14 presumably, and this is based, again, on your
15 workgroup's sort of bottom line thing, and I've
16 summarized a little bit, but somehow we'll be saying
17 something about the adequacy and consistency of the
18 site and personnel data, the adequacy of the
19 interview, and the adequacy of dose reconstruction
20 and probability of causation determination, in some
21 form or another. There would be an individual
22 report of an individual dose reconstruction, and
23 after a time there would be a group of these
24 reports, which might be compiled into some sort of
25 composite that comes back to the Board which

1 identifies strengths, weaknesses, adequacies,
2 inadequacies. And there again, that remains to be
3 fleshed out. But is this where we're headed, that's
4 what I'm asking, in the review process, is this
5 where we're headed? So let me throw that out for
6 discussion.

7 Robert.

8 MR. PRESLEY: I see the group that comes up
9 with the task order being the people that come up
10 with some type of a list or a procedure that we come
11 back to the Board with. If they write the task
12 order, it looks to me like they ought to be able to
13 come up with something that says that here's what we
14 give back to the Board, and it's going to encompass
15 all this.

16 MR. GRIFFON: Yeah, and a draft, you know,
17 review report -- a report that would to the HHS. I
18 guess that's what you're --

19 DR. ZIEMER: Well, one of the questions
20 is --

21 MR. GRIFFON: Right.

22 DR. ZIEMER: -- who does the product go to.

23 MR. GRIFFON: Right. Right, right. And I
24 -- I don't disagree with what you've got up here. I
25 think I was envisioning that sort of like a summary

1 of, over a certain period of time, a summary of
2 types of cases done, and a summary of --

3 DR. ZIEMER: Oh, sure. Yeah.

4 MR. GRIFFON: -- you know, the adequacies --

5 DR. ZIEMER: But the nature of the report,
6 is this kind of information coming.

7 MR. GRIFFON: Yeah.

8 DR. ZIEMER: Okay.

9 Henry.

10 DR. ANDERSON: Yeah, I would think this is
11 the nature. I would think, you know, we need to, at
12 some point, separate where the contractor will
13 provide us, the Board, with something, and then how
14 do we synthesize that, whether we do it as an annual
15 report or whatever, but at some point I think we'll
16 have the individual cases, and it will be up to us
17 to interpret how they all fit together and put
18 together that annual report, and I'm not sure until
19 you've had a chance to look at them and look for
20 patterns, and the other would be consistency, I mean
21 have they applied the same thing, same approach
22 every time. And you may end up with the same
23 result, but if it's approached in a different way I
24 think we need to look at are we going to recommend,
25 first we have to say if it's inadequate, we could

1 say it's adequate, but we see there's some room for,
2 you know, some more consistency, or, you know, the
3 approach, so I think that has to be our subcommittee
4 and our group. I wouldn't want to do that summary
5 too frequently, I would say probably on an annual
6 basis, and then that report would be the one the
7 Board sends on to the Secretary, but we really have
8 to do that synthesis in how we do that I think it's
9 hard to flesh that out until you've had a chance to
10 look at at what that produces. But I wouldn't want
11 a contractor to basically be doing our
12 interpretation of it. They're doing the nuts and
13 bolts in pulling it together.

14 DR. ZIEMER: Thank you.

15 Tony, then we have Roy, and then Robert.

16 DR. ANDRADE: I don't disagree with anything
17 that's been said. I think ultimately the report is
18 going to address the very last bullet. It's going
19 to -- in my mind I think it should be some sort of
20 composite from several cases, perhaps a few cases in
21 the beginning; it's -- it really is the adequacy of
22 the dose reconstruction. And the first two bullets
23 may be elements that are culled out specifically in
24 case there's weaknesses, or strengths. But I would
25 only envision an individual's -- a redacted

1 individual's dose reconstruction being brought to
2 light if -- if some major issue had been found in --
3 in the review.

4 DR. ZIEMER: Yeah. Certainly, I don't think
5 any of us envision a report that would --

6 DR. ANDERSON: No.

7 DR. ZIEMER: -- cull out individuals, other
8 than say there was an example of something or other,
9 you may not even necessarily identify a site because
10 we need to be careful, but certainly this would be a
11 composite type of report ultimately, based on
12 individual reports.

13 I think we have Jim, and then --

14 DR. MELIUS: I think we had somebody else.

15 MS. ROESSLER: Roy was.

16 DR. ZIEMER: Roy. I'm sorry, Roy, then Jim,
17 and then Gen.

18 MR. DeHART: I think the Board has -- also
19 has the obligation that as we're considering policy
20 and procedures for reports that we must consider
21 what happens if we find a fatal error. By that, I
22 mean something that's going wrong consistently and
23 we -- we need to step in and the Board must know how
24 we're going to do that in advance.

25 DR. ZIEMER: Okay. So we have a lingering

1 question. I don't know where we hang that right
2 now. And we've -- we've all proceeded as if maybe
3 that won't happen, but we don't want to be like NASA
4 and second guess. And I don't mean that in a
5 derogatory way, either. Unfortunately, sometimes
6 fatal errors do occur, so what do -- what do we do
7 in that case. And this isn't going to be done in a
8 vacuum because there will be periodic reporting, and
9 NIOSH will be aware, obviously, if there are
10 concerns that start to emerge, so I don't anticipate
11 that there will be, you know, out of the blue,
12 surprises, that all of a sudden somebody says you
13 guys have been doing the wrong thing for the last
14 three years. That might occur, I mean somebody
15 might say that, but I think it's unlikely.

16 Jim.

17 DR. MELIUS: I actually was going to make
18 the same point, and I hope Larry doesn't interpret
19 that as being any statement on the likelihood that
20 we'll find a problem, but I have nothing more to
21 add.

22 DR. ZIEMER: Gen.

23 DR. ZIEMER: On your last point there you
24 mention dose reconstruction and probability of
25 causation. It's quite clear that this is a dose

1 reconstruction audit. I'm not sure that probability
2 of causation comes into it, only as to how the dose
3 reconstruction inputs to it. I think that part is
4 something that the Board does on an ongoing thing
5 and really is not a part of the audit function.

6 MR. GRIFFON: I think this is -- I think
7 this is something that Jim Neton has taught us over
8 the working group sessions that I think we're
9 looking at adequacy of dose reconstruction for
10 purposes of POC determination.

11 MS. ROESSLER: Yeah. I think the wording
12 should be made clear.

13 MR. GRIFFON: Did I get that right?

14 DR. ZIEMER: Well, yeah, and they simply end
15 up being linked here because POC is basically the
16 outcome of the dose reconstructions. Yeah, point
17 well taken.

18 MR. NAMON: Dr. Ziemer, I'm just going to
19 point out that there's also kind of a legal
20 distinction there because the POC determination is
21 not made by the Department of Health and Human
22 Services.

23 DR. ZIEMER: Yeah. Yeah, understood. We'll
24 just consider it in this last one, strike the POC
25 from our minds, it's not really there virtually.

1 Okay, Henry.

2 DR. ANDERSON: Yeah, I was just going to
3 follow up on Roy.

4 DR. ZIEMER: The jury will disregard the
5 POC.

6 DR. ANDERSON: Jim's comment was, I think
7 going two steps back when we have kind of
8 procedures, you know, any -- any problem will appear
9 as a first case, and it would seem we just need to
10 have the flexibility in our case selection that if
11 something looks like there may be a problem, we
12 would then immediately move to look at other similar
13 cases, so you would have an investigative process
14 there that it wouldn't say there's a fatal flaw
15 based on a single --

16 DR. ZIEMER: Right.

17 DR. ANDERSON: -- case. You'd want to see
18 is it a pattern, and so we would then -- we just
19 need to have that procedure in place to move forward
20 from there and have that flexibility.

21 DR. ZIEMER: Thank you.

22 Robert.

23 MR. PRESLEY: When we talked about this in
24 the working group we talked about a -- a group,
25 subgroup coming in and reviewing, before our meeting

1 with our contractor, the cases that we had selected.
2 And then the way we had envisioned this -- and Mark,
3 jump in here if I'm wrong -- is that we would come
4 into the Committee as a whole with a recommendation
5 that we've gone through X number of dose
6 reconstructions, and that we find those to be
7 adequate and correct, or we find 11 out of 10 -- or
8 11 out of 12 to be adequate and correct, and we
9 found one that we would like to send back and have
10 some work redone on it at that point in time so we
11 don't wait, so I -- I consider something, some type
12 of a report to be done monthly, or every time we
13 meet, and then down the road, maybe a yearly report
14 back to the powers that be.

15 DR. ZIEMER: Right. And actually, that --
16 that issue becomes part of our procedures for the
17 review; what is the output, and that can include the
18 frequency of reporting to the Board, the frequency
19 of reporting to the Secretary of Health and Human
20 Services, or whatever. Those -- those remain to be
21 refined. I -- I hadn't envisioned, for example,
22 sending a letter to the Secretary every month
23 telling him what the findings were, but -- and I'm
24 sure he's not interested in that either, but an
25 annual report might be quite appropriate. But

1 certainly the Board wants to be apprised on a
2 regular basis.

3 DR. ZIEMER: Other comments.

4 David, please.

5 MR. NAMON: Just one general point I wanted
6 to make sure the Board was aware of, which is that
7 for this whole review process there's going to be
8 some significant proxy considerations to take into
9 consideration, not the least of which is that the
10 Subcommittee and the Board operate in public, and
11 identifying individual claimants is a significant
12 problem. Ordinarily, we would have to redact
13 reports to the point where they're not recognizable
14 to someone who would have been a coworker of that
15 person, so, which is obviously a pretty significant
16 concern. So just something for you all to keep in
17 mind as you're considering how this is going to
18 work.

19 DR. ZIEMER: Yes, and I don't think the
20 Board anticipates discussing individual cases in
21 Board meetings. The reporting would always be done
22 in terms of groups, statistical summaries of cases
23 reviewed and that kind of thing. Is that not
24 everybody's --

25 Robert, you have a comment?

1 MR. PRESLEY: Yes. On that, what we have
2 talked about in the Committee is coming up with a
3 group to do these with an alternate, and if somebody
4 recognizes that, say Savannah River, they worked at
5 Savannah River, then they would excuse themselves and
6 the alternate would step in. That's the way we were
7 envisioning this happening, right upfront.

8 MR. NAMON: I think you still have the
9 concern that if the Subcommittee is operated in
10 public that -- that you'd still face the possibility
11 that the people who are involved would be discussing
12 matters that the public would then be able to
13 identify individuals. I'm sure this is something we
14 could work out if the time comes, but I wanted to
15 make sure that you all were aware that there be a
16 need for significant redaction.

17 DR. ZIEMER: Thank you. And we are
18 certainly aware of that.

19 Henry.

20 DR. ANDERSON: Yeah, it seems to me that if
21 there is something where details need to be
22 discussed by the Board we do have a mechanism to
23 have it be a closed session, just as we did when we
24 talked about the financial aspect; so it's one thing
25 for the written report obviously, to be sure that,

1 you know, that doesn't have any detail, but if -- if
2 an issue comes up that becomes, you know, where
3 there's disagreement on the review group or
4 something and we need to go over the specifics of a
5 case, it would seem that we could, in fact, close
6 that from the public for the discussion of
7 confidential information just as we did with the
8 contract discussion.

9 DR. ZIEMER: Further comments on this item?

10 (No response.)

11 Now, I have one other item which I'm
12 debating in my own mind whether to show you. How
13 many want to see it?

14 DR. ANDERSON: Go ahead, take a chance.

15 DR. ZIEMER: What -- well, I'm going to hold
16 it until after the break.

17 What I have is a -- I'm still -- I'm still
18 trying to make sure we're on the same page as to
19 what a Basic Review report looks like, and the
20 starting point is the Individual Review. And I have
21 kind of a strawman Individual Review report, and
22 then the only reason for showing this is to make
23 sure content wise that we have captured the salient
24 points that need to be in the review. And this
25 would serve then to assist the workgroup which would

1 come up with that. They can use it as an example of
2 what not to do, or they can use it as an example of
3 what they should do, or they can start from scratch.
4 But we'll save that until after the break, how about
5 that. So let's take 15 minutes and then we'll --
6 oh, a comment first.

7 MR. ELLIOTT: We -- we were just kibitzing
8 here a minute about Henry's comment. It's not clear
9 to me that we can go into closed session for that
10 purpose, whether the Privacy Act requirements would
11 trigger a closed session. We're going to -- I'm
12 asking the counsel to check into that because I
13 think that is important for us to determine.

14 DR. ANDERSON: Yeah, that would solve a lot
15 of problems if we could.

16 MS. MUNN: But that's not clear to me,
17 either. It was my understanding that Executive
18 Sessions related only to personnel and legal
19 matters.

20 MR. ELLIOTT: And financial. Let me, for
21 the record state that all the Board members are
22 bound by the Privacy Act as special government
23 employees. The contractor that you will hire will
24 be bound by the Privacy Act. But when you come
25 before, into the public meeting, we -- we have

1 problems and we need to be very careful and diligent
2 in our redaction efforts are -- are making sure that
3 no one can determine who might have been talking
4 about in a public forum, so.

5 (Whereupon, a break was taken.)

6 BY DR. ZIEMER: (Resuming)

7 We'll delay the administrative housekeeping
8 for just a little bit because Cori has some things
9 she needs to take care of first. So I think we can
10 continue with issues related to completed dose
11 reconstruction reviews.

12 Let me remind you that we still have before
13 us the -- the issue of the decision on who will
14 administer the contract, do the procurement on
15 behalf of the Board.

16 Also, I want to finish what we were talking
17 about here, and maybe we'll do that first and then
18 move to the procurement issue.

19 The last thing that I talked about to show
20 you is based on -- I will need the slides up -- is
21 Jim here?

22 MS. DiMUZIO: No. I will.

23 DR. ZIEMER: Okay. Yeah, it's that one.
24 Just open that. It's a Word document. This is not
25 a Power Point, it's a Word document. I just want to

1 go through that.

2 Now, for reference, if you would move into
3 the tab called Discussion Documents, the Request for
4 Contract document, and go to page 16 and 17; page 16
5 and 17 was the Basic Review. Now, what I did here,
6 and I see already that sometimes when you close
7 these programs and reopen them the automatic
8 formatting overrules everything you did.

9 DR. ANDERSON: You mean 1 and 2 aren't the
10 most important?

11 (Laughter.)

12 DR. ZIEMER: In any event, the only thing I
13 did here was take the Basic Review items as they are
14 here, and I've transformed them into a form format.
15 Now, this -- this serves two purposes: I'm really
16 asking the group is this what we want an Individual
17 Review Report to look like? I don't know if we do.
18 Or does it at least capture what it is we want on
19 the Individual Reviews. And we don't have to -- we
20 don't have to come to an approved form here because
21 this clearly is going to go to the workgroup. But
22 just as a point of guidance for the workgroup, all I
23 did was, you know, this was something that I just
24 ended up doing after I was thinking about the other
25 stuff last night, I asked myself the question what

1 would a review report look like. And based on what
2 was here, I just put it in this format.

3 So let me just put it out here, and we don't
4 have -- you can react to it or whatever, but -- and
5 I don't know if there's a way I can move this up and
6 down. Probably not.

7 So I have Henry -- can you sit there on a
8 chair Henry, to just -- well, don't change the zoom.

9 DR. ANDERSON: I was going to make it
10 smaller and then the whole page will be there.

11 DR. ZIEMER: Yeah, and then we won't be able
12 to read it. It's hard enough to read it. Just go
13 over to the side there -- yeah, we can scroll it.

14 Okay. So it says: Were all requested data
15 from the site received or obtained? Yes. No.
16 Comment.

17 I don't know if that's adequate. Were data
18 -- were the data, should it say: Used for
19 documentation of POC or we should say of dose
20 reconstruction -- it's a new abbreviation for dose
21 reconstruction -- adequate? Yes. No. Comment.
22 And then a whole section of questions relating to
23 interview: Were incidents or occurrences
24 appropriately addressed? Yes. No. Comment. Were
25 monitoring practices appropriately addressed? Yes.

1 No. Comment. Were personnel protection practices
2 appropriately addressed? Were work practices
3 appropriately addressed? And in all of these cases
4 it's: Yea. Nay. Comment. And maybe all of these
5 can't be answered by yes or no because it may not be
6 clear cut. Is the interview information consistent
7 with the data used for dose estimate? If -- and
8 here -- wait, go back -- If no, is there reasonable
9 justification for the inconsistencies? Again, this
10 comes out of the document. It's a little different
11 than just a pure comment.

12 Yeah.

13 MR. GRIFFON: Yeah, I think it's a good
14 starting point. I mean I -- I'm glad I didn't draft
15 the same thing last night because I was thinking
16 similarly. And I think that this would be a good
17 starting point since I have to kind of test this
18 form and see if it's sufficient and --

19 DR. ZIEMER: That's right. You actually --
20 it has to be tested with some real cases and so on.

21 Were the assumptions used in the dose
22 determination appropriate? Yes. No. Did the
23 assumptions used resolve issues in favor of the
24 claimant? That is, give claimant the benefit of a
25 doubt. Were the dose calculations appropriate and

1 sufficient for determination of -- again, we should
2 say dose reconstruction. Actually -- actually, this
3 is the right question --

4 MS. ROESSLER: That's okay. Yeah.

5 MS. MUNN: Uh-huh (affirmative).

6 DR. ZIEMER: -- were they appropriate for
7 determination of probability of causation. Were the
8 data used consistent with rad monitoring protocols?
9 Was the treatment of missed dose done properly? Was
10 the treatment of unmonitored dose done properly?
11 And then I put a catchall in.

12 So, I guess the only thing I'd ask here is
13 this sort of along the right track?

14 MS. ROESSLER: Yes.

15 MR. PRESLEY: Yes.

16 MS. MUNN: Yes. You're fine.

17 DR. ZIEMER: Okay.

18 DR. MELIUS: Can I?

19 DR. ZIEMER: Yeah, Jim.

20 DR. MELIUS: I think it's along -- I think
21 it is along the right track in terms of the report
22 that we would have for the Board, how it would be
23 reported back to the Board. I'm thinking that as
24 the Board or the workgroup -- however we, you know,
25 set that up -- works with the contractor we probably

1 want a longer form where they would fill in details.
2 And this might address some of these privacy --

3 DR. ZIEMER: Well, in fact --

4 DR. MELIUS: -- issues also that would --

5 DR. ZIEMER: -- I'm actually looking at this
6 as a report on an individual one right now because
7 you would have to pool this to get your composite,
8 and in the comments part maybe needs to be fleshed
9 out in a different way, but more specifically.

10 DR. MELIUS: Just thinking about it though,
11 I would think that with the Board members
12 interacting with the contractor, they're going to --
13 I would think that we would want the contractor to
14 provide more detail in a report to the Board members
15 on that --

16 DR. ZIEMER: Oh, I'm with you, yeah, yeah.

17 DR. MELIUS: -- I would think that it would
18 include a work history kind of summary that would
19 then fill in some details --

20 DR. ZIEMER: Right.

21 DR. MELIUS: -- of -- of what kind of
22 personal protection, what --

23 DR. ZIEMER: This is more like the executive
24 summary.

25 DR. MELIUS: Exactly. Yeah, yeah, yeah. I

1 think that's -- this kind of thing would be
2 appropriate to come back to the Board, the overall
3 Board, that it would be the basis for, you know, a
4 summary report and provide, you know, the categories
5 and the consistency for that. But there may be
6 another form on top of that, that they would -- so I
7 think -- the point I was trying to make was I think
8 as the workgroup works on the procedure for review
9 and does some of these mock reviews and so forth,
10 that I think they will, you know, sort of develop a
11 series of forms, and one will be a more detailed
12 one, then one less detailed one according to that.
13 And then they have to make sure that the detail
14 would cover each of these points.

15 DR. ZIEMER: Good.

16 Other comments?

17 Now, we may be ready to move to an actual
18 appointment of a working group, I think on at least
19 or some or all of these tasks that we talked about
20 this morning. Are we at that point? Are you ready
21 to do that? This would be a workgroup just to get
22 this process underway. This is not a subcommittee
23 that's going to do this long-term. This is a
24 workgroup that would deal with initial
25 identification of the available cases, initial

1 determination of a case selection process, initial
2 development of procedures for selection of cases,
3 and procedures for the review of cases. Those are
4 the main issues that we talked about. Now, and we
5 had a little discussion about whether that's all
6 that this one Subcommittee, or one Workgroup, or
7 whether -- whether the actual procedures for the
8 review is a separate group, or a follow on activity.
9 It may be that one group can dig in and do all of
10 these things and then they would report back, at
11 least at the next meeting, and tell us where they
12 are on it.

13 Did you have a comment, Mark?

14 MR. GRIFFON: Well, I was just going to say
15 that I also saw a parallel test with the procedures
16 was the drafting of some of the task order language.

17 DR. ZIEMER: And the task orders, right.

18 MR. GRIFFON: Yeah.

19 DR. ZIEMER: Then let me ask, again, those
20 who were on the previous workgroup, let's reidentify
21 here. Mark chaired it, and we had Roy, and Robert,
22 Gen, and Rich. That's two, three, four, five, five
23 individuals. Let me ask if you five are interested
24 and available to participate in this -- this next
25 workgroup activity. I don't -- I don't think you

1 need to feel obligated in terms that you know your
2 own schedule, but you also have some familiarity
3 with the -- the thinking process that went into
4 developing those procedures.

5 Roy.

6 MR. DeHART: I'm certainly interested, but I
7 will be out of country almost for the entire month
8 of April. That tends to be a critical time.

9 DR. ZIEMER: So we may need to find someone
10 for you.

11 Robert?

12 MR. PRESLEY: I'm available.

13 DR. ZIEMER: Available.

14 Gen?

15 MS. ROESSLER: I'm interested and I'm
16 available. It kind of depends on how much time it
17 will take and when. I mean I have my calendar with
18 me. I think I can work it out.

19 MR. ESPINOSA: Is the intent still to have
20 the working group sessions or working group meetings
21 prior to the Advisory Board?

22 MS. ROESSLER: That's what I thought.

23 MR. GRIFFON: I think we'd have to have them
24 separate, yeah.

25 MR. ESPINOSA: I mean it won't happen like

1 -- I mean we're not going to piggy-back the Advisory
2 -- we won't piggy-back the Advisory Board?

3 MR. GRIFFON: We may. It may be both.

4 MR. ESPINOSA: It may be both.

5 MR. GRIFFON: I would see at least a need to
6 go to Cincinnati as a separate meeting --

7 MR. ESPINOSA: Okay.

8 MR. GRIFFON: -- not necessarily tied in
9 with a Board meeting, and depending on what we find
10 out about SEC Rules, but not necessarily tied into
11 that.

12 DR. ZIEMER: Tony.

13 DR. ANDRADE: Paul, I guess I would suggest
14 perhaps getting a sense of the Board on whether
15 starting two parallel efforts with smaller scopes of
16 work. In other words, one looking at procedures in
17 developing the task orders, for example, that might
18 be a one-day activity, or even less; and then the
19 other, developing the administrative procedures for
20 case selection, case availability, and that sort of
21 thing. If -- if we can reduce the work scope and
22 have two working groups, so to speak, you know --

23 DR. ZIEMER: I understand that. My concern
24 would be the degree of overlap, and the fact that we
25 need to have this all on the same page in a sense.

1 Comment, Jim?

2 DR. MELIUS: Could I suggest an alternative
3 to that, but maybe capture some of that. We could
4 have the initial workgroup get the process started,
5 and then as they define other tasks that need to be
6 done or refine those, and then we look at people's
7 availability over time and so forth because there
8 may be periods of time when people aren't available.
9 It may be that that will be how it would work out.
10 If this initial workgroup came back to us at the
11 next meeting with sort of an update where they
12 stand, what they see needs to be done --

13 DR. ZIEMER: How far they've gotten.

14 DR. MELIUS: -- how far they've gotten, what
15 needs to be done, and then, you know, we have enough
16 people and time to do it in, then I think we can
17 sort of decide from meeting to meeting, and it may
18 very well then make sense for, you know, split the
19 workgroup or bring other people in for particular --
20 particular tasks and so forth.

21 DR. ZIEMER: Gen.

22 MS. ROESSLER: Just picking up on what Jim
23 and Tony have said, I like the idea that Tony
24 brought up of people rotating on and off this group;
25 you'd have maybe a consistent core or consistent

1 over a period of time, then as the need comes up,
2 and I could see this almost, you know, maybe in the
3 second meeting of the group that somebody rotates
4 off, somebody comes on that would be more familiar
5 with all the sites and could help with the site
6 selection; I'm thinking of Mike, for example,
7 someone like that with a specialty need rotate on.

8 DR. ZIEMER: I want to caution you that
9 we're not thinking in terms of a long-term group
10 with people rotating on and off. We're talking
11 about a short-term working effort or task. This
12 would be a workgroup that reports back at our next
13 meeting, and then we will decide whether additional
14 work needs to be done. They may complete everything
15 by the next meeting. This is not a group which is
16 going to be involved in necessarily monitoring the
17 dose reconstruction activities over the next year.
18 This is a group to address these immediate tasks of
19 getting some procedures into place.

20 MR. GRIFFON: Yeah, I had just a comment on
21 what Tony said. I was thinking also about that,
22 concerned about overlap, and, you know, cause there
23 -- there could be an obvious break here with the
24 procedures and the task order parts, and then the
25 selection criteria part, because the -- how are we

1 going to stratify, what kind of sampling processes
2 are we going to use, that kind of work. But I think
3 there would be a little bit of overlap, and I -- I
4 wouldn't mind that our group take a first shot at
5 that.

6 The other thing is that I think to do the
7 selection criteria, and the -- and the
8 identification of the cases is also going to require
9 some distance, and if one group is already there
10 initially, you know, I think we can probably.

11 DR. ZIEMER: My inclination is to ask the
12 A-workgroup to get this underway. It may be that
13 they can report back at the next meeting, and then
14 we can see whether or not either they or some
15 modification of that workgroup needs to do some
16 additional work to complete the tasks. And that
17 would be what I would propose, and what I'm moving
18 toward here, I appoint this -- would be to appoint
19 those available who had been involved in that
20 process who are familiar with the thinking, but we
21 need to, for example, find someone to -- if Roy's
22 availability is in question, maybe somebody who can
23 fill that seat, as it were.

24 MS. ROESSLER: I thought Roy was a very
25 valuable part of this group in the first assignment,

1 and I would suggest that we first look at our
2 calendars and see if we couldn't involve a time when
3 he could be there.

4 MR. DeHART: I have the remainder of
5 February and all of March, and would be pleased to
6 try to adjust my calendar to be available, even
7 though I will be gone.

8 DR. ZIEMER: Let me suggest the following:
9 I will appoint the workgroup and maybe have at least
10 one alternate available.

11 Do we have a limit on numbers on a
12 workgroup? It has to be less than a majority of the
13 Committee membership, which would be six. We can't
14 have seven, but we can have up to six.

15 We have one, two, three, four, five. And
16 the Chair might want to be present just to observe,
17 which would give us six, but who is -- Tony, are you
18 interested in being an alternate?

19 DR. ANDRADE: (Nods head affirmatively.)

20 DR. ZIEMER: Anyone else interested in being
21 an alternate?

22 MR. GIBSON: Yeah, I would be.

23 DR. ZIEMER: Mike, okay.

24 DR. MELIUS: I would be willing to,
25 depending on availability, and time, and the issue,

1 I'd be glad to help out, so.

2 DR. ZIEMER: I will ask Mark to serve as
3 Chair, if you're willing to, Mark. And then Roy,
4 and Robert -- Roy DeHart, Robert Presley, Gen
5 Roessler, and Richard Espinosa to serve on the
6 workgroup; for Jim Melius, Mike Gibson, and who
7 else, Tony Andrade --

8 MS. MUNN: And I could do that.

9 DR. ZIEMER: -- and Wanda, and Henry, are
10 all available as alternates.

11 MS. MUNN: All available. Uh-huh
12 (affirmative).

13 DR. MELIUS: Let's not forget Leon.

14 DR. ZIEMER: So we have a number of folks
15 available as alternates. This workgroup would
16 proceed to develop the procedures for identification
17 of available cases, the case selection process,
18 procedures for the selection of cases, and parallel
19 to that, the development of task orders, and, if
20 there's time, procedures for the review of cases.
21 But they will report back at our next meeting on
22 their progress and with any recommendations that
23 they have at that time based on their experience.
24 They may, by that time, have some specific
25 recommendations and they will have a better feel for

1 the nature of the time needed to complete the tasks,
2 and whether it can be done by that workgroup or
3 whether we have to go beyond that.

4 I don't think it requires Board action for
5 the appointment of a workgroup. I think the Chair
6 is empowered to do that. Of course, any group is
7 empowered to challenge the decisions of the Chair by
8 motion, but if that's a group -- are there any
9 objections to that?

10 (No response.)

11 DR. ZIEMER: There appear to be no
12 objections, so we will proceed on that basis. I
13 will ask the Chairman of the working group to work
14 with the individuals to find a suitable meeting
15 time. I think you can do that individually, you
16 don't have to do that as a group.

17 MR. GRIFFON: Before we leave, I would
18 propose maybe we can all get together and look at
19 our calendars.

20 DR. ZIEMER: And let the Chair know what
21 your plans are.

22 And, Larry.

23 MR. ELLIOTT: Just for the record, you've
24 clearly defined the charge for the working group.

25 DR. ZIEMER: Yes, I --

1 MR. ELLIOTT: That's one thing --

2 DR. ZIEMER: The charge was to develop
3 procedures for identification of available cases, to
4 develop a process for case selection, to develop
5 procedures for the selection of cases, and
6 procedures for the review of cases, if there's time.
7 Those are the tasks that this workgroup is supposed
8 to do, and in parallel with that, develop a task
9 order.

10 MR. GRIFFON: The other thing as far as
11 scheduling a meeting with the working group, we
12 might want to ask Larry when is a good or bad time
13 to be at NIOSH and availability of staff, things
14 like that.

15 DR. ZIEMER: It's always a good time to go
16 to Cincinnati.

17 MR. PRESLEY: Or is Jim going to be able to
18 help us on this?

19 DR. ZIEMER: Well --

20 DR. NETON: I was just checking.

21 DR. ZIEMER: Well, can I ask that you all
22 work that out?

23 DR. ANDRADE: A quick question. Do you want
24 this initial working group to at least brainstorm on
25 case selection criteria as part of their charge?

1 DR. ZIEMER: Yes, that's one of the -- that
2 was a part of it, yes. Didn't I say that? Yes,
3 that is definitely part of it.

4 Now, I'd like now to focus on -- I'm going
5 to focus on the issue of the procurement. We -- we
6 have discussed already two options; one option is to
7 proceed with the procurement under CDC; another
8 option was to have the procurement done through the
9 Department of Labor. Let me ask first if any Board
10 members wish to identify any additional options?

11 (No response.)

12 There appear to be none. Then I propose
13 we'll proceed as follows: Number one, if the Board
14 wishes to proceed with NIOSH/CDC as the procurement
15 agent, then no action has to be taken because that's
16 the track we are currently on. If the Board wishes
17 to utilize the Department of Labor as the mechanism
18 for the procurement, then we will ask for a formal
19 motion to do so. And so the Board -- and so the
20 Chair will now entertain a motion, if anyone wishes
21 to make a motion, to move the procurement to the
22 Department of Labor. Is there anyone who wishes to
23 make such a motion?

24 (No response.)

25 DR. ZIEMER: The Chair hears no such motion.

1 In the absence of a motion, I will declare that we
2 will proceed with the procurement through Centers
3 for Disease Control, and instruct Larry to proceed
4 along that path.

5 And we have some idea of what the timetable
6 is, based on yesterday's discussion.

7 Now, I'd like to ask the working group that
8 prepared the document -- Request for Contract
9 document, if they have any additional changes or
10 modifications that need to be made in the document
11 before we proceed with the procurement? You will
12 recall yesterday Larry indicated that if they are --
13 if we are to proceed right away we need to confirm
14 that this is the document.

15 Mark.

16 MR. GRIFFON: We had -- you probably recall
17 the end of last meeting I had worked with some other
18 folks on some draft amended language for Attachment
19 A, specifically in the Conflict of Interest section
20 there was concerns on the language being too, I
21 guess, too limiting, and we wanted to make sure it
22 was consistent with an evaluation of conflict of
23 interest rather than -- rather than eliminating all
24 possible bidders, so we did redraft an Amendment and
25 I would propose to offer that now for -- to amend

1 Attachment A.

2 DR. ZIEMER: Could you identify specifically
3 the section and part of Attachment A?

4 MR. GRIFFON: It's Attachment A, Section E,
5 Conflict of Interest.

6 DR. ZIEMER: And item number?

7 MR. GRIFFON: The entire section.

8 DR. ZIEMER: Give us a paragraph. This is
9 for the recorder, so --

10 MS. ROESSLER: Paragraph E.

11 DR. ZIEMER: All right. Give us a page
12 number.

13 MS. ROESSLER: Page 9.

14 MR. GRIFFON: It's page 9 --

15 DR. ZIEMER: Page 9.

16 MR. GRIFFON: -- on to page 10, it's Section
17 E.

18 DR. ZIEMER: And the particular paragraph?

19 MR. GRIFFON: It's the entire Section.
20 We've amended the language for the entire Section.
21 Some of it will be similar, but I -- and I have that
22 available if we want to get to it.

23 DR. ZIEMER: I think we need to identify
24 what the change in language would be. Okay. We --
25 we have that on a disk. It will take just a minute

1 to load that, and while that's being loaded, can you
2 describe for the Board the nature of the change in
3 language that is being proposed before we actually
4 see the words?

5 MR. GRIFFON: In a nutshell, I'll try.
6 Basically --

7 DR. ANDERSON: Is it here somewhere?

8 MR. GRIFFON: No, it's -- I've got to get it
9 on disk and give it to you.

10 Basically, we attempted to, rather than have
11 criteria that said -- that looked at, for instance,
12 the potential bidder's work history with DOE, AWE
13 sites and we said that -- I think the language as it
14 exists now says something to the effect that if
15 they've had any work --

16 DR. ZIEMER: In the past two years.

17 MR. GRIFFON: -- in the past two years, then
18 they're excluded from even entering in, you know,
19 it's a black-line sort of criteria, and we rewrote
20 that to say that that work history with DOE, DOE
21 contractors, etcetera will be considered in the
22 evaluation of conflict of interest, but not
23 necessarily an exclusionary statement. I guess that
24 sort of summarizes.

25 DR. ZIEMER: Okay. While the words are

1 being detected and selected, and put up, we can
2 discuss this.

3 DR. MELIUS: On a related issue to how NIOSH
4 is going to manage the contract, and I guess -- I
5 don't think we -- I don't believe we've talked about
6 it before, at least not directly, at least I don't
7 recall, is to how it would be managed within your
8 group, Larry, within OCAS, or is there an
9 alternative for technical or contract oversight
10 within other agencies, other parts of NIOSH, I
11 should say, or other parts of the CDC? And my
12 concern is that -- that there be an issue that comes
13 up where there is conflict between the Board, or --
14 I don't want to say conflict -- disagreement between
15 the Board and you or your staff over what could be
16 done, or how the contract is being handled, or the
17 oversight provided for that. And that that would --
18 that you or your staff would be telling the Board
19 that no, we can't proceed with this task or
20 whatever, or access to records, or something like
21 that, or the process that would -- and you would be
22 telling us no, we would want to go forward, and that
23 would, I think, put you and your staff in a very
24 awkward position. It would be, you know, in
25 appearing to -- appearing to be impeding our review.

1 And I just didn't know if there were alternatives in
2 terms of either technical or contract, or say that
3 it was being from another part of NIOSH or a part of
4 CDC that would help to obviate that issue.

5 MR. ELLIOTT: The only time that anyone
6 would be saying no to this Board in a task order
7 format is when you put something on the table that
8 would be outside the boundaries of the FAR, so
9 outside the procurement requirements. We're going
10 to be, as I said earlier, walking a very fine line
11 here to make sure that we don't influence the
12 Board's direction otherwise, so. Are there other
13 places within CDC, I think there's one CDC
14 Procurement Grants Office, that's where this will go
15 to, you know, so that's where the contracting
16 officer will be. It will -- Martha DiMuzio, as my
17 program analyst, will monitor the expenditures. We
18 have to keep that inside OCAS because that's where
19 the funding -- funding source is, otherwise we have
20 to do some transfer of funds and that becomes
21 somewhat problematic, as you may know; so certainly
22 I don't see any conflict in that regard. I think we
23 will, of course, need to have a -- what's called a
24 technical monitor assigned to this procurement that
25 serves as the contracting officer's technical

1 liaison, if you will, to make sure that what the
2 Board's task orders are as they come forward if
3 there are questions at the contracting officer level
4 that somebody can explain, a technical background.
5 We are fully aware of where we stand in this regard,
6 and, you know, we're going to march accordingly to
7 make sure that we don't appear to be, again,
8 influencing or providing direction to the Board.
9 This is your -- your work and your product; we're
10 just going to serve to facilitate it. That's all I
11 can do to answer your question.

12 DR. ZIEMER: Jim, let me also add to -- to
13 the discussion that ultimately this Board reports to
14 the Secretary of Health and Human Services, and I
15 would suppose that in the unlikely event we had some
16 kind of a major disagreement on some issue that an
17 appeal could be made at a very high level, which
18 would certainly --

19 DR. MELIUS: There are possible situations;
20 for example, review -- more in-depth reviews, about
21 access to records, obtaining records, and so forth
22 that I think could become problematic. I'm not
23 saying that we need an alternative, but I -- I think
24 all those procedures need to be worked out fairly
25 carefully so that we try to avoid conflict or a

1 potential problem in -- in terms of this issue, so
2 we don't put NIOSH in the position of -- or the
3 Board in the position of being in conflict with
4 NIOSH, and you -- you know, Larry, and Larry's staff
5 being seen to hold up or attempting to thwart a
6 quality review. And it may not -- you know, again,
7 I'm not saying it's going to be somebody's fault
8 doing it purposefully, but just giving the
9 appearance of doing that, and -- and I think we need
10 to think about it. Maybe that's something as we get
11 along. I don't think it has to be done now, but as
12 we get along with the task group, the working group
13 ought to be thinking a little bit about it as they
14 outline what the procedures are going to be for you,
15 and is there a potential -- are there potential
16 problems with access and information, what do we do
17 in those instances, and so forth.

18 MR. ELLIOTT: I just can't envision or
19 imagine -- maybe you can help me out here. In your
20 example, where, how would it come about that you
21 would be limited in access to information or
22 records? I mean --

23 DR. MELIUS: Well, if there were long delays
24 in obtaining information, or if there was problems
25 with trying to obtain additional information, which

1 could come up in terms of the more in-depth reviews,
2 so -- because remember, the more in-depth reviews
3 can be some way at looking at how complete and
4 thorough you -- your staff was, or your contract
5 staff was in obtaining information.

6 MR. ELLIOTT: But these are completed dose
7 reconstructions; they are a snapshot in time, so
8 whatever information was used, whatever site profile
9 was available at the time to complete the dose
10 reconstruction should be already in the house, in
11 our hands, and you have immediate access to it.

12 DR. MELIUS: Yes, but we're going to be
13 looking at how adequate that was, was there missing
14 information.

15 MR. ELLIOTT: If we don't have the
16 information, how can we limit your access to it?

17 DR. MELIUS: Well, because we will be
18 looking for additional information that you missed, and
19 there's, I mean -- yeah, yeah, and from DOE. I mean it's
20 not --

21 MR. ELLIOTT: Well.

22 MS. ROESSLER: If you can't get it, you
23 can't get it.

24 MR. ELLIOTT: I don't know how to answer
25 this question because I just can't -- I can't seem

1 to conceptualize the instance --

2 DR. ZIEMER: It doesn't sound like a
3 situation where NIOSH is attempting to thwart the
4 review process.

5 DR. MELIUS: The -- the issue is going to be
6 how the -- the conduit to getting information, for
7 example, from DOE, is going to be the -- NIOSH.
8 We're not going -- the Board is not going directly
9 to DOE for information. And you have the same
10 issue --

11 DR. ZIEMER: Well, you're perhaps
12 identifying something where the Board might be
13 seeking more information from DOE, where in the
14 normal review process we might -- the review might
15 identify that some information is inadequate;
16 whether the review has to actually go out and
17 therefore get that information is -- it seems to me
18 is a separate issue from the review process. The
19 review process is -- is in place to identify, for
20 example, adequacy or inadequacy. If it's
21 inadequate, then that is reported, whether now
22 something has to be reopened and more material, it
23 seems to me now is something other than the review
24 process, but I -- that's how I'm reacting to that.

25 MR. GRIFFON: I mean this is the question

1 that we've thrown around for a while on the Board,
2 but I guess a question of was sufficient effort put
3 forth in the dose reconstruction process to obtain
4 all of the relevant records, and if -- if -- I can
5 see a situation where NIOSH would say well, we knew
6 these other documents existed; we -- we had a
7 general description of them; we deemed them not
8 relevant. And the Board might say well, you know,
9 for whatever reason they feel that they want to look
10 at those documents and make sure that they weren't
11 relevant, just not, you know, inadvertently
12 overlooked, you know, something like that.

13 DR. ZIEMER: I think what I'm saying is it
14 seems to me that if the Board makes that judgment,
15 they can make the judgment saying that we, for
16 example, think these documents should have been
17 obtained. You can make that judgment -- you don't
18 necessarily need those documents to make the
19 judgment because once you get the documents, you can
20 say sure, look, they really were inadequate, or, oh,
21 you were right, they weren't. But the judgment is
22 that you should have had the -- we think you should
23 have had these documents, right. Do we need the
24 documents to make the judgment.

25 MR. GRIFFON: Well, if -- if -- you know, if

1 you get in that situation where they say well, you
2 know, we had a general summary of what those
3 documents were, we believe they wouldn't have been,
4 wouldn't have been relevant and, or significantly
5 affected the outcome of the case, how does an
6 auditor sort of test that, you know, without having
7 the actual documents themselves. That's the
8 question.

9 MR. ELLIOTT: Well, how do we establish the
10 basis of that without seeing the documents ourself?
11 So I don't see us doing that, I think we have to
12 have the documents in order to say they're not
13 relevant.

14 MR. GRIFFON: I'm just -- this is
15 hypothetical.

16 DR. ZIEMER: Yeah, there's a lot of
17 hypotheticals here.

18 MR. ELLIOTT: I don't see -- I don't -- I
19 truly don't see us holding you up. I don't see us
20 interfering; in fact, we're walking this fine line
21 because on the other side of the line is we could
22 use you to our best advantage to pressure DOE, you
23 know, and there becomes in that, in and of itself,
24 another conflict, if you will. I mean we want this
25 information, we want to push DOE to give us this

1 information; we apply pressure as best we can, and
2 we leverage them. And certainly this Board has --
3 has an opportunity to do that for us, okay.

4 DR. ZIEMER: In fact, it would seem to me
5 that if -- if this Board saw a pattern where we felt
6 that there were lack -- there was a lack --
7 consistent lack of adequate documentation that we
8 could in fact go to NIOSH with this information and
9 they could in fact, once we made such a judgment, go
10 back to DOE, for example, and say our Board has told
11 us that we need to get more of whatever it is, so,
12 in fact, could use it as a pressure point for a
13 future date.

14 But I think the point is made, Jim. I think
15 we hear the point and the Subcommittee has, and --

16 DR. MELIUS: Very seriously.

17 DR. ZIEMER: -- and I'm not sure what more
18 we can do on it today except to be alert and to ask
19 that that be considered as we go forward.

20 DR. MELIUS: That's all I was asking.

21 DR. ZIEMER: Right. Thank you.

22 I kind of lost track of where we were. Oh,
23 we have the --

24 DR. MELIUS: Waiting for Mark to get this up
25 on the screen.

1 DR. ZIEMER: We have the language up there,
2 so we want to, for the record indicate the proposed
3 changes in Item E, Conflict of Interest. The first
4 paragraph --

5 MS. ROESSLER: It's not the same.

6 DR. ZIEMER: -- is not the same.

7 MS. ROESSLER: He doesn't have the same
8 document. I thought you were going to put what we
9 have here in front of us and then indicate the
10 changes.

11 MR. GRIFFON: Oh, the last one, oh, no, it's
12 different.

13 MS. ROESSLER: Maybe I'm looking for
14 something different.

15 DR. ZIEMER: Is this a proposed change in
16 the whole Section E?

17 MR. GRIFFON: The whole Section E is -- is
18 revised, yes.

19 MS. ROESSLER: So we need to compare what's
20 up there with what we have in this.

21 MR. GRIFFON: And you'll notice as you read
22 -- I wish -- I should have got printouts of this
23 actually because it's hard to read from the screen.

24 MS. ROESSLER: It is.

25 MR. GRIFFON: I don't know if we -- if

1 that's something we can do fairly quickly, but if
2 you'll -- you will notice similar language as you go
3 through these paragraphs, but things have been moved
4 around, and -- and we grouped -- I grouped something
5 kind of called a Conflict of Interest plan, giving
6 that 10 points, and the Work History, giving that 15
7 points. And there's criteria such as those hard-
8 line criteria are removed, so it's more up to the
9 evaluation panel to consider their work history,
10 rather than an exclusive, you know, hard-line
11 decision.

12 DR. ZIEMER: Okay. Let me ask the Board a
13 question here: Would you like to get some hard copy
14 of this and then have a chance maybe later in the
15 morning or right after lunch to bring this to
16 closure? It's a little hard to work on --

17 MS. ROESSLER: I have a suggestion that
18 might make it faster. I mean what I did was read
19 through what we have here, identified what I thought
20 were the key points, and there are about five of
21 them, and then just evaluated it for what it is.
22 And what I, based on our discussions before, and as
23 far as I'm concerned I've gone through every point
24 and I feel that he's addressed them all according to
25 our recommendations, and well. I only have one

1 question. I don't know if other people would find
2 that efficient or not.

3 DR. ZIEMER: But built into this is a change
4 in the two-year requirement as I understand it,
5 Mark, is that correct?

6 MR. GRIFFON: That's correct.

7 DR. ZIEMER: Mark is proposing that the two-
8 year requirement be dropped in favor of it goes to a
9 nonspecified time period and simply says that that's
10 one of the things that gets --

11 MR. GRIFFON: Right. For instance, that one
12 paragraph says greater emphasis will be placed on
13 work experience within the past two years. But it
14 doesn't exclude a bidder if they've worked DOE, AWE,
15 etcetera, etcetera in the past two years, so.

16 DR. MELIUS: Can we get a -- for now, I
17 think it's a lot easier.

18 MR. GRIFFON: I think it would be easier.

19 DR. ZIEMER: Yeah. We'll ask if we -- if we
20 can get the printout so we each have it sort of side
21 by side, that will be helpful. And we'll take care
22 of some of other business in the meantime, and then
23 return to this. Is that agreeable?

24 MS. ROESSLER: Yeah. So Mark, you --

25 DR. ZIEMER: And we have an issue of whether

1 we can get a printer here.

2 MS. HOMER: I'll have to take it to the
3 front office and see if I can find somebody that has
4 this on their computer. They don't have a business
5 center at the hotel, so.

6 DR. ZIEMER: Is there a Kinko's close by?

7 MS. HOMER: There is something close by.

8 MS. MUNN: But we don't have an interim
9 edited form that shows strikings and moves and.

10 DR. ANDERSON: Well, this is all different.

11 MR. GRIFFON: It was -- see, it was totally
12 removed, so to redline, strikeout, it didn't make
13 sense the way the changes are made, yeah.

14 DR. NETON: It looks like it's only about
15 page 1 on here.

16 MR. GRIFFON: Well, I would actually say --
17 and now I'm going to -- I remember this. The
18 Attachment A, if you go to the very top, Jim,
19 there's a couple of other changes. These were taken
20 from Section -- removed from Section E and put as
21 overriding factors. And because these are hard-
22 line, I believe these were hard-line criteria that
23 could not be, you know, you can't evaluate a bidder
24 on -- these are basically, if you meet one of these
25 you cannot bid, so I pulled those up front because

1 it sort of doesn't make sense to -- to give points
2 -- they're not even allowed to go through the
3 process is what this is saying, so those were pulled
4 up front out of Section E. I think the language
5 remained more or less the same as it was in the
6 original draft.

7 DR. ZIEMER: Well, wait a minute.

8 Section E --

9 DR. ANDERSON: Of Attachment A.

10 MR. GRIFFON: Of Attachment A.

11 DR. ZIEMER: Of Attachment A, okay.

12 MR. GRIFFON: So I think a printout would be
13 helpful --

14 DR. ZIEMER: Yeah. We --

15 MR. GRIFFON: -- of the whole thing.

16 DR. ZIEMER: -- we do need to do that.

17 Let's -- and that may be -- well, originally my
18 thought was that we could kind plow along and maybe
19 even have a late lunch and finish up our business,
20 but maybe that -- we'll see what we can do to get
21 this printed up. In the meantime, let's try to take
22 care of some other issues.

23 MR. GRIFFON: It's on that disk.

24 MS. ROESSLER: We need two Coris.

25 MR. ELLIOTT: Well, I'll fill in for in for

1 Cori while she's running this down.

2 MS. HOMER: Well, what we could do, is I
3 could do housekeeping, and then run this down and
4 get it printed and everybody break for lunch while I
5 do that.

6 DR. ZIEMER: One possibility, and I had
7 earlier given members of the public a heads-up that
8 we might want to move that Public Comment Period up.
9 Could I ask if there are members of the public who
10 did wish to address the Board, and who are here, and
11 willing to that at this time. Are there any members
12 of the public who were planning to address the
13 public this afternoon -- or to address the Board
14 this afternoon?

15 MS. HOMER: Nobody's signed up.

16 UNIDENTIFIED SPEAKER: Nobody's signed up.

17 DR. ZIEMER: Nobody's signed up to address
18 the Board. Okay. Is there anyone here who is
19 wanting to do that at 2:45, and insists on waiting
20 until then?

21 (No response.)

22 DR. ZIEMER: Okay. Just as an informational
23 item, Robert Presley.

24 MR. PRESLEY: I was asked to bring this in
25 front of the Board. The Department of Labor has put

1 out a booklet/pamphlet called Frequently Asked
2 Questions, and it's been passed out in Los Alamos,
3 and Oak Ridge that I know of. And I have had two
4 individuals come to me and say that it's causing
5 some problems. The problems are: When the
6 individual goes to the doctor and says that I have a
7 problem, I need my bills paid under workmans' comp,
8 the doctor immediately says oh, have you filed a --
9 under the --

10 MS. MUNN: EEOICPA.

11 MR. PRESLEY: Yeah. OWA -- I'm sorry. The
12 sick-worker bill, and if their answer is yes, then
13 workmans' comp doesn't cover this, you need to go to
14 the sick-worker bill. So they turn around then and
15 get on the phone and call the 1-800 number and try
16 to get paid, try to get what they have to do to set
17 up appointments, and they say no, you have to go
18 back through workmans' comp. So apparently all this
19 is, is causing more confusion and consternation than
20 it is doing good. And I don't know what to do about
21 it, but I was asked to bring this in front of the
22 Board as a problem.

23 And I think Mark has had, or heard some of
24 the same problems that I have, so it's not -- it's
25 not just a one -- you know, one person having

1 problems with it.

2 DR. ZIEMER: Is this a Department of Labor
3 publication?

4 MR. PRESLEY: Yes, it is. It's from the
5 Department of Labor.

6 DR. ZIEMER: Well, first, this Board is not
7 currently in the business of advising the Department
8 of Labor.

9 MR. PRESLEY: That's exactly right.

10 DR. ZIEMER: Now, there are -- is there a
11 Labor representative still here that we can refer
12 this to and --

13 UNIDENTIFIED SPEAKER: I can carry that back
14 and see if we can resolve it.

15 MR. PRESLEY: That was all I was asked to do
16 was to bring it in front of the Board.

17 THE COURT REPORTER: Can I have your name,
18 sir?

19 MR. COUCH: Yeah, my name is Jeff Couch with
20 the Department of Labor. I'll certainly take that
21 back and pass that word along.

22 DR. ZIEMER: Thank you. We appreciate that.

23 DR. NETON: I'd like to just ask one
24 question, if I could. Bob, was that -- was the
25 person seeking medical treatment for cancer, or was

1 it a non-cancer related illness, do you know?

2 MR. PRESLEY: To my knowledge, it was
3 cancer.

4 DR. NETON: Okay.

5 MR. ELLIOTT: Do you know if this is being
6 handled out at the Resource Centers, is that the
7 source of this document? I mean maybe Jeff knows
8 this question.

9 MR. PRESLEY: I picked this one up when we
10 up to Los Alamos the day after our meeting in Santa
11 Fe. They were having a -- Labor was having a
12 conference up there or some type of a conference and
13 I picked my copy up up there at a conference. It
14 was being handed out, and then the one that came to
15 me through the mail was just a Xerox copy from --
16 from an individual, so I presume -- I really don't
17 know where it's been handed out, but it's been
18 passed around.

19 MR. COUCH: I think that is a product of,
20 you know, that comes out of one of our groups at the
21 National Office.

22 DR. ZIEMER: Okay. Thank you. Your issue
23 has been, in a sense, referred to the Department of
24 Labor for resolution.

25 Let's move on to the Board work schedule.

1 The first question is: Do we have any updated
2 information on the Special Exposure Cohort proposed
3 ruling?

4 MR. KATZ: Hi, so this is Ted Katz.

5 DR. ZIEMER: Walk us through where we're at.
6 Ted Katz of Centers for Disease Control.

7 MR. KATZ: People are working furiously to
8 try to get the NPRM published. And based on that,
9 there's a -- you know, there's a reasonable chance
10 we could -- we could have this meeting on either the
11 27th and 28th of February -- yeah, it's a -- those
12 are narrow windows here because there are other
13 conflicts too. Another possibility is a one-day
14 meeting, which would just focus, I guess, entirely
15 on this Rule, but March 3rd or March 7th are open,
16 too. Those would be on the front end of the comment
17 period, which is, I think, what you would prefer if,
18 you know, if it all works out well, and this gets
19 posted.

20 DR. ZIEMER: Without committing to any
21 specific date, is there a, sort of a expected window
22 when this is going to come out?

23 MR. KATZ: Well, there's -- I mean we're
24 hoping to be able to get it published by the 24th of
25 February. Again, it's still in review, so we could

1 fail that, but that's what we're shooting for.

2 DR. ZIEMER: Well, let me ask it in a
3 different way. Is it likely to be out before then?

4 MR. KATZ: Well, again, there's no
5 statistics to apply to this, but -- but, yes,
6 everybody's -- everybody's working very hard to make
7 this happen.

8 DR. ZIEMER: There is a long shot then.

9 MR. KATZ: It's -- so it's not, I wouldn't
10 say it's a long shot, but --

11 DR. ANDERSON: But I wouldn't bet on it.

12 MR. KATZ: -- but that's what we're -- no,
13 no, that's -- I mean that's what we're shooting for
14 is all I can tell you really. It's not going to go
15 that far.

16 DR. MELIUS: If they're shooting for
17 February 24th, and given -- I mean I would hate to
18 set up a meeting for the end of that week, assuming
19 it would be out. It seems to me that the 7th is --
20 that may -- I'm not sure how the availability is,
21 but that would be more reasonable and would be
22 within the 30-day comment period.

23 MR. KATZ: The 24th is giving us a little
24 bit of a safety margin, so --

25 DR. MELIUS: Three days of safety margin.

1 MR. KATZ: No, no, no. I'm saying it could
2 get published before the 24th, but that's got a
3 little bit of a safety margin in it already. Again,
4 there's problems with availability is why I'm giving
5 you these dates. There's -- the following week, the
6 week of the 13th is out because I believe Larry is
7 out of pocket that week.

8 MS. ROESSLER: What month are we in?

9 DR. ZIEMER: March.

10 MR. KATZ: March. The week of March 13th.

11 MS. ROESSLER: There's no week of March --

12 MR. ELLIOTT: March 10th.

13 MR. KATZ: March 13th is in the middle of
14 the week. Sorry.

15 MS. ROESSLER: The week in which March 13th
16 occurs.

17 DR. ZIEMER: Well, as a starter, let's
18 identify -- it seems to me it's unlikely that we're
19 going to want to meet in February again; here we are
20 into the first week in February.

21 MS. ROESSLER: Oh, but it's so much fun.

22 MR. ESPINOSA: Are we looking at just a
23 one-day meeting?

24 MS. MUNN: Maybe two. It depends on what
25 we get.

1 MR. PRESLEY: What I would propose, if we
2 can come in here on the 5th through the 6th, the
3 working committee could come in a couple of days
4 early. Would y'all want to meet in Cincinnati?

5 MR. ELLIOTT: We would want to do this in
6 Cincinnati or in D.C.

7 MR. PRESLEY: If we did it in Cincinnati the
8 working group could come on in early and we could --
9 we could -- if everybody is available that week.

10 DR. ZIEMER: Well, it's a possibility,
11 just --

12 DR. MELIUS: One thought I had was, and it
13 may help with some of this flexibility is that the
14 Chair appoint a working group to prepare some draft
15 comments on the SEC regs, you know, contingent on
16 timing and so forth, so --

17 DR. ZIEMER: And bring that to the Board,
18 and then --

19 DR. MELIUS: Bring that to the Board, so,
20 you know, that would, I think, be more practical to
21 do the review and prepare our remarks within the
22 one-day, you know, time limit, and so forth and not
23 have to extend it over two days. I think it would
24 help the process anyway. I think we can get better
25 closure when we're there in person, rather than

1 doing it as follow-up conference calls later.

2 DR. ZIEMER: Other comments?

3 (No response.)

4 DR. ZIEMER: We can certainly do that, but
5 let's see what availability of dates are. Let me
6 begin in March. The week of March 3rd, who has
7 conflicts besides the Chair?

8 MS. MUNN: I have a Tuesday conflict, but I
9 could, if we had to.

10 DR. ZIEMER: I'm out of the loop Monday
11 through Thursday, so I could meet on Friday.

12 MR. DeHART: I can meet on Friday.

13 DR. ANDERSON: Friday is okay.

14 DR. ZIEMER: The 7th is available? Okay.
15 That's an available date. Let's look at the next
16 week.

17 DR. ANDERSON: Are you saying no, Gen?

18 MS. ROESSLER: It's kind of difficult, but I
19 could do it.

20 DR. ZIEMER: Okay. One possible.

21 MS. ROESSLER: I might have to quit my
22 regular job.

23 DR. ZIEMER: Minor details.

24 MR. GRIFFON: Are we -- have we excluded
25 February 27th and 28th?

1 MS. ROESSLER: No.

2 DR. ZIEMER: Well --

3 MR. GRIFFON: Those dates are actually
4 better for me.

5 MR. ESPINOSA: Yeah.

6 MS. MUNN: Yeah, they're good for me.

7 MS. ROESSLER: I can't make it that week.

8 MR. DeHART: I can't either.

9 DR. ANDERSON: I can't either.

10 DR. ZIEMER: I guess we've excluded. Okay.
11 The week of March 10th, any bad dates there?

12 MR. ELLIOTT: I can't do it.

13 MR. GRIFFON: I can't do it.

14 DR. ZIEMER: The whole week is out.

15 MR. ELLIOTT: I need a vacation.

16 DR. ZIEMER: The week of March 17th. The
17 week of March 17th, who has got conflicts the week
18 of March 17th?

19 MS. MUNN: Monday, Tuesday's okay, Thursday,
20 Friday's okay.

21 DR. ANDERSON: Friday's out.

22 DR. ZIEMER: Bad days. Okay. The 21st is
23 out. Others?

24 DR. MELIUS: The 20th is out.

25 DR. ZIEMER: The 20th is out.

1 MR. ELLIOTT: Now you're at the last week of
2 Public Comment Period.

3 MS. ROESSLER: 17 and 18, is that available?

4 DR. ZIEMER: We're at the last of the Public
5 Comment Period if, in fact, it is out in time.

6 MS. ROESSLER: 17 and 18 possible? No.

7 DR. ZIEMER: Okay. Do you want to settle on
8 a specific one of these dates? Are we talking about
9 one day then?

10 MR. PRESLEY: I would think.

11 DR. ZIEMER: One day in Cincinnati.

12 MS. ROESSLER: How about if the working
13 group gets together the 17th and/or the 18th, and
14 then the Board meets on the 19th for just a one-day
15 meeting if we do what Jim suggested about having
16 another group do a preliminary on it?

17 MR. GRIFFON: The only concern I would have
18 is if there is significant changes to the SEC rules,
19 which I imagine there are, we don't leave ourselves
20 any follow-up time; we're right at the end of the 30
21 days.

22 MS. ROESSLER: Yeah, that's nervous.

23 DR. ZIEMER: Which then pushes us back to
24 approximately the 7th.

25 DR. MELIUS: What about the working group on

1 Thursday?

2 MR. GRIFFON: I'm not sure I can.

3 MS. ROESSLER: I'll just have to make it
4 work.

5 MR. GRIFFON: Yeah, the working group -- I
6 mean I would like to link it so that the working
7 group could go up maybe Thursday, or Wednesday and
8 Thursday, you know, or at least -- at least
9 Thursday.

10 MR. DeHART: Okay.

11 MR. ESPINOSA: That week is a little bit
12 rough, but if we can pinpoint it to where I know in
13 advance. I mean is it going to be two days for the
14 working group and then a day with the Advisory
15 Board?

16 MR. GRIFFON: I would say just Thursday.

17 MR. ESPINOSA: Just Thursday?

18 MR. GRIFFON: Yeah.

19 MR. ESPINOSA: Because you've got to
20 consider a day of travel going to, and that kind of
21 throws me off if we're going to go the Wednesday and
22 Thursday.

23 MR. GRIFFON: I'm just a little nervous
24 about just giving ourselves one day. We have a
25 pretty large scope of work for the working group

1 also, and --

2 DR. ZIEMER: Well, and also keep in mind
3 that we also still have a meeting in April
4 scheduled, and --

5 MR. GRIFFON: Yeah, there's more
6 opportunities to go back to Cincinnati.

7 DR. ZIEMER: I don't think when we charged
8 the working group we were anticipating you would
9 only have a couple of weeks to get together, so you
10 could give us a status report, but not have
11 necessarily completed everything.

12 Okay. We appear to have reached agreement
13 that we are going to set aside March 7th, one-day
14 meeting, Cincinnati, to deal with the Special
15 Exposure Cohort. This is contingent on the
16 publication in the *Federal Register* actually having
17 occurred.

18 And Cori, I assume in Cincinnati it will be
19 a situation where if we need to cancel you will need
20 to -- well, you're --

21 WRITER/EDITOR: We can't hear you.

22 DR. ZIEMER: I was just wondering, if -- if
23 she goes ahead and blocks off hotels and then it
24 turns out the document is not available, how readily
25 she can cancel, maybe not any easier in Cincinnati

1 than anywhere else. The same problems arise;
2 penalties, and so on, at hotels. We'll have to deal
3 with it.

4 Okay. I guess we've agreed on that.

5 DR. ANDERSON: Just --

6 DR. ZIEMER: Henry.

7 DR. ANDERSON: I mean will we have some
8 advance warning of an actually firm publication
9 date? I mean isn't there two weeks to get it into
10 the *Federal Register* or something?

11 MR. KATZ: No, it actually just takes a
12 couple of days once it's cleared by the Secretary,
13 so.

14 DR. ANDERSON: Okay.

15 MR. KATZ: But we'll give you whatever
16 advance notice we can.

17 DR. ANDERSON: Yeah, I was looking for, you
18 know, as far as scheduling and finalizing the
19 meeting. You're going to have to get it -- our
20 meeting has to be notified sufficiently in advance,
21 so we may have to put the meeting in the *Federal*
22 *Register* before we know that we're even going to
23 have a meeting, and canceling the *Federal Register*
24 meeting becomes --

25 DR. ZIEMER: Now, it's been suggested that

1 we also have a working group to do some advance work
2 on preparation of comments prior to the meeting.
3 Let me ask -- that was the suggestion, let me ask if
4 there is any sort of consensus amongst Board members
5 that you want to have a working group do that.
6 There seems to be a consensus.

7 DR. MELIUS: I think it would just be
8 helpful to have -- somebody have some language
9 ready. We have our prior comments.

10 DR. ZIEMER: Yeah, right.

11 DR. MELIUS: We'll see what changes there
12 are --

13 DR. ZIEMER: I'm going to ask --

14 DR. MELIUS: -- and stuff like that.

15 DR. ZIEMER: -- I'm going to ask -- the
16 Chair will ask for volunteers to be on the
17 workgroup, a minimum of three people. Jim, Mike,
18 okay. I will be the third person and the three of
19 us will try to work out -- so this will be a
20 workgroup to draft some language for the Committee
21 as possible comments on the *Federal Register* notes.

22 Let me ask, does that workgroup also wish to
23 come in to Cincinnati a day ahead, or we might be
24 able to do this by e-mail or phone.

25 DR. MELIUS: By e-mail.

1 DR. ZIEMER: E-mail and phone, okay.

2 Comment?

3 MR. ELLIOTT: Ted, help me here. I think we
4 can help this working group of the Board by giving
5 them a cross-look analysis of what changes were
6 made.

7 DR. ZIEMER: That would be very helpful.

8 MR. KATZ: Yeah, I was just assuming I would
9 attend that working group. How about that?

10 DR. ZIEMER: And Ted, that might be a
11 teleconference sort of thing. We'll get the
12 documents and we can talk. Thank you.

13 DR. MELIUS: Or you can come visit one of
14 us.

15 DR. ZIEMER: Mark.

16 MR. GRIFFON: Just a point for clarification
17 that the dose reconstruction working group plans on
18 meeting on the 6th, one day ahead of that meeting in
19 Cincinnati, March 6th, so we plan on working that
20 day on our tasks.

21 DR. ZIEMER: Agreed. Thank you.

22 Comment?

23 MR. NAMON: I was just going to add that it
24 was our hope that we would have one of your
25 attorneys for the dose working group, but on the 6th

1 we will not be able to do so, but we will certainly
2 be available for other occasions to make sure that
3 especially the privacy angles are covered.

4 DR. ZIEMER: Yeah, and at this point they're
5 still going to be dealing just with procedures and
6 so on, not -- not working on dose reconstructions
7 per se.

8 MR. GRIFFON: I should ask though, Jim Neton
9 if he could have any staff available?

10 DR. NETON: I should be able to.

11 DR. ANDERSON: Paul, do we have a drop-dead
12 date and a fall-back? Do we want to look at the
13 week of the 17th for a fall-back? I mean let's say
14 the 24th isn't met, and instead it's planned to come
15 out on the 5th, and so now we've got two days, you
16 know, and what -- what kind of lead time does one on
17 the workgroup to be able to read -- I guess I don't
18 us to have a one-day meeting and have those of us
19 who were out the previous week not have any chance
20 to take a look at it, so, you know, I just don't
21 want us to all get together and now we'll have
22 another gripe session about how here we are again
23 without insufficient time, so we probably now ought
24 to plan our strategy that if it doesn't come out --

25 DR. ZIEMER: What is Plan B?

1 DR. ANDERSON: Yeah, what's Plan B, if it
2 isn't on the 24th, do we then go to the fall-back
3 period? It's too bad if we have to cancel rooms and
4 there's a cost, but to have a meeting with
5 insufficient time, you know, and not waste our time
6 too.

7 DR. ZIEMER: Good point. Jim, you have a
8 comment?

9 DR. MELIUS: Yeah, I was going to say the
10 contingency may be a little bit more complicated,
11 but I think we pick one day because it's going to
12 depend on when it comes out, and --

13 DR. ANDERSON: Yeah.

14 DR. MELIUS: -- that we pick one day that
15 could either be an alternative meeting day, or an
16 alternative date for a conference call if we, you
17 know, can prepare preliminary comments we need to
18 finish at the 7th, but, you know, we're able to
19 finish them up later or whatever, so.

20 DR. ZIEMER: Good suggestion.

21 DR. ANDERSON: I mean what we -- we don't
22 know how --

23 DR. ZIEMER: There has to be a reason.

24 DR. ANDERSON: -- how extensive the changes
25 are and then how -- how much conversation and

1 concern will be raised by those changes. If there's
2 changes that basically reflect our advice on the
3 first set, we shouldn't have as much of a problem
4 with doing it.

5 DR. ZIEMER: How about if we pick a time, a
6 day in the week of the 17th, that could either be
7 used for a full meeting, if needed, or for a
8 conference call meeting.

9 DR. ANDERSON: Yeah.

10 DR. ZIEMER: What were the conflicts that
11 week?

12 DR. ANDERSON: Just Friday, I think.

13 DR. MELIUS: I have a conflict on Thursday.

14 DR. ZIEMER: 20th and 21st were out; 17th,
15 18th, or 19th, that's Monday, Tuesday, or Wednesday.
16 Any preferences?

17 MR. GRIFFON: Well, how about the 18th, if
18 that's possible for people cause then we could have
19 the working group --

20 DR. ZIEMER: Because then you still --

21 MR. GRIFFON: -- meet on the 17th, if --

22 DR. ZIEMER: -- have your working group.

23 MR. GRIFFON: -- that's a good day for the
24 working group, as well.

25 DR. ZIEMER: So we'll mark -- is that

1 agreeable with everybody? We'll mark as Plan B, the
2 fall-back date would be March 18th with the working
3 group meeting on the 17th, or the Dose
4 Reconstruction Review Workgroup.

5 Okay. Thank you.

6 Let me ask, Cori, do we have other
7 housekeeping items?

8 MS. HOMER: Just a couple.

9 DR. ZIEMER: Yes.

10 MS. HOMER: If you want to turn to the last
11 page of your Minutes where the action items are
12 listed. There were four listed; bullet one and
13 bullet three were actually taken care of today:
14 Providing the Board with a list of sites lagging in
15 responding to records requests and a breakdown of
16 reasons why; and, an update on implementation of the
17 conflict of interest policies was requested. And I
18 believe both of those have been handled during this
19 meeting. The last one was just a projected meeting
20 dates and we've already taken care of that.

21 Just as an update, I have not signed a
22 contract, but have pending dates in Oak Ridge for
23 April 28th and 29th, and will get back with you as
24 soon as possible as soon as those dates are
25 confirmed with the hotel.

1 MR. ELLIOTT: What the Board needs to decide
2 is, you know, are those -- do they want to meet
3 again on those dates, I think.

4 MS. HOMER: Okay.

5 MR. ELLIOTT: And now is the time to figure
6 out if, you know, if you're going to meet in April
7 and, you know, what do you -- I mean we talked about
8 some IREP scientific issues that we might be able to
9 explore a little bit, but what would your agenda
10 look like, I guess.

11 DR. ZIEMER: Well, particularly if we meet
12 in March on the Special Exposure Cohort.

13 DR. MELIUS: I was --

14 DR. ZIEMER: Well, the other -- the other
15 thing that we would be far along on the -- on this
16 issue and so I guess it would be the review
17 procedures issues, task order, and the selection.

18 DR. MELIUS: I don't know if, on some of
19 those IREP scientific issues, whether it will be
20 timely to -- if that will give you enough time to
21 prepare one of those or something.

22 MR. ELLIOTT: I think the end of April.

23 DR. ZIEMER: Yeah, this is basically the end
24 of April.

25 MR. ELLIOTT: I think HERB could be ready,

1 that's the research branch at NIOSH, and I think
2 they can be ready by April to give you a
3 presentation on the status of DOE workforce studies.

4 DR. MELIUS: Maybe start on the smoking
5 thing or something, I don't know, just see where
6 you, how it would work out.

7 DR. ZIEMER: Okay.

8 MS. MUNN: I guess I need to whine and carry
9 on a little bit about that April date. At the time
10 we were talking about them I did not realize that I
11 would be in China for the preceding two weeks,
12 and --

13 DR. ZIEMER: This is prior to the Oak Ridge?

14 MS. MUNN: Prior to the Oak Ridge meeting,
15 yeah. The earliest date I could be back from China
16 would be Sunday, the 27th, and probably Monday, the
17 28th, which means I have a choice of stopping on the
18 West Coast and changing my clothes, or just
19 continuing to fly to the East Coast. And I'm not at
20 all sure whether I'd be awake at all while we were
21 here. If there's --

22 DR. ANDERSON: We can handle the medication
23 side.

24 MS. MUNN: Thanks. Thanks a lot. Yeah, I
25 appreciate that part. Do I get go-pills or no-go-

1 pills?

2 DR. ANDERSON: I've got some military
3 contacts.

4 MS. MUNN: Yeah, yeah, if the Air Force can
5 do it, then I can do it. I guess the -- the 1st and
6 2nd would be so much better for me if it's at all
7 possible to do that.

8 DR. ZIEMER: Well, the 1st and 2nd were the
9 alternative dates.

10 MS. MUNN: Okay.

11 DR. ZIEMER: In the meanwhile, Cori, did you
12 already check, are we locked into April?

13 MS. HOMER: We are not locked in.

14 DR. ZIEMER: Are the other two dates
15 available, or?

16 MS. HOMER: Those are the only two dates
17 available at the hotel in Oak Ridge; Knoxville, I'm
18 still searching.

19 DR. ZIEMER: I certainly don't object to
20 waiting till Thursday and Friday. We can still go
21 into Oak Ridge, right, without having -- we don't
22 need to stay in an Oak Ridge hotel necessarily.

23 MR. DeHART: I won't be able to be there on
24 the 1st and 2nd.

25 MS. MUNN: Roy.

1 DR. ZIEMER: Was there a reason we excluded
2 the 30th? For example, suppose it was the 29th and
3 30th, or the 30th and the 1st.

4 MS. MUNN: The 30th and 1st I could do.

5 DR. ZIEMER: Did somebody have a conflict?

6 DR. MELIUS: I have a conflict on the 30th.

7 DR. ZIEMER: That was the problem. Well,
8 the other thing is recognizing we were trying to
9 keep this sort of early in May because there was a
10 big gap between this meeting and then, but we have
11 another meeting in between, so we could go later in
12 May if we needed to. There would be no reason we
13 couldn't do that. It might even be nicer in Oak
14 Ridge.

15 What is your pleasure?

16 MS. MUNN: The following week is --

17 DR. ZIEMER: I see no urgency to meet early
18 May if we have another meeting next month anyway.

19 MS. MUNN: The following week is good for
20 me.

21 DR. ZIEMER: How is the following week?

22 And we're not locked in, you said?

23 MS. HOMER: No, we're not.

24 DR. ZIEMER: How is the week of May 5th?

25 MR. DeHART: I'm out.

1 DR. ZIEMER: Out all week?

2 MR. DeHART: Yeah.

3 MR. ESPINOSA: Are you out the whole month,
4 or?

5 MR. DeHART: What?

6 MR. ESPINOSA: You were saying something
7 about being out a whole month.

8 MR. DeHART: No. That was April. I'll be
9 in China with her. Keep it quiet.

10 DR. MELIUS: We'll meet there.

11 MS. MUNN: Yeah, okay. Fine.

12 DR. MELIUS: Larry won't invite us to the
13 beach, maybe you two could invite us to China.

14 DR. ZIEMER: How about the week -- how is
15 the week of the 12th?

16 MR. ELLIOTT: I can't do that.

17 DR. ANDERSON: Okay.

18 MR. GRIFFON: I think the only -- I was
19 going to say the only thing I'm a little concerned
20 about is if we start moving too far back, if we get
21 this -- which we hope we will get this contract out,
22 the clock, if I remember right, is 120 days, and
23 that will be like June -- mid June, and I'd like to
24 have these task orders like ready to go.

25 DR. ZIEMER: Yeah, ready to go.

1 MR. GRIFFON: Right, so just keep that in
2 mind.

3 MS. MUNN: So you said you couldn't make the
4 1st. Could you make the 2nd?

5 MR. DeHART: No.

6 MS. MUNN: You're out the 1st and 2nd.
7 Okay. You can have your choice; you can have me, or
8 you can have Roy. Take a toss up.

9 DR. ZIEMER: This is a tough one. How many
10 favor Roy?

11 (Laughter.)

12 MS. MUNN: All in favor of Roy, all in favor
13 of Wanda?

14 DR. ANDERSON: A sleepy Wanda, or an absent
15 Roy.

16 DR. ZIEMER: Yeah, I don't like to look at
17 it that way?

18 MS. ROESSLER: What was wrong with the week
19 of the 5th, again?

20 DR. ZIEMER: That was out for --

21 MS. ROESSLER: Who?

22 DR. ZIEMER: Roy. And the week of the 12th
23 is out for Larry. And is the week of the 19th
24 actually too late you think, Mark?

25 DR. ANDERSON: We've already marked that as

1 a follow-up. That was a --

2 DR. ZIEMER: May.

3 MR. ELLIOTT: Yeah, we did. We already
4 marked that as May 19th and 20th was also
5 acceptable.

6 DR. ANDERSON: But that was for conference
7 calls.

8 DR. ZIEMER: No, that was the regular
9 meeting time.

10 MS. MUNN: That was a regular meeting, yeah.

11 DR. MELIUS: February 19th was the
12 conference call.

13 DR. ANDERSON: Okay.

14 DR. ZIEMER: I'm wondering, are we still
15 okay, I hate to meet with people having to be
16 absent.

17 MS. MUNN: Yeah, I do too. The 19th and
18 20th is fine for me.

19 DR. ZIEMER: Any objection to May 19th and
20 20th?

21 DR. ANDERSON: Where would it be?

22 DR. ZIEMER: Oak Ridge, I think.

23 MR. PRESLEY: Oak Ridge.

24 DR. ANDERSON: Because I have to be in
25 San Diego on the 21st.

1 MS. MUNN: That's easy. Easy. It's a long
2 day, and you're going to a major hub. Don't worry
3 about it.

4 DR. ANDERSON: Well, I just need to get out
5 on the afternoon of the 20th, so if we end on the
6 20th at noon, I'm okay.

7 MS. MUNN: Yeah, you're going West, just
8 stay up all night.

9 DR. ANDERSON: Thanks a lot.

10 DR. ZIEMER: Okay. It appears that we have
11 consensus for May 19th and 20th for our Oak Ridge
12 meeting, as opposed to the May 1st. That's only a
13 two-week delay, so maybe we'll be okay.

14 Thank you. Any other housekeeping items
15 then, Cori?

16 MS. HOMER: Just provide Larry with your
17 written outside hours if you've worked on a working
18 group, or prep time. Please be as specific as
19 possible, so that I can submit the request
20 accurately.

21 One other thing, because I haven't requested
22 this in a while. Take a look at the roster and
23 check your information; make sure it's all correct,
24 and if I need to update it, please let me know as
25 soon as possible.

1 DR. ZIEMER: Now, the only task we have left
2 to do is to address the proposed changes in Section
3 -- or Attachment A, and it's going to be a little
4 while before the -- the computers or printers here
5 has a virus I understand and they actually had to
6 send this out. I was hoping we could simply work
7 through and finish before lunch, but it looks like
8 we'll take a lunch break, and deal with that
9 immediately after lunch.

10 MR. GRIFFON: I can scroll through it.

11 DR. ZIEMER: I'll leave it up to the group,
12 but --

13 MS. ROESSLER: I'd like a printed copy if we
14 can get it.

15 MS. MUNN: It makes it a lot easier.

16 DR. ZIEMER: We all have to eat lunch
17 anyway, so.

18 MS. MUNN: Yeah.

19 DR. ZIEMER: Let's do that and take a break.
20 Let's try to be back here as close to 1:00 as we
21 can; if you're here by 1:00 we'll start, and finish
22 up -- certainly finish up before 2:00 o'clock, maybe
23 sooner.

24 (Whereupon, a luncheon recess was taken.)

25 BY DR. ZIEMER: (Resuming)

1 I'm going to ask Robert Presley to quickly
2 determine the level of interest for the Oak Ridge
3 meeting in a tour of ORNL and K-25.

4 MR. PRESLEY: Would anybody be interested in
5 taking -- when we go to Oak Ridge, taking a two-,
6 two-and-a-half-hour tour of the second -- the last
7 half of the second day? And what we will do is get
8 permission to go over to ORNL; drive through; talk a
9 little bit about what went on; and Larry's mentioned
10 going to the graphite reactor; we're going to get
11 permission to do that; go to K-25; drive through;
12 let you see the buildings; talk about what went on
13 at K-25; come back over to Y-12; go up on the Ridge,
14 the Overlook at Y-12; and talk about what went on in
15 some of the buildings at Y-12. That's -- you're
16 talking about two, two-and-a-half hours.

17 DR. ZIEMER: Can we see a level of interest?
18 How many would want to do that if we can arrange it?

19 BOARD MEMBERS: (Board Members raise hands.)

20 MS. MUNN: I guess that sounds like a few.

21 MS. ROESSLER: In the audience, too.

22 MR. PRESLEY: The public, sorry, it will
23 only be Board members.

24 MS. DiMUZIO: Staff also?

25

1 MR. PRESLEY: Staff -- yes, staff can go.

2 DR. ZIEMER: Okay.

3 MR. PRESLEY: All right. We're talking
4 about 20 people, so we'll need a bus to hold 20
5 people.

6 MS. MUNN: Yeah, we're talking about a
7 little bus.

8 MR. PRESLEY: I'll try to set that up.

9 DR. ZIEMER: Now, the item we have before us
10 is Attachment A. And Mark and the working group met
11 during the lunch hour to give us some level of
12 assurance that the working group has agreed to the
13 changes. And Mark will lead us through these items
14 and show us where there's no change. As an example,
15 the first three items appear in the current
16 contract, or the current Attachment A, but he's
17 moved them from other locations. So lead us through
18 and show us what the changes are, and I would say
19 most of the document, there's no wording changes
20 either, but we have some that are perhaps critical
21 here, so Mark, take us through very quickly,
22 starting at the beginning there.

23 MR. GRIFFON: I can say that I'll go through
24 the new document and then we get to Section E, I've
25 opened the old document up and I've numbered the

1 paragraphs there and I can show you where we kind of
2 cut and pasted because things got moved around; a
3 lot of the language is very similar, but things got
4 moved around and it would be hard to do a side-by-
5 side, so I'll take you through Section E separately.
6 But first, looking at the overall document, like
7 Paul said, the first three items were moved to the
8 front end and it's both the areas where points are
9 assigned, you'll notice, and that was because these
10 are more or less hard-line criteria; if they don't
11 meet these prerequisites, if the bidders don't meet
12 these prerequisites, they can't bid on this
13 contract, so we thought they needed to be pulled out
14 of the point system and into the front part of the
15 document. So this is the one that's been handed
16 out, Wanda, is that -- is everyone looking at the
17 one that just got handed around? Okay.

18 Section A, if you --

19 DR. ZIEMER: Just as a matter of interest,
20 the first item in the old contract --

21 MR. GRIFFON: Well, I was going to --

22 DR. ZIEMER: Okay.

23 MR. GRIFFON: I'm going to do that later,
24 let's step through the whole document first, then
25 I'll go back to that, yeah.

1 DR. NETON: Excuse me, one second. What
2 file was that on here?

3 MR. GRIFFON: It's Attachment A, underscore
4 5.

5 DR. NETON: The last one in that group?

6 MR. GRIFFON: Yeah. Yeah, that's it, the
7 last one.

8 If you look at Section A, Personnel, in this
9 new document -- they're going to hand it around --
10 it's all the same, to the best of my knowledge. I
11 haven't done a word-by-word through it, but I think
12 the only section that we edited was Section E,
13 actually; so Section B is the same; C is the same; D
14 is the same; E is drastically changed, but a lot of
15 the paragraphs were cut and pasted, but they were
16 modified somewhat, so we should step through that;
17 and then Section F remains the same.

18 So now if you -- if you could open the old
19 document that's in our binders, if you look, for
20 instance, at the first paragraph E-1, I labeled that
21 E-1, the first paragraph in the old document, that
22 ends up being in the new document under the Conflict
23 of Interest Plan section, the 10-point section, the
24 first paragraph there. The language is not the
25 same, but the concept is the, you know, that's where

1 that concept moved to.

2 DR. ZIEMER: Which paragraph is that?

3 MR. GRIFFON: It's the second paragraph, the
4 first paragraph under the Conflict of Interest Plan
5 on the new.

6 DR. ANDERSON: Where it says Conflict of
7 Interest Plan, 10 points?

8 MR. GRIFFON: Right. And this -- I should
9 step back a second -- the section is divided up into
10 two sections; Conflict of Interest Plan, 10 points,
11 and Work History, 15 points, and the bullets that
12 sort of fall into each, that's why there was some
13 cutting and pasting from the previous document
14 because they weren't always in the appropriate
15 order, so we moved them around a little. And this
16 Plan is what -- basically what we're expecting.
17 They're not disqualifiers, it's that this is the
18 information that you should include in your plan, a
19 minimum to disclose potential, perceived, actual
20 Conflicts of Interest on -- on your team. And then
21 the Work History below, is actually -- there will be
22 15 points assigned, paying attention to the key
23 personnel staff, and organizational conflicts of
24 interest; and it goes on, but the one striking
25 difference in that section is that previously we had

1 a hard-line where we said if the bidders worked --
2 the bidders were key personnel and worked with DOE,
3 DOE contractors, etcetera, etcetera, or NIOSH, or
4 ORAU within the last two years they were
5 disqualified. Well, we -- we took that out and we
6 replaced it with the phrase about that greater
7 emphasis will be placed on the work history within
8 the past two years -- work experience within the
9 past two years; so again, that gives the panel more
10 flexibility, and points will be assigned based on
11 this, but it's not, they're not disqualifiers
12 anymore, like they were in the previous document.
13 That was the idea, to give --

14 MS. MUNN: That's good.

15 MR. GRIFFON: Yeah. Part of the reason this
16 arose was the concern that we would be excluding too
17 many potential bidders, and yeah, unintentionally,
18 but -- but it would have happened probably, so. So
19 then if -- if we brought -- let's see, let's start
20 at the front end of this document, the front end of
21 the new one. If you want to do a paragraph-by-
22 paragraph, these three points that I listed there as
23 prerequisites now, used to be in the -- the first
24 one was Section E of the old document, paragraph
25 number 6, which is on page 10.

1 MS. ROESSLER: Under number one, I think the
2 intent was here to eliminate anybody who's working
3 for NIOSH. And then as far as ORAU goes, that's the
4 part of ORAU under the contract -- Dose
5 Reconstruction Contract, that doesn't mean all of
6 ORAU, does it? Back in the document it does put in
7 parentheses under Contract Number 200-so-and-so, or
8 does that -- is the intent there that nobody who
9 works for ORAU?

10 MR. GRIFFON: The intent was any work for
11 ORAU. If you look back at the part of E-6, it
12 doesn't have that reference to the contract. That's
13 for another.

14 MS. ROESSLER: Okay. So anyone who's
15 currently, or in the past -- well, currently working
16 for ORAU, which is a really big group, is
17 automatically eliminated.

18 MS. MUNN: For key personnel.

19 MR. GRIFFON: Right.

20 MS. ROESSLER: Yeah, I mean I just want to
21 make sure that that was the intent.

22 MR. GRIFFON: Yeah.

23 MS. ROESSLER: I don't know that that's bad,
24 but I --

25 MR. GRIFFON: That's the intent.

1 MS. ROESSLER: Okay.

2 MR. GRIFFON: I think we -- we did have some
3 debate on that, but that's, if you look at E-6 in
4 the original document --

5 DR. ZIEMER: It's the same words.

6 MR. GRIFFON: -- that's the same words.
7 Yeah. And you'll notice Paragraph E-6 of the
8 original document was split in half, and the reason
9 for that, if you look when we get back to Section E,
10 is that we didn't want that hard-line of a criteria
11 for DOE or DOE sites, DOE contractors, but we still
12 thought the bright line should apply to NIOSH and
13 ORAU because it just -- this was too close to what
14 they'd be doing under this contract, and so we give
15 more flexibility, and if we look in Section E you'll
16 see that. And the idea there was that they may have
17 other work, and they'd be evaluated based on that,
18 so that if their other work with DOE was really
19 closely related to dose reconstruction, I think that
20 will work against them, as opposed to if they had
21 other work with DOE that wasn't in any way related
22 to dose reconstruction, I think you'd say that, you
23 know, that's fine, so. So the second paragraph on
24 the top of the document there comes from Paragraph
25 E-4 in the original document.

1 DR. ZIEMER: The only change is the word
2 "additionally" in the original document.

3 MR. GRIFFON: Right. This is the expert
4 witness question that we've gone through.

5 And then the third paragraph is the one that
6 Gen, that you were talking about. This says -- I
7 think, maybe I'm wrong -- but this says that anyone
8 that's under the current NIOSH contract obviously
9 can't also be on the auditing contract.

10 MS. ROESSLER: Okay. So the first one is
11 broad, and the third one is specific.

12 MR. GRIFFON: Right.

13 DR. ZIEMER: And again, this is the same
14 wording as before, the only exception being that the
15 original paragraph had the word "finally" --

16 MR. GRIFFON: Right.

17 DR. ZIEMER: -- at the beginning of it,
18 which is not needed.

19 WRITER/EDITOR: Say that word again.

20 DR. ZIEMER: For the third point, finally.
21 The original document had the word "finally" at the
22 beginning because of the way it was sequenced in
23 here. It's just item three. But that doesn't
24 change the meaning in any way.

25 MR. GRIFFON: Then going on to Section E

1 itself, the first paragraph, as far as I can tell on
2 my quick cross walk here, is a new paragraph. And
3 that was just to put the overall goal or objective
4 of this -- this Conflict of Interest section in
5 perspective. I think a key phrase here at the end
6 of this is that, you know, the Board's statutory
7 dose reconstruction review mandate in order to
8 assure the highest degree of independence, while
9 balancing these concerns with technical
10 qualifications. So this is the idea, just to put
11 the rest of this section into perspective. We're
12 looking for balance between technical qualifications
13 and conflict of interest issues.

14 And under Conflict of Interest Plan, the
15 10-point section, that first paragraph comes from
16 E-1 in the original document. Okay. And it looks
17 longer, so I'm assuming it was modified a little
18 bit. It generally talks about disclosure of your
19 personnel basically, and what their potential,
20 perceived, or actual conflicts would be. And this
21 is the plan itself. Okay.

22 Stop me when it's appropriate.

23 The next paragraph comes from --

24 DR. ZIEMER: Mark?

25 MR. GRIFFON: Uh-huh (affirmative).

1 DR. ZIEMER: Let me insert here. The first
2 part of that, I guess it's the first couple of
3 sentences are the same or similar, but then this is
4 expanded from before, including this: The entire
5 plan shall be made public.

6 But doesn't that parallel what we had on, or
7 what ORAU had in their requirement?

8 MR. GRIFFON: I thought it did, yeah.

9 MR. NETON: I don't think we committed to
10 making the plan public, but we did.

11 DR. MELIUS: Yeah, I think that's --

12 DR. NETON: I don't think the contract
13 requires specifically that we make the Conflict of
14 Interest plan public.

15 MR. GRIFFON: That's actually in the -- in
16 the original E-1 paragraph, isn't it?

17 DR. NETON: I don't think so.

18 MR. GRIFFON: E-1 in the -- in the last
19 draft that we did.

20 MR. DeHART: Yes.

21 DR. ZIEMER: Well, and incidentally, that
22 last sentence of that paragraph, Mark, is somewhat
23 similar to the second to last paragraph at the end
24 of the document, which says something about what we
25 plan to do in the future; it's not a grading or an

1 evaluation. You're sort of telling the contractor
2 that, oh, by the way, we can make this information
3 public, so it would seem to me that as an option we
4 might suggest the contracting officer, if there's
5 another place in the contract to put that, it could
6 be moved; it's certainly not part of the evaluation
7 screen itself.

8 DR. MELIUS: Though I think -- I agree with
9 that, though I think it also, to me it would be
10 helpful if I was applying for this to know,
11 understand that oh, I have to do a, you know, a
12 conflict of interest, and by the way, it's going to
13 be a public record.

14 DR. ZIEMER: Right. I'm saying it -- it
15 could be in another part of the document, not in the
16 evaluation criteria --

17 DR. MELIUS: Right.

18 DR. ZIEMER: -- we're not evaluating them on
19 that.

20 MR. GRIFFON: Agreed. Agreed.

21 DR. NETON: It might be the case, though,
22 that someone would not want to have their conflict
23 of interest plan public, and in which case they
24 could be docked under this criteria.

25 DR. ZIEMER: Good point, but we're not

1 leaving that as an option, are we?

2 DR. NETON: No.

3 MR. GRIFFON: Right. That's why it may
4 be --

5 DR. NETON: We could put it in both places,
6 I suppose.

7 MR. GRIFFON: Maybe it can be -- yeah, I
8 don't object to it being moved to the main body or
9 something like that.

10 DR. ZIEMER: I think we can leave it in here
11 now, but I'm just saying it's -- we're not
12 evaluating per se on that basis.

13 MR. GRIFFON: Yeah.

14 The next paragraph was the former paragraph
15 E-5. I think that's very close to the original
16 language, except that NIOSH and ORAU are removed
17 from that because that's a hard-line at the front of
18 the document now, the NIOSH and ORAU --

19 DR. ZIEMER: They're already --

20 MR. GRIFFON: Right. That's a hard-line, so
21 you don't lose -- right.

22 The next paragraph is from the original
23 document, paragraph E-6, it's the other half --
24 remember I said E-6 was split in two pieces -- this
25 is the other section, not related to NIOSH and ORAU,

1 but related to DOE and AWE, and this allows that
2 they can pursue other radiation-related work with
3 DOE or DOE contractors, but they should demonstrate
4 how this will not affect their performance on this
5 contract, and their potential conflicts related to
6 this contract.

7 DR. ZIEMER: Mark, let me back you up one
8 minute. That paragraph we just covered is talking
9 about past work, I think, and the -- the hard-line
10 elimination in 1, 2, and 3 at the front of the
11 document, I believe only refers to current work with
12 ORAU and its team partners. Doesn't this paragraph
13 refer to past work with DOE, AWE, and therefore
14 could also include ORAU and the team partners?

15 MR. GRIFFON: I think you're right. I
16 think --

17 DR. ZIEMER: It seems to me the original
18 document which included them was probably correct.

19 MR. GRIFFON: Yeah, I might have over edited
20 here. I think you're right.

21 DR. ZIEMER: As I look at those two side-by-
22 side, I'm suggesting that we put the words back to
23 the way they were in the original document, which
24 includes both NIOSH and ORAU, ORAU teaming partners
25 because it's -- it's talking about past, not current

1 activities. Am I correct on that?

2 MR. GRIFFON: The only thing I reflect on is
3 it's talking about --

4 DR. ZIEMER: It says at any time in the
5 past.

6 MR. GRIFFON: -- it's talking about will not
7 perform reviews related to that site. And NIOSH and
8 ORAU are not sites, right? Maybe that's why I
9 edited it. I think that's why we changed it. I'm
10 doing this on the fly here, too.

11 DR. NETON: This is just related reviews --

12 MR. GRIFFON: Right.

13 DR. NETON: -- conflict -- conflicted at
14 that site.

15 MR. GRIFFON: So it's similar to ORAU's
16 policy where they, anyone from their team who worked
17 -- formerly worked at a site will not be involved in
18 the -- will not be the reviewer on that, on those
19 sites. So I think the new version is more correct.

20 DR. NETON: I think so.

21 MR. GRIFFON: Yeah.

22 DR. ZIEMER: So in that case, ORAU personnel
23 could have been a DOE contractor at a site and
24 that's what it covers in here.

25 DR. NETON: Right.

1 MR. GRIFFON: Yeah. Yeah.

2 So the next -- the next paragraph was -- was
3 the other half of E-6 in the old document. And this
4 allows just what I said before -- I know this gets
5 confusing because we jump around -- this allows for
6 bidders to also pursue other work with DOE, but they
7 should explain in the plan how this is not going to
8 affect their performance on this contract, or their
9 independence.

10 MR. DeHART: Mark, would you read the first
11 few words of the first -- of that paragraph so I
12 make sure I'm in the right spot?

13 MR. GRIFFON: Yeah. E-6 is -- it starts off
14 with: The offeror, teaming partners --

15 MR. DeHART: Yeah, teaming partners.

16 MR. GRIFFON: -- and key personnel.

17 MR. DeHART: Now, where are you reading
18 right now, the same line, right below work history?

19 MR. ELLIOTT: You're talking about the new
20 document?

21 MR. DeHART: On the new document.

22 MR. GRIFFON: Oh, in the new document. It's
23 the third paragraph under Conflict of Interest Plan.

24 MR. DeHART: Okay. I see.

25 DR. ZIEMER: In addition, it says.

1 MR. DeHART: Yeah, I've got it.

2 MR. GRIFFON: All right. The Work History,
3 the first paragraph in the new document, relates
4 back to Paragraph E-2 in the original document. And
5 again, the key here is that, you know, we had the
6 hard-line test in the original document where if
7 they have worked in the past two years at all, they
8 were excluded, and now we -- we rephrase that down
9 halfway, about halfway through the paragraph it
10 says: Greater emphasis will be placed on work
11 experience within the past two years, including
12 current contract relationships.

13 So we're -- we're considering it and it's
14 going to be part of the review and the evaluation
15 scheme, but they're not excluded if they worked with
16 them in the past two years.

17 And the next paragraph --

18 DR. ZIEMER: Mark, I'd like to ask a
19 question. As I looked at the words here, in the old
20 document you talked about the needs justification;
21 in this one we talked about a justification. It did
22 not occur to me, is there a difference, or is that
23 the same thing? Is there such a thing? Do the
24 words mean anything different, that's all I'm
25 asking, "needs justification"?

1 MR. GRIFFON: I didn't think so. I thought
2 justification just was more accurate.

3 DR. ZIEMER: It's certainly encompassing.

4 MR. GRIFFON: Yeah.

5 DR. ZIEMER: I wasn't sure. Okay. I'm
6 happy with that. I just wanted to make sure.

7 MR. GRIFFON: The next paragraph is from the
8 original document Paragraph E-3, and this does
9 similar -- it does a similar thing for previous work
10 with NIOSH and ORAU, stating that a greater emphasis
11 will be placed on the last two -- experience within
12 the past two years, the same kind of criteria, but
13 that there's no exclusion -- excuse me, there's no
14 exclusion principle.

15 And then the last item there, key personnel.
16 This whole -- the last two paragraphs here came from
17 the original document in Paragraph E-9, and you'll
18 see that I -- I stripped out the bigger portion of
19 this paragraph and put a header on it saying:
20 Limitations on Changing Key Personnel, moved to the
21 body of the contract. That was sort of a question
22 for us to consider, similar to the point that Paul
23 just raised. All of that paragraph there is
24 important, but we don't think it's really criteria
25 which we can evaluate against. It's the limitations

1 going forward for the bidder that they should be
2 aware of about changing personnel.

3 DR. ZIEMER: So that might be moved to a
4 different part of the contract --

5 MR. GRIFFON: Right.

6 DR. ZIEMER: -- as an information item.

7 MR. GRIFFON: And I think Larry -- if I'm
8 not wrong, I think Larry said that that possibly
9 could be added to the body of the -- the task order
10 contract.

11 DR. NETON: Could you define what you mean
12 by diversion, you just mean change of personnel, or
13 replacement of personnel? That sounds --

14 MR. GRIFFON: Where?

15 DR. NETON: At the second sentence: No
16 diversion shall be made by the contractor, blah,
17 blah, blah.

18 MR. GRIFFON: I don't know. I thought this
19 -- I actually thought we lifted this language from
20 the ORAU/NIOSH agreement. Maybe I -- maybe I edited
21 it.

22 DR. MELIUS: It sounds like contracting
23 language.

24 MS. ROESSLER: It sure does. I don't
25 understand --

1 MS. MUNN: Yeah, whatever that means.

2 MR. GRIFFON: Yeah, I rarely use the words
3 ratify too, so.

4 DR. NETON: Yeah.

5 DR. ZIEMER: If it's agreeable, something
6 like that, or we think we are following contract
7 language, if it's the wrong words maybe we could
8 allow the freedom to edit that.

9 MR. ELLIOTT: The contracting officer would
10 be the one to move this to the right place in the
11 body of the RFP, and evaluate that language as to is
12 it saying the right thing according to the FAR, so.

13 DR. ZIEMER: Mark, could I ask you now to
14 move the adoption of these changes, and then we'll
15 get it on the floor.

16 MR. GRIFFON: Okay. Yeah, I'd like to make
17 a motion that we move to accept these amendments of
18 Attachment A.

19 DR. ZIEMER: Seconded?

20 MS. ROESSLER: I second.

21 MR. DeHART: Second.

22 WRITER/EDITOR: I'm sorry. Who seconded?

23 DR. ZIEMER: Gen, or --

24 MS. ROESSLER: I'd like to second it.

25 DR. ZIEMER: We have two seconds here.

1 MS. ROESSLER: Roy likes to second it, too.

2 DR. ZIEMER: Now we'll open the floor for
3 discussion. I did commit to Mike Gibson, who had to
4 leave, to relay to the group that Mike has reviewed
5 this and he is in agreement with the proposed
6 changes, and I told him I would pass that along to
7 the Board.

8 Okay. Other comments? Yeah, Jim.

9 DR. MELIUS: I would just, again, probably
10 going back to our last meeting, speak certainly in
11 favor of these. I think that it's sort of
12 recognizing that people may have what we call minor
13 relationships, and I think someone used the example
14 the lectureship, or being paid for a lectureship
15 through ORAU, or a travel contract, or something
16 like travel arrangements or something like that,
17 similar arrangements I can imagine with NIOSH and so
18 forth, so it certainly would open it up and I think
19 be much fairer in that way. There's, I guess a
20 certain amount of risk involved in a sense that it
21 would allow more balancing this versus technical
22 qualifications, and -- but I think that risk is
23 worth -- worth taking if it will help us to get a
24 better pool of bidders for this process.

25 DR. ZIEMER: It certainly makes it more

1 flexible, does it not?

2 DR. MELIUS: Yeah.

3 DR. ZIEMER: Now, we'll have whatever
4 additional discussion is needed. We can -- we can
5 vote on this as a document unless people want to
6 look at specific sections and make changes in what's
7 been proposed, in which case we can go back and --
8 and modify, and then complete those modifications,
9 and then adopt the document with whatever additional
10 modifications there may -- so if anyone wishes to
11 address or propose changes to what Mark has
12 presented, this would be the time to do it.

13 I'd like -- is Dave still here? I just want
14 to find out if they had a chance to review this.
15 Were there anything that jumped out that sort of --
16 the whole document just jumps right out.

17 MR. NAMON: Based on the five minutes we've
18 had to look at it, the only thing that jumped out at
19 me was something that Jim already mentioned, was the
20 word "diversion", which I gathered no one really
21 knows why it's there. But I also gather it means,
22 in this case, it was talking about change in the
23 personnel.

24 DR. ZIEMER: Yeah, we think we know what the
25 intent is there, so if it's not the right word,

1 well, we'll --

2 MR. NAMON: I'm not really in a position to
3 tell you, you know --

4 DR. ZIEMER: Or if there was anything that
5 jumped out because I know you had a chance to look
6 through it -- or any of the other staff, who...

7 The real thrust of the changes -- the real
8 thrust is the issue of the two years.

9 MR. GRIFFON: (Nods head affirmatively.)

10 DR. ZIEMER: That's sort of the bottom line,
11 going from the sharp-line two years to the flexible
12 two years.

13 MR. NAMON: There was one more question,
14 which is under the first paragraph under Conflict of
15 Interest plan.

16 DR. ZIEMER: In the new document?

17 MR. NAMON: In the new document. The second
18 sentence: This includes, but is not limited to, a
19 detailed current and past history of the offerors
20 contracts and financial relationships.

21 And the financial relationships seems to be
22 the new concept that wasn't in the previous
23 document. I didn't know what the thinking was
24 there.

25 DR. ZIEMER: Mark --

1 MR. GRIFFON: That's -- yeah.

2 DR. ZIEMER: -- can you clarify that?

3 MR. GRIFFON: New language, just thought it
4 was more comprehensive. That's true, that is the
5 new language.

6 DR. ZIEMER: And again, I suppose that if
7 there is some sort of legal limitation contractually
8 that doesn't allow collection of certain kinds of
9 financial information, obviously that could be
10 reworded, right?

11 MR. GRIFFON: Yeah.

12 DR. ZIEMER: This is sort of an intent at
13 this point?

14 MR. GRIFFON: Yeah.

15 DR. ZIEMER: Larry.

16 MR. ELLIOTT: I'd rely on Martha to correct
17 me if I'm out of bounds here, but there is -- the
18 evaluation panel will deal with this, but the
19 contracting officer and their group will deal with
20 the review of past performance and government
21 performance, and a review of financial stature, I
22 guess, is the term. Is that correct, Martha?

23 MS. DiMUZIO: (Nods head affirmatively.)

24 MR. ELLIOTT: Yeah. So the evaluation panel
25 won't review financial documentation, but the

1 contracting officers do that.

2 DR. ZIEMER: But it has to be provided,
3 which --

4 MR. ELLIOTT: It has to be, yeah, as part of
5 the provision under the RFP.

6 DR. ZIEMER: Thank you.

7 MR. ELLIOTT: Let me also, while I've got
8 the mike here, just go on record to make this
9 comment for the Board's edification. The -- all we
10 can say at this point about the technical evaluation
11 panel, and all the Board can say is that the panel
12 will be made up of government employees and
13 nongovernment folks. We can't talk about the
14 composition of the panel, or who those nongovernment
15 persons would be, so you cannot go away from this
16 table and speak about this. It's off limits.

17 DR. ZIEMER: Including any discussions that
18 were held during the executive session --

19 MR. ELLIOTT: That's correct.

20 DR. ZIEMER: -- last time.

21 MR. ELLIOTT: Once the award is made, then
22 we will be in a position to speak to the
23 affiliations of the panel members, but not the
24 individual identifications, so we can speak to who
25 served on the panel as far as their affiliations.

1 Does everybody understand? Thank you.

2 DR. ZIEMER: Thank you, Larry. Is there a
3 question on that?

4 MS. MUNN: No. But I have one very minor
5 point. Mark, could we -- could we replace the date
6 on your document as 2/2/03 because I know that two
7 months from now I will have a hard time remembering
8 whether what I have here with draft 1/31 on it came
9 before --

10 DR. ZIEMER: Let's call it 2/6/03.

11 DR. MELIUS: Yeah.

12 DR. ZIEMER: So mark your document so you
13 recall this is the document we reviewed today.
14 Thanks for that.

15 Is the Board ready to act on the motion
16 before us, which is to adopt this revised language
17 for Attachment A?

18 MS. ROESSLER: Yes.

19 DR. ZIEMER: It appears that you are ready
20 to vote. All in favor, say aye.

21 BOARD MEMBERS: Aye.

22 DR. ZIEMER: Are there any opposed?

23 (No response.)

24 DR. ZIEMER: No. Any abstentions?

25 (No response.)

1 DR. ZIEMER: Then the record will show that
2 the Board has approved this, and we thank the
3 working group for handling that for us.

4 Are there any other matters to come -- well,
5 let me give one more opportunity. Is there anyone
6 from the general public that wishes to speak? Is
7 there anyone from the general public still here?

8 (No response.)

9 DR. ZIEMER: Are there any items for the
10 good of the order?

11 (No response.)

12 DR. ZIEMER: If not, we stand adjourned.

13 (Whereupon, the above-entitled proceedings
14 were adjourned at 1:51 p.m.)

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C E R T I F I C A T E

STATE OF GEORGIA)
COUNTY OF FORSYTH)

I, Debbie G. Williams, Certified Court Reporter in and for the State of Georgia, do hereby certify that the foregoing proceedings were taken down by me; that the foregoing proceedings were reduced to print by me; that the foregoing VOLUME II, consisting of pages 263 through 413 represent a true, correct and complete transcript of the proceedings; that I am not a relative, employee, attorney or counsel of any of the parties; that I am not a relative or employee of attorney or counsel for any of said parties; nor am I financially interested in the outcome of the action.

This certification is expressly withdrawn and denied upon the disassembly or photocopying of the foregoing transcript of the proceedings or any part thereof, including exhibits, unless said disassembly or photocopying is done by the undersigned certified court reporter, and the signature and original seal is attached thereto.

This, the 22nd day of February, 2003.

DEBBIE G. WILLIAMS
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