

1 individual program. We're trying to come up with
2 worker compensation decisions for individuals and if
3 we -- if there's an admission that the records were
4 not complete enough to allow us to an individual
5 dose reconstruction, then why not just look at it --
6 okay, let's not -- you know, I think then you're
7 taking the next step and saying we don't have enough
8 to do the individual dose reconstruction -- here's
9 where I get a little uncomfortable. We don't have
10 enough to do the individual dose reconstruction, but
11 we think that this -- somehow we're pretty sure that
12 this source term and the information about the
13 processes on the site is complete enough that we can
14 do a worst-case estimate, and that's where I lose a
15 little bit of faith, maybe, that --

16 **DR. NETON:** But also on top of that, we have
17 no idea which workers were in those situations which
18 would have received the larger exposures. You can
19 imagine 100 workers in a facility where a large
20 cesium source is not monitored, you don't know which
21 ones were sitting maybe out in the hallway,
22 somewhere else -- this is 50 years later. It's
23 just not possible to reconstruct that. So your
24 alternative is to just be extremely claimant-
25 friendly and everyone that comes through just say

1 well, you were in a situation that would potential
2 endanger your health and make -- do a dose
3 reconstruction very favorable and pass them all
4 through the process.

5 **MR. GRIFFON:** Yeah, I --

6 **DR. NETON:** I mean that's sort of the
7 equivalent of having an SEC, in my mind.

8 **MR. GRIFFON:** Well, I'm not saying it
9 shouldn't be a rigorous process to determine -- to
10 narrow -- I mean I'm not arguing for broadening the
11 class infinitely. I'm just saying that, you know,
12 the examples of -- for examples, you know, with
13 processes where you were working with recycled fuel,
14 you know, process information shows that
15 transuranics will be isolated or concentrated in
16 certain sub -- you know, certain processes, certain
17 buildings, and I think you can do a reasonable
18 effort to determine what subset of workers were in
19 those areas, and that's a work duration thing. You
20 might say anyone who worked in that process area
21 where the -- you know, that process was going on for
22 over a year and should have been monitored for this
23 stuff but was not, that is good -- you know, we
24 couldn't calculate your individual dose. That's the
25 precursor to all this is we couldn't calculate your

1 individual dose.

2 DR. NETON: Right.

3 MR. GRIFFON: And then the next thing is --

4 DR. ZIEMER: But we can get a bound then.

5 MR. GRIFFON: Right, let's make sure that --
6 you know, the check for endangerment of health would
7 be just that you worked in those processes where --
8 you know.

9 DR. NETON: Well, you're suggesting that we
10 wouldn't look at endangered health based on --

11 MR. GRIFFON: That's the --

12 DR. NETON: -- probability of causation.

13 MR. GRIFFON: That's the question, and I
14 know it's a fundamental question.

15 DR. NETON: Well, I think the Act says that
16 we have to determine if their health was endangered.
17 That's a criteria. I mean that's one of the
18 conditions that we're tasked with looking at. And
19 endangered health is the fact that there was an
20 unmonitored material -- that doesn't pass that test,
21 I don't think. Unmonitored material doesn't
22 necessarily endanger health to the definition which
23 we've adopted which is to have caused cancer as
24 likely as not.

25 MR. GRIFFON: Yeah, I don't have the Act

1 right here with me, but I'm not sure the Act
2 specifies how you would define endangered health.

3 **DR. NETON:** No, it doesn't.

4 **MR. GRIFFON:** Or interpret endangered
5 health. Right?

6 **DR. NETON:** No, but the rule does. I mean
7 we've taken that approach, endangered health --

8 **MR. GRIFFON:** Yes, the rule does now, yes.
9 But that's what I'm commenting on.

10 **DR. NETON:** If you believe in a linear, no
11 threshold hypothesis, then any atom that wasn't
12 monitored potentially endangered their health. You
13 have to have some objective criteria to quantify
14 that. I mean you just can't say because there was
15 an unmonitored small amount of material, that that
16 endangered health. There may be a one in 100,000
17 chance of endangering the health, but is that really
18 what we're tasked with doing? I don't think so.

19 **MR. GRIFFON:** I see your point.

20 **DR. MELIUS:** I think what's bothering us
21 with this is we've got this IREP model which is a
22 very elegant model for taking into account
23 uncertainty and given (inaudible) based on whatever
24 is available in terms of epidemiological and other
25 health information. And then we wed it up with this

1 situation that Mark is just describing -- I've gone
2 through some examples with him -- and we do this
3 very convoluted calculation -- leukemia and two
4 different tumor types -- somehow imply a certain
5 amount of accuracy to that process, I think more
6 accuracy than it may deserve. And you worry that it
7 would become sort of an arbitrary decision as to how
8 you would make that determination. Then how do you
9 then calculate how -- what's -- who is the cohort?
10 What's the duration of people -- you know, how -- is
11 it anybody that would have been in that laboratory
12 over that period of time or is it they have to be
13 there for 30 days, how do you make that calculation.
14 And in a situation where we've already said there's
15 insufficient data to do individual dose
16 reconstruction and -- it just seems to be a very
17 convoluted way of making this determination. I
18 think it sort of implies that there's a stronger
19 basis for the determination than we really have. I
20 think -- use Ted Katz's analogy, it's like having
21 him go outside and look at the weather one day and
22 run in to this supercomputer that then will
23 calculate what the average temperature's going to be
24 in Atlanta that day, and you're sort of making --
25 you know, you ask Ted to come up with well, is it

1 going to rain or not and Ted runs in and presses the
2 button and does all these calculations. But Ted's
3 guess is -- sort of bothers me a little bit as how
4 we're going to rely on that versus somebody else's
5 guess as to what the weather will be that day. And
6 then we do a calculation that somehow implies that
7 that's a good guess. You know, I don't know.

8 **MR. GRIFFON:** I also -- I do understand and
9 I appreciate Jim's response that -- and I don't
10 think -- you know, when I go back to the statute, I
11 certainly don't think the intent was to try to
12 include people in the Special Exposure Cohort like
13 vendors that were on the site once a week -- just an
14 example, but just a vendor coming in once a week,
15 wasn't badged, wasn't monitored, we didn't know
16 anything about his dose and -- you know, but the
17 chances are very small that he had any significant
18 exposure. That's not the intent and so I appreciate
19 your response that way, but -- you know, and I'm not
20 sure how to -- I'm not sure how to put that other
21 trigger on there, but I have a concern of just this
22 notion that you can -- that you've exhausted all
23 your possibilities for individual dose
24 reconstruction and yet you're going to try to in
25 some way quantify this endangered health aspect. So

1 I'm still wrestling with it myself, but that's --
2 that's the concern.

3 **DR. ZIEMER:** But it appears that the
4 methodology is not one like the weather case where
5 you're trying to predict the weather. It's more
6 like what's the worst possible -- what's the hottest
7 day you can have in December, and use that as the
8 upper limit. So you can say well, it's unlikely,
9 statistically, that some level which you have
10 decided is out here somewhere -- that the weather
11 will be hotter than some value in Atlanta in
12 December. So we're working way out at the extreme
13 of the prediction. Remember that these are
14 prediction models. There still is a chance for
15 error in any of these. There still is a chance that
16 someone who has a cancer caused by radiation will
17 not be compensated, but the chance is very small --
18 but not zero. Okay?

19 And I think in the way they're approaching
20 this, it says basically we're trying to find worst
21 case. We can't reconstruct dose, but we can bound
22 it in a reasonable way that is fair to anyone --
23 it's not the Coke machine guy who comes in for a
24 minute, but it's the worker who's in there. And
25 usually on these cohorts you're specifying when they

1 worked there. And some may have been there a month
2 and some may have been there a year, but they still
3 qualify if they were there when certain things were
4 there, which is set within the boundary of the
5 cohort.

6 **MR. GRIFFON:** Well -- go ahead, Jim.

7 **DR. MELIUS:** I think there's two things,
8 though, that are still a concern. One is that
9 there's going to be situations where the
10 information's going to be very weak. And that
11 initial number that Jim and his staff is going to
12 come up with is going to be -- have a very flimsy
13 basis. Not their fault. I mean good judgment and
14 everything, but just there's so little information.
15 And then we're sort of plugging that number into
16 this very fancy calculation. I mean it's --

17 And the second thing is why are we doing
18 this, given -- knowing the fact that this is going
19 to be, in many cases, a very weak number, based on
20 judgment and so forth, all -- given that. Then
21 we're doing this averaging between leukemia and some
22 other cancer. I mean it just -- that calculation --
23 the two calculations and so forth just seem to me
24 not appropriate, given the nature of the number
25 we're doing. It seems to me it implies more

1 accuracy than -- the number than is probably
2 warranted by the situation that this process is
3 meant to handle, and I just think it's sort of an
4 unnecessary step to take and tends to be arbitrary
5 and why do that. But again, we're going to -- we,
6 as a committee reviewing these -- the NIOSH report,
7 we're going to be looking at the basis for that
8 number. Now I mean that's really what we're going
9 to be looking at and providing some input to that
10 and so forth, so that may take care of this issue.
11 But it's still -- I worry about the situations where
12 there's just so little information and we're trying
13 to make that information fit into this calculation.

14 **DR. ZIEMER:** Rich.

15 **MR. ESPINOSA:** Well, I also see a
16 possibility to where there's going to be a lot of
17 information provided, but the information might not
18 be sufficient to do a dose reconstruction or
19 possibly put these members on a cohort. For
20 example, there's electricians at CMR in Los Alamos
21 pulling wire. They're pulling wire through three or
22 four different lab rooms a day to where they're
23 exposed to four or five different isotopes, but
24 they're not on a bioassay program, but they are
25 badged with the TLD that's biased to one or the

1 other.

2 **DR. ZIEMER:** Roy?

3 **DR. DEHART:** Jim, I understand your concern.
4 What is your consideration for the alternative? How
5 would you do it, other than just taking the whole
6 cohort and awarding?

7 **DR. MELIUS:** Well, you could either come up
8 with, first of all, some duration type of
9 calculations. It's not clear to me yet how they're
10 going to consider duration and exposure. And I
11 would certainly simplify this process of doing the
12 two cancers and so forth. I just don't think that
13 -- I just don't think it makes sense, given how weak
14 this data is going to be. So I would get rid of
15 that doubling -- that consideration of two different
16 types of cancers and so forth.

17 **MR. GRIFFON:** And along those lines, Roy,
18 the -- I mean I think where -- to get to this point,
19 we've also seen that you've got to go over that
20 first hurdle, that they couldn't calculate an
21 individual dose with sufficient accuracy. And I
22 think from what we've seen in -- I think they're
23 going to -- even for the low/low cases where they --
24 you know, they're going to use worst-case data,
25 worst-case estimates if they're nowhere near 50

1 percentile, they're not even going to reach that
2 next hurdle of okay, we can't -- you know, they're
3 going to give them the best, most -- you know,
4 benefit of the doubt and try to do an individual
5 calculation if they don't reach that hurdle. So I
6 think that throws away that concern of are we going
7 to be putting people in this class that really had
8 no chance of any -- I mean that would -- that's my
9 notion, anyway, is that you're going to lose those
10 in that process. You know, those that had no
11 significant chance of any significant exposure.
12 Then once you've reached that, you say okay, but for
13 -- you know, we can't define this dose. Then I
14 think -- you know, I think that step of just a
15 duration-based approach and -- you know, should have
16 been monitored or were monitored approach might be
17 adequate. That's my opinion, because I think those
18 other ones are going to fall off before you get --
19 before you meet the first set of criteria, which is
20 can you estimate with sufficient accuracy. And you
21 know, sufficient accuracy is defined is complete the
22 dose reconstruction for purposes of compensation.
23 It doesn't have to be -- as we've said before, it
24 doesn't have to be an accurate dose, it just has to
25 be accurate enough to make a determination for

1 causation. So that, I think, could get -- you know,
2 I hear the concern about well, we don't want to just
3 be adding people to this class that really had no
4 potential of any significant exposure at all. I
5 think that's part of the reluctance to go to a
6 qualitative measure for endangered health. But that
7 would be my rebuttal is that I think that's -- those
8 are going to fall off in that way.

9 **DR. ZIEMER:** Mark, where are we on your --
10 we did number three. Sufficient accuracy, we sort
11 of covered that before, and do you want to -- we
12 need to take a break.

13 **MR. GRIFFON:** We should take a break 'cause
14 number two is very complicated and maybe Ted can
15 look at number two during the break and step through
16 those responses because --

17 **DR. ZIEMER:** Yeah. Let's take our break and
18 recognize we also have to discuss the dose
19 reconstruction recommendations yet, too. Fifteen
20 minutes, folks.

21 (Whereupon, a recess was taken.)

22 **DR. ZIEMER:** We'll return to our business.
23 I have one housekeeping item, and that concerns the
24 minutes of the meeting which we approved, but I
25 pointed out that I would like you to individually

1 provide your editorial changes or -- the mis-
2 spellings or anything like that. I have a master
3 copy -- this is Cori's master copy -- and anyone who
4 has editorial changes we'd like you to mark them in
5 the master copy.

6 How many of you have such changes? Let me
7 see. Okay, I'm going to start this around with
8 Wanda. Mark yours in and then pass it on to the
9 next person, just as we go here. Just mark yours in
10 there so that they're all in that one copy. This is
11 in addition -- this does not include the actual
12 substantive changes that we made yesterday. We
13 already have those on the record, so these are just
14 the editorial changes, any grammatical or spelling
15 or whatever, that kind of thing.

16 Now let's return to Mark's document and the
17 clarification of issue regarding SEC class applying
18 for non-SEC-listed cancers. And Mark, before you
19 get into this, I want to ask a question which I
20 think is part of this and also I think relates to
21 Richard Miller's question yesterday, the question
22 about combining of the special cohort upper boundary
23 dose values with other doses. And maybe Jim, you
24 can help us answer this.

25 Under the guidelines and procedures, could a

1 person who has a period of work -- let's say they
2 were Special Exposure Cohort period -- or
3 potentially Special Exposure Cohort period, but
4 perhaps didn't meet that criteria. Let's say that
5 it was determined that their dose could have been no
6 more than let us say ten rem. And then the
7 calculations showed that it was not sufficient to
8 meet the probability of causation for that
9 situation. But in addition to that, at some other
10 location perhaps, they had monitored doses and dose
11 reconstructions could be done, and suppose it was
12 found that they had another ten at one location and
13 five at another. The question is, can they add in
14 the hypothetical dose from the period for which dose
15 reconstruction was not done, and add that as an
16 upper bound to the other doses that could be
17 reconstructed? I think that -- that's sort of the
18 nature of what Richard Miller was asking about
19 the --

20 **MR. GRIFFON:** And that's my question 2(c)
21 here is exactly that.

22 **DR. ZIEMER:** Right.

23 **MR. GRIFFON:** Yeah.

24 **MR. KATZ:** Well, actually I think 2(c)'s
25 different.

1 **MR. GRIFFON:** Is it?

2 **MR. KATZ:** But -- yeah, because that's
3 asking for the class, would the class determination
4 I think you're getting at there, can --

5 **MR. GRIFFON:** I think that's what he said.

6 **MR. KATZ:** -- dose is up.

7 **DR. ZIEMER:** But if they're in a class
8 that's been approved, they're getting compensated
9 already, so that's a moot point. Right?

10 **MR. GRIFFON:** No, potential -- go ahead,
11 answer his question.

12 **MR. KATZ:** Potential class, they're not
13 really in a class. Let me --

14 **MR. GRIFFON:** Answer his question.

15 **MR. KATZ:** Well, let me -- I'm going to go
16 through all of these really -- why don't I just go
17 through all of these, instead of starting at the end
18 there.

19 An individual's in an SEC class but has
20 exposures outside of that time period, location, et
21 cetera that defines the class, and the question is
22 can that individual apply for compensation outside
23 of the procedures of the Special Exposure Cohort to
24 the DOL. And that's already answered. That's
25 actually not a policy issue at all. Right now and

1 always -- the Department of Labor, when they get a
2 claim for a cancer that is not an SEC cancer, that
3 claim will come to us for dose reconstruction. So
4 there's no barrier for an individual who doesn't
5 have an SEC cancer, a specified cancer, coming to us
6 for dose reconstruction. There's no even decision
7 or appeal they have to make.

8 **MR. GRIFFON:** And that question was put in
9 there more as a clarification. I --

10 **MR. KATZ:** Right, so I'm clari--

11 **MR. GRIFFON:** -- was a little concerned
12 about the statement that Richard Miller read
13 yesterday from the transcripts in New York seemed to
14 interpret things differently and that's --

15 **MR. KATZ:** Right, let me -- and that's --
16 you know, he said some Federal official -- it's me.
17 I'm the responsible party. I'm speaking very
18 narrowly in that case because I think people, for
19 the most part, were understanding that with the
20 atomic weapons employers that their whole facility
21 and work experience would be -- comprise the class.
22 But anyway, that's my -- if I had to do it over
23 again, I wouldn't make a narrow expression like
24 that. I did -- I did it. So --

25 **MR. GRIFFON:** That was just for

1 clarification.

2 **MR. KATZ:** So send me back to Buffalo.

3 (Laughter)

4 **MR. KATZ:** Please don't. So if so, can the
5 dose assigned to the class be added to the
6 individual -- that's, I think, the question Dr.
7 Ziemer's raising just now. Can you take -- so say
8 you don't -- say you don't -- I guess there are two
9 scenarios here, really. Say the situation were you
10 don't add a class. There's a petition for a class
11 and you determine the dose wouldn't make that
12 minimum threshold of possibly causing a specified
13 cancer. And the question would be then so that
14 you'd come up with some -- how high could it have
15 been, the dose. You'd come up with some number
16 there. Would you add that into the individual dose
17 reconstructions. And we haven't crossed that bridge
18 to -- we didn't think down this lane to answer that
19 question. I mean it's certainly a question that's
20 germane for our dose reconstruction procedures and
21 we're going to have to answer it, but we haven't.
22 So I can't stand up here now and tell you what -- we
23 would take that dose or half that dose or not take
24 that dose or what, but I agree, that's an issue. It
25 belongs here with the Board as an issue, too, and

1 we'll have to resolve it.

2 But let's then take the other situation
3 where you have added a class -- I'm sorry.

4 **DR. ZIEMER:** Let me interrupt, but
5 nonetheless, if that person then -- if you were
6 doing a dose reconstruction, that would be a period
7 of time in their history for which you would have to
8 do something.

9 **MR. KATZ:** Thanks.

10 **DR. ZIEMER:** Right?

11 **MR. KATZ:** Thanks, that's --

12 **DR. ZIEMER:** And the logical thing to do
13 would be to do the upper-bound calculation that you
14 would have done anyway for the class.

15 **MR. KATZ:** So that's an option, right. And
16 that's something that has to be --

17 **DR. ZIEMER:** It's a kind of dose
18 reconstruction.

19 **MR. KATZ:** Exactly right. That's an option.
20 That's something that's going to have to be decided,
21 but we haven't -- we never -- we didn't get to that
22 question yet. Okay?

23 Then we have the situation -- the different
24 situation of we've added a class. Okay? And that
25 window -- some individuals -- in the same situation,

1 some individuals have exposures from other periods,
2 and then they also have their experience during that
3 period in place covered by the class.

4 **MR. GRIFFON:** Okay, I'm not sure your
5 example's -- I think you're reviewing a potential
6 class here. Right? And then you're considering --

7 **MR. KATZ:** Well, I mean --

8 **MR. GRIFFON:** -- exposures outside the
9 window? Okay, go ahead. Go ahead.

10 **MR. KATZ:** If it's a potential -- I mean it
11 really -- there are two -- if it's a potential
12 class, we're going to have to resolve the issues of
13 whether we can do a dose reconstruction and so on.
14 I don't think that helps clarify -- I mean really
15 there are two scenarios at the end of the day is
16 whether the class is added or not. And the reason
17 those are distinct --

18 **DR. ZIEMER:** If they are, the other doses
19 don't matter then 'cause they're compensated.

20 **MR. KATZ:** If they are, for the other
21 cancers --

22 **MR. GRIFFON:** And if they're not --

23 **MR. KATZ:** -- they're compensated.

24 **MR. GRIFFON:** That's the question, if
25 they're not.

1 **MR. KATZ:** We've addressed the situation of
2 if they're not --

3 **MR. GRIFFON:** No, no, no, no --

4 **MR. KATZ:** -- if the class is not added.

5 **MR. GRIFFON:** -- if the class is not
6 added --

7 **MR. KATZ:** Then that's what I just
8 explained, if the --

9 **MR. GRIFFON:** No, then for class
10 determination, can you add previous exposures?

11 **MR. KATZ:** That's the third -- let me go to
12 that last. Okay? That's the last of your questions
13 and I promise I'll get to that.

14 **MR. GRIFFON:** I thought you were there. I'm
15 sorry.

16 **MR. KATZ:** I'm sorry. Again, so we've
17 answered the question of what happens if the class
18 is not ultimately added. Then we have a decision to
19 make, and the Board has a role here, too, I suppose,
20 advising us on this.

21 But here's the other scenario. We add a
22 class, and we just went through how we would do
23 that, right, how we would make that determination.
24 In that case, we don't actually have an upper-bound
25 estimate radiation dose 'cause we didn't do a dose

1 estimate. All we answered was the question, could
2 the dose have exceeded some benchmark, but we didn't
3 put a cap on that. And in many cases, the cap may
4 be -- you know, the sky's the limit, almost. Right?
5 It could be exceedingly high.

6 So in that case we don't have the same
7 material to work with in terms of what we would do
8 for the individual who has a different cancer and
9 has doses outside of the class. Right? What we
10 will do there, again, I think -- I think we're going
11 to need to consider that situation and the advice of
12 the Board, but it's -- again, we did not imagine our
13 way down that path, so that's why we don't have a
14 procedure. But anyway, it's an issue for the dose
15 reconstruction process.

16 So then the final question which Richard
17 raised yesterday and you have raised again here,
18 which is what about -- I think I have this right.
19 What about considering the individual's doses
20 outside of the class period as an element -- as
21 facts to contribute to whether you add that class or
22 not. Right? Do I have that right?

23 **MR. GRIFFON:** Yeah.

24 **MR. KATZ:** Right.

25 **MR. GRIFFON:** And this is kind of the -- you

1 know, this is -- and I don't know how often the
2 situation might even arise, but it's the borderline
3 case where you're reviewing a class -- a potential
4 class --

5 MR. KATZ: Right.

6 MR. GRIFFON: -- and they don't meet that
7 hurdle.

8 MR. KATZ: Right.

9 MR. GRIFFON: But maybe they've all had
10 previous exposures or some of them have had previous
11 exposures, significant exposures --

12 MR. KATZ: That were recorded.

13 MR. GRIFFON: -- do you take those into
14 account when you're considering that class or not,
15 and that's --

16 DR. ZIEMER: Or how does that differ from
17 the first case?

18 MR. GRIFFON: That were reconstructable.
19 Right, that were -- the earlier exposures were
20 reconstructable.

21 DR. ZIEMER: That's similar to the case we
22 talked about before then.

23 MR. GRIFFON: But --

24 DR. ZIEMER: You've got one part
25 reconstructable, one part not.

1 **MR. GRIFFON:** Except in this case you're
2 making a decision on the class instead of on the
3 individual dose reconstruction. Right?

4 **MR. KATZ:** Right. The first case --

5 **MR. GRIFFON:** So you're adding the dose to
6 one instead of the other -- you know.

7 **MR. KATZ:** Right. The first case is really
8 simple because we're just completing the dose
9 reconstruction. The second case, you're saying how
10 do we -- and again, we did not think there, either.
11 And I believe -- and I'll just have to say that
12 vaguely because I'm not certain -- the way the
13 regulation's written now, I don't think you could
14 take the exposures outside of the time period and
15 bring them into consideration of the class.

16 Now the problem -- I mean there may be
17 circumstances like that where everyone had the same
18 exposures outside that were monitored but then hence
19 also had exposures within -- the issue that
20 certainly has to be satisfied is that they all have
21 to have a common exposure experience to be
22 considered as a class, so we're going to have to
23 satisfy that criterion.

24 **DR. MELIUS:** Could you define the class
25 based on their -- in a way that would include a

1 criteria for additional individual exposure? That
2 would be one way of approaching it.

3 **MR. KATZ:** I think the way you define -- I
4 think you would -- I mean to get at this, I think
5 you would simply define the class beyond the period
6 when the records were inadequate, but including the
7 period when records were adequate as well as the
8 period when records were inadequate to come up with
9 -- do you understand what I'm saying?

10 **DR. MELIUS:** Yeah, that's another --

11 **MR. KATZ:** And then -- but everyone would --
12 in the class would have to meet both of those -- in
13 other words, elements. They would have to be during
14 the period when records were adequate, as well as
15 the period when records were inadequate. Do you
16 understand? Does that make sense?

17 **DR. MELIUS:** That would be another option.
18 I mean --

19 **MR. KATZ:** Right. That's the one I can
20 imagine.

21 **DR. MELIUS:** I think there are a couple of
22 options for doing this and it may depend on the --
23 probably on the particular situation. Pardon me if
24 this is very convoluted, but...

25 **DR. ZIEMER:** Have we completed yours, Mark?

1 **MR. GRIFFON:** Yes.

2 **DR. ZIEMER:** Okay. Now I want to add one
3 more thing into the mix here for Special Exposure
4 Cohort, and that is to input into our sort of
5 knowledge base the outcomes of the Town Hall meeting
6 -- meetings, because they may be pertinent to know
7 what the public comments were. So Ted, this would
8 be a good time I think for us to hear your summary
9 on some Town Hall comments. Is Ted still here?

10 **DR. MELIUS:** While Ted's returning to earth
11 here, can I just make one comment on that --

12 **DR. ZIEMER:** Sure.

13 **DR. MELIUS:** -- last section?

14 **DR. ZIEMER:** Sure.

15 **DR. MELIUS:** I think one of our
16 recommendations might be, as a Board, is that NIOSH
17 review these regs to make sure that they don't
18 preclude any of these options for dealing with some
19 of these situations. I don't think we can ask them
20 at this time to develop every possible scenario, but
21 make -- try to go through this and make sure they
22 haven't precluded some of the options for the future
23 in terms of --

24 **DR. ZIEMER:** And that argues for
25 flexibility, which was one of the issues that I was

1 concerned about if we became too proscriptive.

2 **DR. MELIUS:** Right.

3 **DR. ZIEMER:** Okay. Ted, are you set?

4 **MR. ELLIOTT:** While he's getting -- cutting
5 the lights and all of that to present, I would just
6 inform the Board that the transcripts from the last
7 two Town Hall meetings should be up on our web site
8 and available for anybody who wants a hard copy upon
9 request the first of next week -- early -- perhaps
10 Tuesday of next week.

11 **UNIDENTIFIED:** That'll be fun to read.

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

13 **UNIDENTIFIED:** I said that should be fun to
14 read.

15 **MR. KATZ:** Okay. So I'm just going -- I'm
16 just going to give you a flavor for the comments we
17 received, both on the rule and on other matters,
18 too, because in fact we received a lot of comments
19 and questions and so on on matters outside really
20 the parameters of this rule. But it was very useful
21 I think for us to be out there explaining things for
22 lots of people who don't understand much related to
23 dose reconstruction, and other issues, as well.

24 So one of the first questions we received
25 everywhere -- almost everywhere, I'm sure -- was why

1 didn't Congress include us in the cohort. Why is
2 the burden of proof higher for us? And sort of
3 following along these lines, couldn't Congress have
4 included us, for example, because we worked with the
5 same radioactive materials that they used at the
6 gaseous diffusion plants. Those came to us
7 afterwards, so why aren't we there? Or because
8 maybe our exposures are likely to be higher than
9 they were there? But we heard this first.

10 **DR. ZIEMER:** What did you tell them?

11 **MR. KATZ:** Well, we explained that we don't
12 have reporting really from Congress to be able to
13 give them a clear answer as to how Congress decided
14 on the locations that would be included originally
15 in the cohort.

16 So -- and similarly, why aren't our
17 illnesses covered? Why is cancer the only health
18 outcome covered among illnesses related to radiation
19 or radioactive materials?

20 Why aren't all toxic exposures covered? We
21 had questions in Los Alamos about what about non-
22 ionizing radiation, and we had questions I think at
23 all locations about chemical exposures.

24 Why aren't employees of the AWE's covered
25 who worked during periods when there was residual

1 contamination? We had a lot of questions about
2 that, about the defined periods currently of the
3 AWE's, and we explained to them what's going --
4 ongoing with our radiation -- residual contamination
5 study that we're doing and what the status of that
6 is.

7 And then lots of questions along Jim's
8 continuing concern about how long it will take to do
9 a dose reconstruction or determine that we can't; to
10 obtain contractor support for the dose
11 reconstructions; to decide the outcome of a
12 petition. And there was concern about delay arising
13 from the Congressional review period. I think
14 everywhere that sort of raised consternation, sort
15 of visible consternation. And you know, we
16 experienced a lot of anger about the duration that's
17 already -- the water under the bridge, how much time
18 has gone by on all of this and their claims awaiting
19 adjudication.

20 And questions about what's a class, how it's
21 defined, how large or small it can be. Can it be a
22 whole facility, so on. And we had recommendations
23 at some of these meetings that their -- they
24 believed their facility should be added as a class.

25 This is a question that we've actually dealt

1 with at length in this Board meeting already, so I
2 won't go into it at length, but this is my
3 statement, sort of drew this out. Can members of a
4 class opt out of a class that's been added? And as
5 I explained, they wouldn't need to opt out. They
6 would automatically come to us -- this relates to
7 situations where people have cancers that are not
8 covered -- not a covered -- under the Special
9 Exposure Cohort procedures and they would come to us
10 for a dose reconstruction in any event
11 automatically.

12 Can a claimant withdraw a claim before
13 adjudication is final and submit a petition? I mean
14 this -- presumably their concerned well, if they
15 find out down the road that their dose is likely to
16 be low, can they instead take another route and
17 submit a petition for a class.

18 And just to answer that -- but I mean
19 there's nothing -- there is nothing in the
20 procedures that preclude them from doing that. They
21 can, at any point, submit a petition. We don't
22 limit them based on that.

23 Why does a claimant have to petition if
24 NIOSH cannot do a dose reconstruction? This was
25 sort of the question of why do we have to petition

1 at all in that case? Why don't you just simply go
2 on about evaluating a class?

3 **DR. ZIEMER:** What was your answer?

4 **MR. KATZ:** And I'm sorry, the answer --
5 we've talked about that here, too, is as we read the
6 law, the law requires a petition to start the
7 process.

8 Why are the SEC procedures so complicated?
9 And then we had we had a whole --

10 I mean -- there's a great quote from John
11 Adams I could give here, but maybe I'll pass. Why
12 are the -- do you want me to give that?

13 John Adams was asked -- this could not be
14 recorded, but John Adams was asked by a Frenchwoman
15 once why the American form of government was so
16 complicated, and his response was well, you could
17 take all the wheels out of a watch, but it wouldn't
18 necessarily tell time.

19 And lastly, how will NIOSH reconstruct
20 doses? There were lots of questions about how would
21 you reconstruct a dose given this situation or that
22 situation, given that records may not be complete,
23 and so on.

24 But that -- I mean I think that's a decent
25 flavor of what we heard on the road.

1 **DR. ZIEMER:** Okay, let's see if there's any
2 questions for Ted on the issues discussed at these
3 Town Hall meetings.

4 **DR. MELIUS:** Could you give us some idea of
5 what the turnout was at the different meetings?

6 **MR. KATZ:** Yeah -- oh, yeah, I'm happy to.
7 So the first two meetings, Buffalo was under 20 and
8 Ohio -- just outside of Cincinnati -- was again
9 under 20. And I think that is in part a product of
10 the very little lead time we had between announcing
11 the meetings and the meetings being convened, and
12 the fact that newspapers hadn't gotten out a story
13 in advance of the meeting and so on.

14 So -- and then out west we had really much
15 better turnout. At Hanford we had about 350 -- I
16 haven't actually seen the numbers, but I've heard
17 that a number of times and it looked like that. We
18 had to open up another room to fit all these people.
19 They were going right out the hotel lobby and into
20 the street. So there was about 350 at Hanford and
21 then at -- near Los Alamos in Espanola there were
22 approximately 50 to 60, I think.

23 **DR. MELIUS:** And in the Buffalo meeting,
24 which is some of the older atomic weapons plants or
25 -- was the flavor of the questions or the nature of

1 the questions different or did you get -- we really
2 haven't talked a lot about dealing with those
3 employers in this committee and I'm just curious as
4 to are there -- given time periods involved and some
5 of their eligibility issues, were there any
6 particular things that came up that the Board should
7 be cognizant of in terms of working with those
8 employers?

9 **MR. KATZ:** Jim's standing up, I'll have him
10 give --

11 **DR. NETON:** I think the key issue in my
12 mind, we had a number of questions related to
13 residual contamination and period of covered
14 employment. I mean that was a good theme for a
15 large part of the meeting, why they had to work in a
16 certain defined time period to be eligible to apply
17 and who set those time periods and are they going to
18 be changed and that sort of thing. A lot of
19 frustration from the people in that area.

20 **MR. KATZ:** Then the other sort of
21 distinctive thing at Buffalo was -- I mean it was
22 clear this would -- this makes sense probably to
23 everybody, is that they had even less information
24 than at the other sites about everything in general,
25 and a lot of pent-up frustration related to that.

1 Go ahead, Mark.

2 **MR. GRIFFON:** I was just going to ask if Jim
3 or Ted can expand on the residual contamination
4 report -- from what I understand, their report was
5 -- a study was required, is ongoing. I'm not sure
6 where that stands now.

7 **MR. ELLIOTT:** I'll speak to that. The six-
8 month progress report which was due to Congress at
9 the end of June is going through inter-department
10 clearance right now and OMB approval so that it can
11 be sent over to the Hill.

12 **DR. ZIEMER:** Okay. Are there further
13 questions?

14 (No responses.)

15 **DR. ZIEMER:** It appears that there are not.
16 Thank you, Ted, for that report.

17 **MR. KATZ:** Thank you.

18 **DR. ZIEMER:** Now we're going to return to
19 this topic of the Special Exposure Cohort after
20 lunch. I will ask the working group if they would
21 mind maybe sitting around the lunch table together
22 and discussing the form of the document that we
23 prepare. We want to get sort of on the table for us
24 yet this morning the report of the dose
25 reconstruction working group so that we have that

1 before us, as well. And Mark, if you could lead us
2 through now your current -- I think there's a
3 handout. Did everybody get it?

4 **MR. GRIFFON:** Did it circulate to everyone?
5 I'm not sure.

6 **DR. ZIEMER:** We have a --

7 **MR. ELLIOTT:** It has been placed at each
8 person's --

9 **DR. ZIEMER:** -- version 2.0 of the working
10 group --

11 **DR. NETON:** No, we -- that was a draft that
12 we distributed early for review by just the working
13 group.

14 **MR. GRIFFON:** Yeah, we were planning on
15 meeting at the break to go -- 'cause I --

16 **DR. ZIEMER:** Okay, so you don't want to sort
17 of --

18 **MR. GRIFFON:** Well, that would be the
19 question from me to the working group since I did a
20 lot of this last night and they didn't have a chance
21 to look at it.

22 **DR. ZIEMER:** I gotcha.

23 **MR. GRIFFON:** I don't know if they're ready
24 to give it to the entire Board or if they have
25 comments for me and changes that we want to make

1 first. I didn't have a chance to --

2 DR. ZIEMER: I'll leave it up to the working
3 group. Do you want to have any input on this before
4 -- are you --

5 MR. GRIFFON: They've had input, don't get
6 me wrong. We discussed all this --

7 DR. ZIEMER: No, no, I know you have.

8 MR. GRIFFON: Yeah, yeah.

9 DR. ZIEMER: Go ahead, that would be my --

10 MR. GRIFFON: You think it's okay?

11 DR. ZIEMER: Yeah, I would --

12 MR. GRIFFON: I think we can distribute this
13 then to the entire Board and I can go quickly
14 through it. It's not that -- it shouldn't take that
15 long.

16 (Pause)

17 MS. MURRAY: Dr. Ziemer, may I ask a
18 question while he's distributing this?

19 DR. ZIEMER: Uh-huh.

20 MS. MURRAY: This afternoon when you go over
21 the SEC rule, will that be the clarification of the
22 answers to all these questions? Because frankly,
23 from the discussion this morning and my notes, I'm
24 not sure that I'm clear on what the answers were to
25 all of them.

1 **DR. ZIEMER:** Right, I'm not sure that we're
2 clear on what the answers are, either, but to the
3 extent that we're able to address those and come up
4 with some language, I think we're hopeful that many
5 of those will be at least addressed in some way.

6 **MS. MURRAY:** Great. I just wanted to make
7 sure I hadn't missed anything.

8 **DR. ZIEMER:** No, if your notes are
9 confusing, they're very much reflecting the meeting,
10 I think.

11 **DR. MELIUS:** The answers are yes, yes, no,
12 maybe.

13 **MR. GRIFFON:** Should I give -- I mean people
14 haven't looked at this. Do you want to --

15 **DR. ZIEMER:** Maybe you could lead us through
16 it, huh?

17 **MR. GRIFFON:** Okay. It's not that --

18 **DR. ZIEMER:** Yeah, it's not that extreme.

19 **MR. GRIFFON:** -- different. It's version
20 two of the last -- which we approved by vote of --
21 sort of an original scope of work for the dose
22 reconstruction --

23 **DR. ZIEMER:** And remember, if you want to
24 have the early version, it's the attachment two on
25 the minutes --

1 **MR. GRIFFON:** Right.

2 **DR. ZIEMER:** -- so if you need that --

3 **MR. GRIFFON:** And for the most part, this is
4 a redline strike-out type version --

5 **DR. ZIEMER:** Of that.

6 **MR. GRIFFON:** -- except for the -- it
7 doesn't completely hold true 'cause of my edit. I
8 didn't start doing that till mid-way through, but
9 anyway, I'll point out where the differences are.
10 I tried to expand a -- based on what we were
11 discussing yesterday and what we went over the last
12 couple of days, we tried to refine, at least a
13 little bit further, some of this initial scope for
14 the dose reconstruction review. The independent
15 panel section, we -- yesterday we did talk about
16 establishing a criteria, sort of a professional
17 criteria that we would look at or that we would
18 draft for NIOSH then to do the -- go through the
19 procurement process and hire these independent
20 experts. We haven't -- we didn't have NIOSH's RFP
21 and we wanted to look at that language, so we didn't
22 really include that in there, but we're still
23 planning on adding that to the independent panel
24 section.

25 **DR. ZIEMER:** Mark, could I interrupt and --

1 **MR. GRIFFON:** Uh-huh.

2 **DR. ZIEMER:** -- maybe we can get some
3 comments on each section as we go here.

4 **MR. GRIFFON:** Sure.

5 **DR. ZIEMER:** On independent panel, could you
6 clarify the working group's -- how you envision --
7 when you talk about the two Board members and one
8 expert, is my understanding you're envisioning this
9 as not necessarily being the same two people for
10 each review, but that this workload would be
11 distributed in some way amongst the total Board
12 members, including the newer people coming aboard,
13 so we --

14 **MR. GRIFFON:** Yeah, that is correct and we
15 need to -- we didn't -- we didn't know how to
16 describe that, I guess. A rotating basis or
17 something like that, but the intent is that the two
18 Board members participating in the panel would
19 rotate and hit everybody so we can spread the
20 workload.

21 **MR. PRESLEY:** The panel will meet prior to
22 the meeting so it won't be a separate meeting. It
23 might be the day before.

24 **MR. GRIFFON:** Yeah, that was just another
25 consideration that we had just to reduce the travel

1 burden on everyone and everything to try to -- for
2 the most part, we see the independent expert doing
3 the bulk of the work on these reviews, then pulling
4 that in with the two Board members and giving the
5 two Board members an overview and sort of a
6 preliminary read on it, and then the next step would
7 be to present to the entire Board. So that's kind
8 of the sequence there. But we'll refine that
9 language to reflect that it'd be a rotating -- two
10 Board members would be on a rotating basis.

11 **DR. ZIEMER:** Another question here, Mark.

12 **MR. GRIFFON:** To be assigned by the working
13 group. Maybe I'll add that in, too -- no.

14 **MR. ELLIOTT:** I'd like to understand this as
15 best I can. So let's say if you had 30 dose
16 reconstructions that you were going to review in --
17 from one quarter, the first quarter.

18 **MR. GRIFFON:** Uh-huh.

19 **MR. ELLIOTT:** As I understand this, you
20 would identify two experts, let's say, and identify
21 in that sample of dose reconstructions those which
22 would require certain members of this committee to
23 recuse themselves from, so you'd match up with that
24 individual expert two members who were not
25 conflicted.

1 that, Wanda, because we don't make the decision. I
2 don't want to confuse the claimant with that, that
3 there's a decision being made by NIOSH. I'm sorry.

4 **MR. GRIFFON:** We're certainly open for --
5 you know, we --

6 **DR. ZIEMER:** I think the point is, as far as
7 Jim's question is concerned, your intent is not to
8 exclude those -- that spread of awards versus
9 denials and so on, so that'll be included.

10 **MR. GRIFFON:** I mean we may --

11 **DR. ZIEMER:** And actually this is really --
12 presumably it's a statistical random sample. The
13 random sample, by itself, to some extent should do
14 the stratification except that claims may not come
15 in randomly in the sense that they may -- some sites
16 might be over-represented, so that's why they're
17 trying to stratify, I think. Otherwise, a random
18 sampling would cover the types -- the various types
19 of claims, the -- all the things you're talking
20 about --

21 **MR. GRIFFON:** Another possibility --

22 **DR. ZIEMER:** -- that's your random --

23 **MR. GRIFFON:** -- that might address Jim's
24 issue is that the struck-out language, we might be
25 able to leave that in and then parenthetically say

1 based on the NIOSH efficiency process -- you know,
2 through the NIOSH efficiency process, 'cause I think
3 we do get those categories, yeah.

4 **DR. MELIUS:** No, I'm comfortable with what
5 you're doing, I'm just concerned --

6 **MR. GRIFFON:** I know.

7 **DR. MELIUS:** -- some of this is for -- is
8 the credibility of the program --

9 **MR. GRIFFON:** Oh, yeah, sure.

10 **DR. MELIUS:** -- and we have to communicate
11 -- you know, one of these drafts when we were -- got
12 a document together -- communicate and I want to
13 make sure that the claimants and people out there
14 understand what we're doing, that's all.

15 **MR. ELLIOTT:** I'd like to make a couple of
16 comments for your consideration. Maybe you
17 discussed this in your working group. Did you
18 discuss weighting? The only weighting you show here
19 is weighting based upon number per site. What about
20 weighting on this category of denial or --
21 compensability or non-compensability and weighting
22 -- I'm thinking of -- if I were making this decision
23 for you, I'd say the heaviest weight should be on
24 that middle category that the most work is going to
25 be expended upon, so that's one question or comment.

1 And the other comment that I would offer you
2 for consideration is that to work in here a sentence
3 on -- with language that says you reserve the right
4 or you have the ability to change these -- the
5 selection -- case selection criteria as claims come
6 forward and time progresses. You may see a
7 different mix that you want to achieve.

8 **MR. GRIFFON:** The first one we did discuss,
9 and maybe I can massage some words there to have
10 weighted into -- the intent was to weight on those
11 NIOSH efficiency strata --

12 **DR. ZIEMER:** And you could --

13 **MR. GRIFFON:** -- just as you said. That
14 makes sense to us, too.

15 **DR. ZIEMER:** Mark, possibly you could simply
16 add "and other criteria that arise in the course of
17 your evaluations" or -- you need a sort of a catch-
18 all that would allow you the flexibility of
19 considering other criteria that may not be obvious
20 right now. I think that's what probably you're
21 saying.

22 **MR. GRIFFON:** Is it? Yeah, okay. We'll try
23 to do that. I also -- you know, I am mindful when
24 we're doing this of having concrete guideline -- not
25 too much -- you know, too much flexibility so that

1 we're vague in what we're doing, you know.

2 Any more on the case selection?

3 **DR. ZIEMER:** Go ahead.

4 **MR. GRIFFON:** The scope and protocol, the
5 first paragraph there was in the last -- for the
6 most part, in the last report. We modified one
7 bullet there, in number one, slightly. And then the
8 next page, on the top of page two, this was entirely
9 new draft of sort of a protocol, so this is sort of
10 -- the first piece being the broad scope and then
11 this sort of a protocol on how the panel would
12 conduct the dose reconstruction reviews. And we
13 talked about the type of review, and this is just
14 what we've considered.

15 Mainly in our discussions the last two days
16 we talked about sort of a basic level and then
17 advanced level, or a more comprehensive level I
18 guess might be a better word, actually. And then in
19 previous meetings -- and I added this in, going
20 through my notes last night -- we did discuss
21 possible blind reviews. And I should note that when
22 I said -- so we have these three categories, basic,
23 advanced and blind. And I would think that the
24 blind -- we haven't put numbers or percentages on
25 these, but I would expect that the blind reviews

1 would be a small percentage of the overall cases
2 that the panels review. But we think -- yeah.

3 **MR. ELLIOTT:** I'm lost on blind. What do
4 you mean by blind in this context?

5 **MR. GRIFFON:** Blind means -- no, don't put
6 that in there. Blind means -- I -- just a blind
7 review where NIOSH would provide -- and let me make
8 sure I get this right -- the administrative record,
9 everything NIOSH used to calculate an individual's
10 dose and then the panel would themselves come up
11 with the -- or generate the form that would feed
12 into IREP, rather than be provided that up front.

13 **MR. ELLIOTT:** So you're saying blind to the
14 inputs.

15 **MR. GRIFFON:** Right.

16 **MR. ELLIOTT:** I understand now. You would
17 not see what the determination would be from the
18 dose reconstruction.

19 **MR. GRIFFON:** Right.

20 **MR. ELLIOTT:** That's what you'd be blind to.

21 **MR. GRIFFON:** That's right.

22 **MR. ELLIOTT:** I understand now. Thank you.

23 **MR. GRIFFON:** Okay. So if you -- I'll just
24 -- if I can go through this sort of broadly, a basic
25 review -- A, B, C and D are in both the basic and

1 the advanced review and sort of broke it up into
2 categories. Review data gathering. B is review
3 interview and documentation provided by the
4 claimant. C is the review of the internal dose
5 estimates. D is review of the external dose
6 estimates. And let's see, the main difference -- I
7 guess people can read through -- I don't want to go
8 through every line on this, but the main difference
9 between the basic and the advanced is if you look at
10 A, there's a number three that was added which says
11 review the entire administrative record to determine
12 if relevant information exists which was not
13 considered by NIOSH. Whereas in the basic review,
14 we would just look at what NIOSH used in doing the
15 dose reconstruction. And as we learned in the last
16 couple of days, Jim Neton said that on the database
17 system, those records which NIOSH uses for the
18 actual reconstruction will be at the top of the
19 hyper-linked file so you'll have all the -- and
20 they'll be distinct from the rest of the
21 administrative record. So it'd be a less compre--
22 the basic would just entail looking at that as
23 opposed to looking at the entire administrative
24 record. The entire administrative record already
25 for some of these cases is upwards of 300, 400, 500

1 pages of various records, so that's much more
2 comprehensive review.

3 Also in C and D you'll see the expanded --
4 numbers four and five in both C and D are the same,
5 but they're -- in the advanced version they're
6 looking at the -- determine whether dose estimate is
7 consistent with relevant radiological information
8 within the NIOSH site profiles. And NIOSH is
9 establishing site profiles for all the sites, and
10 this is -- this is actually something we discussed
11 at length in the last day or so, that this is a real
12 place where this review panel can have value-added
13 to make sure that -- 'cause this is one of the
14 things that we hear in public meetings, et cetera,
15 that -- you know, we want to make sure that this
16 panel double-checks and make sure that dose
17 reconstructions are not just being conducted based
18 on personnel records, or at least those -- if they
19 are done on those personnel records, they're checked
20 to some extent against site profile data so that
21 there's not major inconsistencies, that something's
22 missing.

23 And five is similar along those lines,
24 compare case information and assumptions with
25 relevant co-worker case information and assumptions

1 for consistency. And that's the idea of having --
2 you know, of five or six operators from the Hanford
3 300 area, if you're looking at one with -- in
4 isolation in the basic review and in the expanded
5 review we might do cross-checks and make sure that
6 similar assumptions were made -- were appropriate,
7 et cetera. That sort of thing. And that's --

8 And then the blind, the last thing on the
9 bottom after all my deleted things, is the blind
10 dose reconstruction, which we just, to some extent,
11 described there with Larry. And then -- you know,
12 and then on the next page, which is sort of that the
13 -- that would be the report -- reports results to
14 the Board.

15 **DR. ZIEMER:** And so, Mark, you envision that
16 every one of the reviews, the panel would have some
17 sort of a documentation that said, for example,
18 determine whether all assumptions used in dose
19 determination are appropriate. Yes.

20 **MR. GRIFFON:** Yeah, this was sort of --

21 **DR. ZIEMER:** You would have a --

22 **MR. GRIFFON:** Along the lines of what --

23 **DR. ZIEMER:** -- written report and you'd
24 report that to the Board, we determined that all
25 assumptions are appropriate, that the data are

1 consistent, et cetera, down the list. Or if there's
2 questionable ones, you would raise that and --

3 **MR. GRIFFON:** I think -- I expect that the
4 expert would be going into this protocol and then
5 the two Board member -- the panel would agree on
6 that, you know, those conclusions. And then they
7 would --

8 **DR. ZIEMER:** And there actually -- there
9 would be documentation that --

10 **MR. GRIFFON:** Right.

11 **DR. ZIEMER:** -- of such an agreement and --

12 **MR. GRIFFON:** Right. This was -- this draft
13 here of the protocol was done in the spirit of your
14 idea of -- or several people's ideas of a checklist
15 sort of concept, yeah.

16 **DR. ZIEMER:** Okay, any comments or
17 questions?

18 **DR. MELIUS:** Yeah.

19 **DR. ZIEMER:** Jim.

20 **DR. MELIUS:** I think the working group did a
21 very good job with this. I think it -- I have one
22 question as to whether -- I guess this would be for
23 the advanced reviews. One of the I think major
24 concerns in terms of credibility of the process is
25 the issue of what information is available that

1 wasn't -- was not made available or was not included
2 or not considered in your review. And that you seem
3 to be approaching that purely from a records review
4 point of view. You're looking at the site profile.
5 You're looking at the administrative record and so
6 forth. Did you give any consideration, as part of
7 the review, of going back to people at the site and
8 asking some of the site experts -- and we can talk
9 how to define that -- about should other information
10 be considered for a person working in that area?
11 And I think that -- I know that -- my understanding
12 from NIOSH for their site profile are going to have
13 that process, but I'm not sure that that -- when
14 NIOSH does that that we're -- have a way of
15 ascertaining whether or not -- how complete that
16 site profile is. And would it be sort of value-
17 added enough to make it worth the -- is the effort
18 worthwhile to go back and talk to some people from
19 the site and -- just to make sure that all relevant
20 information is included, has been considered. I do
21 think that could help the process some.

22 **DR. ZIEMER:** Let me respond as a -- first
23 and -- it sounds on the surface like a good idea.
24 I'm wondering about the practicality. That's a
25 separate kind of audit. That's not an audit of the

1 dose reconstruction. That's an audit of the data-
2 gathering thing, which may be a good thing to do.
3 I'm not sure that's a burden we want to put on the
4 dose reconstruction subgroup, so we may want to
5 think about that as a separate question. How do we
6 have assurance that, number one, it's not --
7 probably not a simple task for this Board to go on
8 to sites and do that, but aside from the logistical
9 thing, perhaps we need to think about is there a way
10 to develop some level of comfort with the
11 information that's used in the site reconstruction
12 -- or the site profiles.

13 **MR. GRIFFON:** Yeah. I mean, you know, we
14 certainly -- and this is my biggest issue since I've
15 been on this -- but I guess what we were trying to
16 do was to -- and I certainly have concerns about the
17 site profiles and the -- NIOSH's staff power. You
18 know, do they have the resources and are they
19 getting the data to build these site profiles to be
20 what we would like them to be. We tried to bound
21 this dose reconstruction review to look at -- to tag
22 into those site profiles, but also my feeling is
23 that our Board needs to also push and make sure
24 NIOSH has the resources to make sure those site
25 profiles -- and a thought that I've been considering

1 is the idea of having some sort of site-specific
2 boards or panels of professionals, workers that
3 assist NIOSH in developing those site profiles. But
4 that's a whole 'nother set of work --

5 DR. ZIEMER: That's my point. I don't
6 think --

7 MR. GRIFFON: Yeah.

8 DR. ZIEMER: -- the dose reconstruction --

9 MR. GRIFFON: I think --

10 DR. ZIEMER: -- groups can do that.

11 MR. GRIFFON: Well, I think we -- in our
12 scope we did say that we would review the quality of
13 the data used for the dose reconstruction, and I
14 guess I was trying to push that as far as I could
15 and then -- but I -- and that's why I'm saying that
16 that -- maybe to push this from two sides makes
17 sense to make sure that these site profiles are
18 beefed up as best as possible, and then actually the
19 dose reconstruction review -- reviewers, the panels,
20 will be reviewing those site profiles and they will
21 have a lot of that substantial data that Jim might
22 be talking about, but I don't know. Yeah.

23 DR. MELIUS: Well, it seems to me, though,
24 that this is one of the opportunities to check on
25 that. We're hiring a consultant. We've had the

1 site profile -- site profiles will have sort of
2 developed a list of some of the experts, people that
3 are familiar with the site and could be helpful and
4 that some process for that consultant to go back and
5 just check with those people for this particular
6 work area where this person worked or case, was
7 there some other information that should be
8 considered in some way. And we're not talking about
9 doing it on everybody. We're just doing on the ones
10 -- you know, the second tier here.

11 **MR. GRIFFON:** Yeah.

12 **DR. MELIUS:** And I think it would provide
13 one check on that process. I agree that the site
14 profiles themselves may need some sort of review
15 process, also, and we don't want to get this whole
16 process bogged down in that. But to me, if we're
17 going to look at dose reconstruction and the
18 information -- I think it might be able -- possible
19 to do that. I share concerns about the logistics
20 and so forth and how complete that can be, but this
21 seems to be the opportunity. We're drawing a
22 sample. We're -- I don't know if that frightened
23 you and you fell off the -- but it seems to me that
24 if we beef this part of it up, it might be able to
25 take care of that at the same time now.

1 **MR. PRESLEY:** I don't think you want to put
2 that on an industrial hygienist or -- not an
3 industrial -- but an HP's back, do you, because he
4 doesn't know -- the people that we're going to be
5 hiring to do this, the majority of them have had no
6 experience into what the workers have done. You're
7 going to have to have somebody go back with a little
8 bit of experience to see that in the areas. I think
9 you're going to -- that's why -- I'm like Larry. I
10 think it's going to have to be a separate portion of
11 this.

12 **MR. GRIFFON:** I think that's almost an
13 argument for it.

14 **MR. PRESLEY:** Yeah, I agree. I'm arguing
15 for it, but I think it's going to have to be a
16 separate --

17 **DR. ZIEMER:** You're asking who should really
18 do that. Right?

19 **MR. PRESLEY:** That's exactly right.

20 **DR. ZIEMER:** Well, certainly the quality of
21 the information is still a part of this, and it may
22 be that in the process that certain kinds of
23 questions could be identified that might form the
24 basis for developing a process for going back and
25 doing what you're talking about. I think it could

1 be a fairly substantial task. To just ask the
2 question on any particular site or any subset of a
3 site, do we have the site profile for this operation
4 at Hanford.

5 **DR. MELIUS:** Yeah. No, I understand that
6 part. I just worry for the credibility of the
7 process if we haven't done that and claimants are
8 there concerned about well, they just didn't take
9 into account -- they didn't consider the fact --
10 this happened or that happened or there was this
11 exposure and -- that didn't come up and no one seems
12 to be paying attention to that. And I think that
13 could occur.

14 **DR. ZIEMER:** One thing we might think about,
15 and this would probably be the subject of perhaps
16 the next meeting, would be to say okay -- NIOSH is
17 developing the site profiles and they've gathered
18 information from various sources -- to say okay,
19 let's look at that in some way. Let's start with an
20 audit of what we got and how we got it, and then
21 think about what strings do you pull or what the
22 next -- I don't know that we can solve that here,
23 but I think that might be an issue that we want to
24 put on the issue board for future consideration.

25 **DR. MELIUS:** But can I just add -- if we can

1 have some way of going back and testing that site
2 profile versus --

3 **MR. GRIFFON:** Right.

4 **DR. MELIUS:** -- these actual cases, is it --
5 are they helpful enough?

6 **MR. GRIFFON:** That's -- I just made a note
7 to that effect, Jim. I think that might be
8 something we can add in to test, even on a
9 percentage of the advanced, maybe even, you know.
10 Maybe it's not all of the advanced ones, right.

11 **DR. ZIEMER:** Larry has a comment and then I
12 think Tony and then Roy.

13 **MR. ELLIOTT:** Just to make sure that we're
14 all working with the same understanding, the site
15 profiles are -- they're going to be developed, and
16 right now I'd say they're fairly sketchy, and
17 certainly you could spend your time looking at what
18 a site profile might look like at this point in
19 time. But I think you'd be better benefitted in
20 spending your time, as we get to a point where it
21 may make more sense, to expend the effort and the
22 time to look at what the site profile speaks to.

23 Certainly I think it does make a lot of
24 sense for the comprehensive review stage to take a
25 sample or where you think it's appropriate to have

1 the consultant make contact with whoever is
2 appropriate at a given site, ask that question.
3 This is the information I've seen and used; is there
4 anything else we didn't have that wasn't used, that
5 should have been -- that you are aware of. And
6 maybe we can -- we can make that happen, I think.

7 In the examples of the dose reconstructions
8 you all witnessed this week, I think you also saw
9 some instances where information was provided that
10 was not used. And I would ask how do you account
11 for the -- in the quality of a dose reconstruction,
12 how that's been handled. I don't see that addressed
13 here. You know, where in instances the claimant
14 said I've got this information. I'm searching here
15 to see how you handled -- in your review, in a
16 quality of the dose reconstruction process -- that
17 the claimant understood why it was not used or why
18 it didn't make sense to use it. I think that is
19 just as important -- you know, when a claimant comes
20 forward with information that they've spent time,
21 money and their own energy in collecting and
22 assembling, and then they don't see it used, we're
23 going to hear as many complaints on that side of the
24 fence as we are on the other side of the fence, I
25 think.

1 **MR. GRIFFON:** Yeah, I think we --

2 **MR. ELLIOTT:** And I don't see that addressed
3 here.

4 **MR. GRIFFON:** (Inaudible) maybe not
5 extensively enough -- and I'll remind that -- was
6 drafted at 11:00 last night. I thought we tried to
7 capture that in the review of the interview and
8 documentation provided by claimant, determine
9 whether NIOSH appropriately addressed all
10 allegations made by the claimant and assure that the
11 interview information is consistent with the data
12 used in the dose estimate. And then in the first --
13 number three on the -- or A-3 on the advanced, the
14 distinction between the basic and the advanced was
15 that we're reviewing the entire administrative
16 record, which from my understanding of how NIOSH is
17 -- you know, the administrative record includes all
18 the data they got. They may not have used some of
19 that data and the independent expert and panel would
20 be able to then -- then they have to go through all
21 that administrative record, and if they found
22 certain things that they thought were relevant to
23 the dose reconstruction but were not considered by
24 NIOSH, then they've have a -- they'd question it.

25 **MR. ELLIOTT:** Thank you.

1 **MR. GRIFFON:** So I think that's where we got
2 it.

3 **MR. ELLIOTT:** I think it's covered then.

4 **DR. ZIEMER:** Tony?

5 **DR. ANDRADE:** I just wanted to comment that
6 it's not entirely clear in my mind yet what
7 comprises a site profile, but as the discussion has
8 evolved I think I've got a couple of ideas and I
9 think that eventually we're going to see that a,
10 quote, site profile is going to come about and maybe
11 -- how shall I say it -- even a technical area
12 within a site profile will come about from many
13 different avenues, one being the dose reconstruction
14 process itself and the interviews that are done for
15 that process; number two, well-known accidents that
16 have been documented; and number three -- and this
17 is true probably more so in recent years than in the
18 early years -- the development of databases of
19 incidents in which we know there have been updates
20 or intakes of radioactive material.

21 And for example, at our plutonium facility
22 we have developed a site profile that goes back
23 fairly -- a fairly long ways that we use as a prior
24 distribution for Bayesian* analysis or for looking
25 at the possibility that a real intake has occurred.

1 So if we're going to choose to develop these things,
2 I think we're going to have to develop -- we're
3 going to have to realize the diversity of sources of
4 data that we're going to have to use to build these
5 as we go along.

6 Did Jim want to respond to that?

7 **DR. NETON:** I was just going to amplify on
8 what Dr. Andrade said. It's true, a site profile is
9 that and more. All of those things go in there.
10 What I would like to say, though, is a site profile
11 is a dynamic thing. And Larry's right, right now we
12 don't have a volume of information in there, but
13 they are growing as we do dose reconstructions.

14 In many cases, some of the simpler ones that
15 the working group saw, we needed very little site
16 profile information to construct a dose. We needed
17 to know very limited things, like frequency of badge
18 exchange and maybe the detection limit of a badge
19 and what the badge consisted of and we could be
20 finished.

21 In the more complicated cases, as we get
22 into those middle ground cases where we need to pull
23 out all stops, that's where the site profile's going
24 to grow dramatically, where we have four classes of
25 information in site profiles -- characterization of

1 the internal monitoring program, the external
2 monitoring program, the medical radiation monitoring
3 program, and the environmental monitoring program.
4 There are four key areas that we're expanding on,
5 and only in those cases typically where we go to a
6 full-blown dose reconstruction would all four of
7 those areas be exercised or utilized. So it is
8 possible to have limited site profile information
9 yet have dose reconstructions move forward, and I
10 think that's what the Board would see now if they
11 actually took a snapshot. But down the line I think
12 it might make some sense where we start doing cases
13 where we have no monitoring and we're going to rely
14 on air sampling data and that sort of things that
15 are -- that may be in there, environmental area
16 surveys, that sort of thing. It might be better to
17 -- down the line to look at those profiles.

18 **MR. GRIFFON:** I guess also in some way I'm
19 not sure if this falls into internal and external,
20 but I think some sort of process --

21 **DR. NETON:** Right, source-term knowledge,
22 that sort of thing. I think you saw a good example
23 of that on an AWE where we went out and really tried
24 to pull all the stuff that was in there.

25 **MR. GRIFFON:** Right. But as everybody's

1 realizing -- I mean this is not a small task, and
2 from what we could gather in our tour of the
3 facility, the site profiles are, as Larry said,
4 sketchy at this point. They're -- and there is a
5 massive undertaking, I would say, to get those up to
6 speed. And another concern I would have is that I
7 know that dose reconstructions are going to feed
8 into that process to help you fill out that, but I'd
9 hate to have the cart before the horse -- is that
10 the expression? I mean I hate to be -- you know, if
11 we don't have a full picture and then we have to go
12 back and redo dose reconstructions again for a lot
13 of people because we missed something --

14 **MR. ELLIOTT:** We don't want to do that. And
15 please understand that as soon as this contract's
16 awarded, there's going to be a group in the
17 contractor that we're going to sit down with and
18 that's their primary responsibility.

19 **MR. GRIFFON:** Right.

20 **MR. ELLIOTT:** Start the research effort, put
21 the site profiles on the table --

22 **MR. GRIFFON:** I understand.

23 **MR. ELLIOTT:** -- figure out what information
24 gaps exist in those profiles and let's get them
25 filled.

1 **MR. GRIFFON:** Right.

2 **MR. ELLIOTT:** Okay?

3 **MR. GRIFFON:** Right.

4 **MR. ELLIOTT:** Move on that, because it's
5 going to aid the individual dose reconstructions as
6 the individual dose reconstructions aid the
7 profiles, and we need both -- we need to track these
8 at the same time and put as much emphasis on both
9 tracks as we can.

10 **DR. ZIEMER:** Roy and then --

11 **DR. DEHART:** I would caution the Board on
12 expanding this audit activity. This is an
13 administrative paper audit, if you will. And to
14 make it an investigative audit, to go into the work
15 site -- by phone, in person, whatever -- is going to
16 complicate, delay -- and I'm not speaking in
17 opposition of doing that, but don't do it with this
18 process.

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

20 **DR. MELIUS:** No, Wanda had her --

21 **DR. ZIEMER:** Oh, were you up first, Wanda?
22 Go ahead.

23 **MS. MUNN:** I almost hesitate to broach this
24 because I recognize how involved it might become.
25 But in the process of doing site profiles, would

1 there be a value to having that material, as it
2 develops, be available on the web site for other
3 individuals to provide data that perhaps might not
4 be in the official record, which would be helpful?
5 And I recognize, as I ask that question, that the
6 quality of information that you get might be
7 questionable and that the quantity of it might be
8 overwhelming. But it's simply a question. Would
9 that be of value in assisting to accommodate the
10 goal of site profiling that you have in mind?

11 **MR. ELLIOTT:** Well, you know I'm a big web
12 site person. I think we've got the best web site
13 going, and I think this would be a certain
14 beneficial aspect to see this information provided
15 publicly. And the benefit I see in that is somebody
16 out there may say hey, I've got a piece of
17 information I don't see there. Have you not found
18 this?

19 Certainly it's going to be problematic for
20 us to do so, given -- you know, I can envision large
21 amount of information -- we've already got a large
22 amount of information on our web site, but this will
23 take us to another whole level, so we'd have to
24 evaluate that. But I think the benefit outweighs
25 the difficulty.

1 **MS. MUNN:** Be ready for it.

2 **DR. NETON:** I do think that's a good idea.
3 And we already plan on having this on our intra-net
4 internally to use for our contractor. I would say,
5 though, that certain pieces of it may not be able to
6 go on the general web. We plan on having these
7 drill-down menus where it will take you down to
8 specific cases and classes of workers so that ends
9 up being part of the profile information, so it
10 would have to be generic monitoring information, not
11 any claimant-specific type stuff.

12 **DR. ZIEMER:** But something to be considered.
13 Jim?

14 **DR. MELIUS:** I would just add that while
15 these site profiles are currently not very robust, I
16 think it's all the more important that there be some
17 process to check that now. And whether it's this
18 working group or another working group, how we
19 figure out that process, I don't know procedurally,
20 but I think we need to consider that and figure a
21 way that we're going to provide some affirmation of
22 that information within the constraints of resources
23 and time for doing this. And it may be that down
24 the road when these profiles are -- you know, a few
25 years from now when they're much stronger, then that

1 process -- that part of the process will be less
2 important. But until then, I think -- I'm just real
3 worried that people are going to question the
4 results -- question our review of the results unless
5 we find some way of taking that into account.

6 **DR. ZIEMER:** Other comments? We're
7 approaching the noon hour and we have a public
8 comment period. I have three individuals who've
9 requested speaking times from up to ten minutes
10 each, which means 30 minutes. So I'd like to ask if
11 any or all of the three -- Bruce Lawson, Jerry Tudor
12 and Bob Tabor -- we have Tudor and Tabor -- can any
13 or all of you would be willing to wait till after
14 lunch to speak? If it's a problem, we'll do it now.

15 **MR. TUDOR:** The only problem I have, I would
16 like to -- if it would be first thing after lunch,
17 that would be fine. I just don't feel like, you
18 know, I need to stay that late.

19 **DR. ZIEMER:** Okay, let's have you -- we'll
20 go right now. I just want to check with the other
21 folks.

22 You're okay after lunch and you're okay
23 after lunch? Okay.

24 Let's go then with -- let's see now, this is
25 -- you are --

1 **MR. TUDOR:** Tudor.

2 **DR. ZIEMER:** -- Tudor. Okay, Jerry. Why
3 don't you address us now then, Jerry. Do you want
4 to use the podium, if you want to go up to the
5 podium or --

6 **MR. TUDOR:** Nah.

7 **DR. ZIEMER:** -- either one? Right here,
8 okay.

9 Jerry is with -- is from Clinton, Tennessee,
10 USOL.

11 **MR. TUDOR:** Yes.

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

13 **MR. TUDOR:** Yes, I'm Jerry Tudor and I'm
14 with USOL and that's United Sick, Oppressed
15 Laborers, who's a sick organization, Oak Ridge, and
16 I'm with CHE, who's the Coalition for a Healthy
17 Environment. And we met with our Congressman in Oak
18 Ridge yesterday, or his aides, and he informed us
19 it'd be next year before any laws could be passed to
20 change anything about this.

21 The problems I see with it is the amount of
22 time to become a special cohort is ridiculous, you
23 know, because -- I've already been applied a year,
24 so should they determine that DOE don't have
25 records, then I have to wait another year to year

1 and a half? Is that not the time limit?

2 DR. ZIEMER: There is a 180-day waiting --

3 MR. TUDOR: Yes, plus --

4 DR. ZIEMER: -- period after something is
5 filed before --

6 MR. TUDOR: Plus --

7 DR. ZIEMER: -- Congress approves it, yeah.

8 MR. TUDOR: Plus you have 200 days to act on
9 it after that. Okay.

10 DR. ZIEMER: Right, so there is a time span,
11 right.

12 MR. TUDOR: And most people are sick, you
13 know. I have fourth stage prostate cancer, and a
14 lot of people are already upset with the amount of
15 time it's, you know, been taking on this. And
16 another problem I have with -- when I set at home
17 and read the minutes of the meeting and the calls
18 and whatever and May the 29th -- 8th on a
19 teleconference call, y'all said that the majority of
20 the claims would be denied. Well, that bothers me.
21 And you know, looking at it from a sick worker, you
22 know, if y'all are saying the majority of the claims
23 will be denied already, before any dose
24 reconstructions are done -- they're up to seven now
25 -- you know, that kindly (sic) bothers me. And they

1 said there'd be a lot of mad people, and they will
2 be, you know.

3 And another thing with -- problem with
4 comparing me to somebody that worked in -- chemical
5 operator, which that's what I was, you can't compare
6 me with a person that worked at the other end of the
7 room even because I done a job different from him.
8 I might have been exposed to a bunch and he might
9 not have been exposed to any. I might not have been
10 exposed to any he's exposed to a bunch, you know.

11 And working at Y-12 all those years, I know
12 records were inadequate. I also know that if a
13 program had a bunch of money in it, they clocked my
14 time to that program. I may have not even worked on
15 that program. I may have been doing something over
16 here -- cleaning -- sweeping the floor, cleaning up
17 a spill or something, and was charged to a job that
18 I didn't do, you know. And that creates a problem
19 when you start doing dose reconstructions and you
20 look -- say well, he done this this day. That is
21 not the way it happens at Y-12. I'm sure some of
22 you know this. And I just thought I'd come up today
23 and, you know, try to get my two cents in.

24 **DR. ZIEMER:** Thank you, Jerry, for those
25 comments. Now we always like to provide an

1 opportunity for the Board, if they have questions or
2 want anything clarified, to see if there are any
3 questions or feedback for Jerry.

4 (No responses.)

5 **DR. ZIEMER:** Okay. And your remarks will
6 appear in the record, as well. Thank you.

7 **MR. TUDOR:** Thanks a lot.

8 **DR. ZIEMER:** Thank you very much. Let's now
9 recess for lunch and right after lunch we'll hear
10 from Bruce and Bob, and then we'll return to our
11 session on the Special Exposure Cohort.

12 **DR. MELIUS:** What time?

13 **DR. ZIEMER:** We're due back at 1:30. We
14 want to be prompt on that because I know starting at
15 3:00 some people have to start bailing out.

16 (Whereupon, a luncheon recess was taken.)

17 **DR. ZIEMER:** Okay, I'll call the session
18 back to order. We would like to hear now from Bruce
19 Lawson. Bruce is with PACE Medical Screening
20 Program and is from Oliver Springs, Tennessee. And
21 Bruce, glad to have you here to address us this
22 afternoon.

23 **MR. LAWSON:** Thank you. And for those of
24 you who don't know, Oliver Springs is a suburb of
25 Oak Ridge.

1 As he said, I'm Bruce Lawson. I worked at
2 the K-25 site at Oak Ridge, which is one of three
3 DOE facilities in Oak Ridge. I was a craftsperson.
4 I was there a little over 30 years. The last nine
5 years I was the union health and safety
6 representative for the site and just a couple of
7 general comments. I'll keep this brief. I hate to
8 be the first speaker after lunch. Everybody's
9 wanting to -- anyway.

10 I saw first-hand what Joe Carson alluded to
11 yesterday, some of the things he mentioned about
12 records, and I saw exactly what he was talking
13 about. I saw industrial hygienists, health physics
14 people and safety people, professionals, silenced
15 and their minds changed by a simple frown. It
16 didn't take any pressure at all to get them to
17 rewrite records, redo reports. As a matter of fact,
18 they were under the onus to clean up reports before
19 DOE ever saw them. So what -- most cases, what DOE
20 saw, the final analysis was a cleaned-up or very
21 much edited version of what actually took place.

22 I now work with the local worker health
23 protection program, the medical screening. We --
24 very often we're the first point of contact for the
25 claimants in this EEOICPA thing. We meet the

1 individuals face-to-face and we hear -- I could
2 repeat, but I won't, a lot of the comments that you
3 heard at the public meetings that was referred to
4 earlier. We hear that every day, many times -- of
5 course similar verbiage.

6 Most of our claimants are not -- I wouldn't
7 say most, but a large portion of them are
8 uneducated, almost to the point of being illiterate.
9 Their spouse, be it a husband or wife, said very
10 little, if anything, about what they did at work,
11 what their job was, what their job duties,
12 especially. So they know virtually nothing about --
13 they just know -- and in our case, we see people who
14 weren't even sure which one of the three plants
15 their husband worked at. And they were told, of
16 course, you don't talk about what you did years ago,
17 and they certainly don't understand this process.
18 To them, it's much too complicated and they don't --
19 they're not -- they just don't understand dealing
20 with bureaucracy and Federal procedures.

21 We -- a lot of them can't get their records
22 from DOE, and a lot of them can't get their records
23 from local physicians and hospitals. I know of one
24 case where this lady -- and this is a person who is
25 existing on Social Security. They wanted to charge

1 this lady \$300 to give her her medical records. She
2 couldn't afford it. She walked away. She came to
3 us. We made some phone calls and was able to
4 persuade them to give them to her.

5 But anyway, we've seen a lot of people throw
6 up their hands and quit because they can't deal with
7 the established bureaucracy as it is. They get a
8 couple of requests for information, the claims
9 office -- the DOL claims office loses their records
10 and so on and they write back for more
11 documentation, and they just throw up their hands in
12 disgust and say I knew I couldn't do it anyway.

13 Based on what I've heard about dose
14 reconstruction and the requirements -- record-
15 keeping from DOE, we're very, very wary of it. We
16 believe that more -- far more deserving claimants
17 will be denied than actually paid. And there again,
18 around the Oak Ridge area, all too often the word on
19 the street is if you didn't work at K-25, you can
20 forget it. It's -- you know, people have their
21 claims in the pipeline for over a year, and the word
22 is getting around. I talked to Dr. Bingham*
23 yesterday and their business is way down. So is
24 ours, not quite to the extent -- what she said, but
25 it is down. But that's -- word of mouth in any kind

1 of business is the best advertising, or worst
2 advertising you can get. And right now, we're
3 getting some very negative word of mouth
4 advertising, the entire process is.

5 I applaud your efforts, and especially what
6 you mentioned this morning about streamlining the
7 process, getting on with it, get -- get these claims
8 moving, get them through. And I know you guys are
9 bound by the law, but in the back of your mind,
10 remember, these people were probably -- most of them
11 were probably exposed to far greater hazards from
12 chemicals than they were from the radiation
13 exposures that they got. So don't feel the least
14 bit hesitant to go ahead and push a claim through
15 that's questionable in my mind because these people
16 are definitely deserving. Most all of them are.

17 That was about it. I just jotted down some
18 notes that I thought you might want to hear from the
19 street, and that's where we are, street level.

20 **DR. ZIEMER:** Thank you, Bruce. Let me ask
21 if any of the Board members have questions for
22 Bruce.

23 **DR. MELIUS:** I have one.

24 **MR. LAWSON:** Sure.

25 **DR. MELIUS:** Thank you for your comments,

1 Bruce. What -- do you have any ideas on how we deal
2 with this situation where the official records may
3 not be truthful or accurate, accurately reflect
4 people's exposures? Would we get -- be able to get
5 that information from interviewing some of the
6 people down there or how do you get at that? I mean
7 I know it's not easy, but do you think people are
8 generally aware of the issue when the records are
9 not being -- have not been properly kept for a
10 period of time or --

11 **MR. LAWSON:** Not in every case, certainly,
12 but there are some that are. We did a lot -- I say
13 we, I'm talking about our local union there and the
14 international did a lot of risk mapping where we
15 called the workers themselves. And there again, I
16 heard reference to expert -- site experts. If there
17 are experts at these sites, it's those guys who were
18 out there every day -- and ladies, of course -- who
19 were out there every day with their hands on. They
20 knew what was going on in this area as opposed to --
21 someone mentioned earlier that you could be at the
22 opposite end of the room doing an entirely different
23 procedure, different process, which is true. But we
24 gathered people together and -- with maps of the
25 buildings, different areas -- what was here, what

1 went on and so on -- and from that we -- we have a
2 lot of information.

3 **DR. ZIEMER:** That suggests that perhaps
4 there's another source of information that could be
5 tapped into --

6 **MR. LAWSON:** There is, yes.

7 **DR. ZIEMER:** -- your risk mapping.

8 **MR. LAWSON:** There certainly is. Mark
9 Griffon was involved in a lot of this, the sessions
10 that we did.

11 **DR. ZIEMER:** And that is information that
12 would not derive from requests to DOE, I assume. Is
13 that correct?

14 **MR. GRIFFON:** That's correct, yeah. But
15 this is -- I think medical surveillance program data
16 was actually explicitly mentioned in one of the
17 regulations or the -- yeah --

18 **DR. ZIEMER:** Right.

19 **MR. GRIFFON:** -- and this is all under the
20 medical surveillance -- DOE medical surveillance
21 programs.

22 **DR. ZIEMER:** So it is available via the DOE
23 route, then, or not? This sounded like a
24 separate --

25 **MR. LAWSON:** Probably if you request the

1 right document, would be my guess.

2 **DR. BINGHAM:** Well, I'm a PI on one medical
3 surveillance project, and these are cooperative --

4 **DR. ZIEMER:** You need to identify yourself.

5 **DR. BINGHAM:** Eula Bingham, the University
6 of Cincinnati College of Medicine, Department of
7 Environmental Health. The PI, the -- I'm the PI on
8 this one. These are cooperative agreements and
9 because the workers were so concerned about DOE and
10 its reputation and so forth, we were very careful.
11 And we agreed not to give it to them. I mean if a
12 worker decides to give it, that's their choice, and
13 we have them read a confidentiality agreement and so
14 forth. But the data belongs really to the project
15 and it's only given in de-identified form. And
16 theoretically that could be done by each of the
17 projects, not by DOE.

18 Now certainly DOE could encourage the people
19 who have the projects to do it, but they do not own
20 the data. The only thing they would own that we
21 have is if monitoring data for a certain facility,
22 then they own that and that's covered under the
23 Privacy Act. So I think you'd have to go to the
24 different surveillance projects and ask that, and I
25 think most people would be happy to share what they

1 have.

2 As a matter of fact, we've already shared
3 some of the information with NIOSH on what we called
4 institutional histories of some of the sites where
5 we knew what the processes were and during what
6 periods of time. Not perfect, but at least
7 something.

8 So -- but for this, the actual owning of the
9 information is for each project, but you know, you
10 could never give up identified data. That's up to
11 each worker. Is that right?

12 **MR. GRIFFON:** I guess I was thinking more
13 along the lines of the summary reports, which are --
14 all the de-identified summary reports which capture
15 -- at least may help in the site profile side of
16 things. Certainly the interviews and the identified
17 data, Eula's correct on that.

18 **MR. LAWSON:** And what we call the needs
19 assessment documents where we had the initial
20 meetings, in a generic form.

21 **DR. ZIEMER:** It seems to me we'd want to
22 make sure those got into the system if they're --

23 **MR. ELLIOTT:** Yeah, let me speak to this a
24 little bit, and I appreciate Eula speaking on it, as
25 well. And she's certainly very accurate, DOE

1 doesn't own much of this information, and so we've
2 been working with several of the PI's and in some
3 specific situations regarding perhaps construction
4 workers, we've been working for the Center for
5 Protection of Worker Rights for -- trying to put in
6 place a sole-source contract with that -- with a
7 consortium under the Center for Protection of Worker
8 Rights to get information from these different
9 programs for five different sites, the work history-
10 related information for construction workers. And
11 also we should be aware that any one of the former
12 workers who go through the program are given
13 information back to them individually which should
14 be part of their claim. They can submit it as part
15 of their claim, and so that personal, individual
16 information can be utilized as it comes from the
17 individual. And we certainly -- every time we deal
18 with a claimant and we identify that they were a
19 member of a former worker screening program, we ask
20 do you have this information and it certainly would
21 be beneficial if you would provide it. And so
22 that's one way we try to get around this issue of
23 the individual information and not having a release
24 form signed through the whole program.

25 **MR. ESPINOSA:** What are the five sites?

1 **MR. ELLIOTT:** Well, there's -- we're still
2 working on the negotiation of this agreement, sole-
3 source agreement with CPWR on it. I can't go into
4 it at any more detail than that right now.

5 **DR. DEHART:** Again, thank you for your
6 comments -- Roy DeHart. There was a point of
7 clarification. You had mentioned that in Oak Ridge
8 the word is that if you didn't work at K-25, forget
9 it. Under the special cohort, the gaseous diffusion
10 operation was covered. Did it cover anyone working
11 in the reservation -- in the K-25 reservation
12 itself, or just specific site and operational
13 activities?

14 **MR. LAWSON:** Just the K-25 site. Of course
15 we had a lot of workers who transferred between
16 sites. That happened very frequently. But if they
17 worked as much as 250 days --

18 **DR. DEHART:** In that building?

19 **MR. LAWSON:** -- at K-25, they -- we're a
20 special cohort.

21 **DR. DEHART:** Okay.

22 **MR. LAWSON:** They would be considered.

23 **DR. DEHART:** And when you say K-25, you're
24 talking about K-25, the building --

25 **MR. LAWSON:** The gaseous diffusion plant

1 itself.

2 **DR. DEHART:** -- the building.

3 **MR. LAWSON:** The physical -- physical plant
4 --

5 **MR. PRESLEY:** No, no.

6 **DR. ZIEMER:** The site.

7 **DR. DEHART:** The whole site. Okay.

8 **DR. ZIEMER:** The site.

9 **DR. DEHART:** The whole site. Okay.

10 **DR. ZIEMER:** Other questions for Bruce?

11 Thank you very much.

12 **MR. LAWSON:** You're very welcome.

13 **DR. ZIEMER:** All right. Now we'll hear from
14 Bob Tabor. Bob's been with us before from Harrison,
15 Ohio. Bob, are you here?

16 **MR. TABOR:** Yes. I'm Bob Tabor -- Robert
17 G., for the record. I'm a member of the Fernald
18 Atomic Trades and Labor Council. I work at the
19 Fernald site, 21-year veteran there, millwright by
20 trade and a labor representative. I spoke to you
21 folks in the past and I guess the first thing I
22 would like to say is I'm happy about the new members
23 of the Board and glad to see that that issue's been
24 addressed and the addition of those folks. I'm also
25 happy to be able to be here again, you know, to

1 participate and listen to the Board's activities.
2 Doing so certainly helps elevate the learning curve
3 because without a doubt to say, this is a kind of a
4 complex issue, some of these things are.

5 And I guess on that note, some of the things
6 I'd like to talk about, it'd be really hard for me
7 to reiterate those things in such a manner that I
8 might get as detailed as some of you who really
9 understand the science behind this. So some of my
10 comments will basically be in reference and in
11 general, because the things I've been thinking about
12 the last few days that I would like to comment to
13 have been explored by a lot of conversation and
14 discussion here this morning, so I just want to
15 reiterate the issues that Mark brought up and that
16 Jim brought up, especially those on the issue
17 regarding the SEC class applying for non-SEC-listed
18 cancers and those particular issues there. I want
19 to be sure that we give thorough thought to how to
20 adjust or how to fix those type of issues and
21 answers.

22 I mean I recognize that as this whole
23 process evolves there's certain things that were not
24 thought of in the beginning in the rule that have
25 come up that need to be addressed. And I just want

1 to reinforce the fact that, you know, we need to do
2 everything possible to fix those things so that we
3 don't have a lot of black holes that complicate
4 things as we go down the pike, you know, on making
5 claims.

6 One of the other issues deals with -- let's
7 see here. My concern over the fact that Fernald was
8 unfortunate that we didn't get ourselves as --
9 identified as part of the original cohort groups,
10 such as Paducah and Piketon. And in lieu of that,
11 it leaves us in a position to possibly explore what
12 is now before us, which is the Special Exposure
13 Cohort, those particular avenues. And one of the
14 things that bothers me a little bit is that the
15 rule-making or the guidelines, if I'm expressing
16 that correctly, that was set forth for the original
17 cohort groups, that those same things are not true
18 for that of the Special Exposure Cohorts, and so I
19 have some concerns relative to the equity in that
20 process. That's about the best way I can explain
21 that I think we've talked a little bit about it here
22 this morning in detail, but I want to reiterate
23 that.

24 And then I guess in part of that thought
25 process comes the issue that Mark touched on

1 relative to, you know, the endangered -- the
2 definition of an endangered health. There seems to
3 be some complicities (sic) there, in my mind,
4 relative to how we're going to approach, you know,
5 defining that with respect to maybe dose
6 reconstruction of the individual and possibly what
7 that might be -- you know, for the site or something
8 to that effect. It's difficult for me to talk to
9 that somewhat in detail, but I think Richard's
10 touched on it, as well as we've addressed that issue
11 here this morning. And I just, once again, want to
12 reiterate those two particular areas that we need to
13 work on for good clarification.

14 One of the other things that came to my mind
15 this morning in some discussion and it came up a
16 couple of times, and I'd like to touch on it again.
17 Let me grab my notes here. There was -- you know, I
18 had asked -- I was writing down some questions I
19 asked -- I asked myself a couple of questions I
20 guess I really knew the answer to, but let me just
21 read those. I said to myself here, you know, some
22 questions.

23 I said in doing the dose reconstruction, is
24 the only category of collected data, you know, that
25 of consideration for doing the reconstruction would

1 be that of just exposure records. Well, I got to
2 thinking about that and said now, Bob, that's -- no,
3 there's other things that are considered, as well.
4 And then it posed a question in my mind, you know,
5 does the nature of where you worked in an operation
6 and what maybe the individual did and what they were
7 exposed to, does that have bearing on the
8 development of the dose reconstruction? And the
9 answer to that is well, yes, it does.

10 Then my thought process went to the
11 questions that were generated or the conversation
12 that was generated this morning under the issue of
13 -- let me think here a second -- the memorandum of
14 agree-- I mean memorandum of understanding relative
15 to what are we going to do about DOE and getting
16 additional information, and what is that information
17 going to be limited to. I think you've heard me
18 speak a few times in the past over my genuine
19 concern about the record-keeping processes,
20 especially with respect to the record-keeping
21 processes -- well, wait a minute, let me back up.
22 Maybe not the record-keeping processes, but the
23 retention of records at some of these sites, and
24 especially of those sites who are kind of on the
25 short list.

1 Now by the short list, I mean sites that are
2 destined for closure in the near future. At one
3 time here for a while there was this moratorium on
4 the disposal of records, and I think I mentioned the
5 last time that that moratorium has been lifted. Now
6 a lot of those records are going to be on processes
7 that we did at the site, the various types of, you
8 know, things that went on -- you know, where the
9 people worked, what they did. I was hoping that
10 something that might be generated in addition to
11 maybe a special letter which you folks indicate that
12 maybe you should write to the DOE or Congress
13 addressing the memorandum of understanding relative
14 to information, that we might address the fact that
15 maybe they should reimpose a moratorium on these
16 records. Because as these sites close, it's going
17 to be really, really hard to find these things.
18 Without a moratorium, they can ship that stuff off
19 to anyplace and it just gets hidden in a -- you
20 know, in the closet. And then you have information
21 that you may need, other than just the medical
22 records on the individual to make certain decisions,
23 obtaining that information gets only that much more
24 difficult when you don't have availability to those
25 records. And I have a big concern over that and was

1 disappointed in the fact that they have lifted that
2 moratorium. So I would like to reiterate that
3 aspect for your consideration and whether or not you
4 would like to address that in your letter or if it
5 ties into that or if it's something you should
6 address, you know, independently, you know. Because
7 Fernald's probably going to be one of the first
8 sites, other than Weldon Springs, that's going to be
9 what we call, you know, a closure site that's come
10 to completion. We have a lot of retired employees
11 right currently and, you know, and as these things
12 -- as these issues crop up and these applications
13 become more familiar with the employees and that
14 they make application, you know, for compensation,
15 the record issue might get real muddy. So I wanted
16 to reiterate that.

17 So other than that, I believe I don't have
18 any other comments for today. At least that's what
19 I've jotted down.

20 **DR. ZIEMER:** Thank you very much. Again,
21 let's see if we have questions -- yes, Tony?

22 **DR. ANDRADE:** Seems we don't have enough
23 microphones to go around the table. Sorry about
24 that, Bob.

25 **MR. TABOR:** Okay.

1 **DR. ANDRADE:** Bob, I haven't been --
2 truthfully, I haven't been keeping up with what's
3 going on with moratoriums on -- moratorium on
4 records-keeping. Do you know if this permits sites
5 to actually destroy records or is it directing sites
6 to send records to other facilities?

7 **MR. TABOR:** I'm not certain. It's not
8 really totally clear in my mind. Moratorium means,
9 you know -- in my mind means don't do anything with
10 them, in the sense of like destroying, or you have
11 to keep what you've got. I think when they lift the
12 moratorium, exactly what the total guidelines are on
13 what you can do with the records, quite frankly, I'm
14 not so sure the DOE has developed a true, pure, good
15 set of guidelines on what you can get rid of and
16 what you can't.

17 Now let me give you just a far-fetched
18 scenario. I think that probably you could destroy
19 maybe cash register receipts from the cafeteria, and
20 that wouldn't be any big thing. And they're not
21 going to -- whew -- put that stuff out someplace in
22 a big vault. But then there's this other set of
23 delicate records that will have a greater meaning,
24 you know, to -- you know, to our future citizens or
25 our future society, certainly may have a greater

1 meaning to an organization like ourselves and the
2 processes that you're involved in. I don't know
3 exactly what their rule-making is going to be on how
4 they're even going to approach this.

5 I've had some discussion with some higher-
6 ups, at least at the field level, asking them since
7 the moratorium has been lifted, what are your
8 guidelines for how you're going to go about this, if
9 you have a plan, and what specific records. Quite
10 frankly, my impression is is I'm not so sure that
11 they have guidelines in place to say you can do this
12 to this extent or you can do that to that extent.
13 I'm not really sure about that, if you want to know
14 the truth. But I have concern about it because my
15 impression is okay, if a moratorium is lifted, then
16 begs the question what you're just asking, just what
17 can you get rid of. And even to complicate things
18 more, what you may retain, where's it going to go.

19 **DR. ZIEMER:** We have a comment from Larry
20 and then from Bob.

21 **MR. ELLIOTT:** The moratorium on destruction
22 of records for epidemiologic purposes has not been
23 lifted.

24 **MR. TABOR:** That is correct.

25 **MR. ELLIOTT:** It is still in place, and so

1 in that regard, any system of records that has use,
2 utility, benefit to epidemiologic studies and the
3 understanding of exposure associated with health
4 outcome, are protected. And NIOSH has, in the last
5 12 years, a long history of involvement in advising,
6 arguing with, recommending to, working with DOE on
7 making sure that those records are intact and
8 retained and not destroyed. I know that the health-
9 related energy research branch at NIOSH, which I was
10 the branch chief for, has worked very closely with
11 the people who do record reviews across the sites.

12 What I think you're very accurate and your
13 point is very well-taken on, Bob, is what happens to
14 those records that are protected when a site closes
15 down, and where do they go and how do we find them.
16 And that's been our concern for a number of years as
17 to the finding aids and the systems of records that
18 are protected for these purposes and how to make
19 sure that they're not lost in a Federal archive
20 somewhere and they are retrievable and traceable.
21 And that's something we have commented on and been
22 concerned about, and I think that's where I hear
23 your point dwelling and hitting home with me very
24 strongly.

25 But the moratorium on destruction of

1 records, in my understanding -- unless you have some
2 memo within DOE I have not seen yet -- has not been
3 lifted.

4 **MR. TABOR:** Well --

5 **MR. ELLIOTT:** It's still intact.

6 **MR. TABOR:** And I agree with you there,
7 Larry. I understand that things like medical
8 records, and then you framed it as epidemiological
9 records and things like that, my impression is that
10 yes, there's not a moratorium to lift that. I mean
11 in other words, those things have to be -- stay
12 intact. But you're right, the issue is where may --
13 you might find them in the future.

14 I think that what I'm also referring to here
15 is things that might be associated that people would
16 look at or you folks may look at in developing maybe
17 probability of causation --

18 **MR. ELLIOTT:** But it's all records. We have
19 been integral in deciding with DOE what systems of
20 records -- and it's not only the medical records,
21 it's not only the dose records, we have targeted the
22 process records --

23 **MR. TABOR:** Okay.

24 **MR. ELLIOTT:** -- the processing information
25 records, the changes in historical practices at a

1 given site, employee benefit records, the PSQ's --

2 **MR. TABOR:** Okay.

3 **MR. ELLIOTT:** -- we say don't destroy those
4 --

5 **MR. TABOR:** Well, maybe that's not been
6 clear to us in the past, but those are the things
7 that I have concern about, you know --

8 **MR. ELLIOTT:** And if you go --

9 **MR. TABOR:** -- process records.

10 **MR. ELLIOTT:** If you go into DOE's routine
11 use authority under the Privacy Act that gives NIOSH
12 routine use authority to access those records,
13 you'll see a long list of systems of records. And
14 those systems of records, by their nomenclature,
15 will give you an indication of the variety of
16 information that's protected. And it's not only
17 just medical and dose, it's a long whole list of --
18 there must be -- I recall like 27 different systems
19 of records that we said we need to see. And we had
20 to make some very strong arguments for why a certain
21 system of records was important to --

22 **MR. TABOR:** Yeah, well, that would be my
23 concern.

24 **MR. ELLIOTT:** -- research and understanding
25 of exposure and health outcome.

1 **MR. TABOR:** Okay.

2 **DR. ZIEMER:** And let's see, Robert had a
3 question or a comment.

4 **MR. PRESLEY:** I agree on some of these
5 records. In the past three years that's what I've
6 worked on extensively. And I know at Paducah
7 there's stuff -- when the new company took over --
8 out the door. Or in a trailer. And we're in the
9 process of going through some of that stuff.

10 The other thing is, Larry, I think what we
11 need to do is send that letter out again, because a
12 lot of the people -- the new companies are taking
13 over. You've got the new contractors. They are
14 looking at that old data as -- this is not mine, I
15 have no responsibility. Then I put my people in the
16 records center. They don't know the difference
17 between a purchase order and a -- I hate to say it
18 -- and a medical report. Those things get shoved in
19 a box. They get sent to Atlanta with a destruction
20 date and they're gone.

21 **MR. ELLIOTT:** I think you're absolutely
22 right. I think -- you know, the point you make is
23 different than what Bob was making earlier that --
24 where the record go is one thing, but
25 acknowledgement of a contractor or the records

1 manager at a certain site, who's new to that site
2 and new to DOE's process, may not have found that
3 memo that said moratorium on destruction of records
4 for epidemiologic purposes covers these systems of
5 records. I agree, I think that would be a very
6 important thing to articulate in your letter.

7 **MR. TABOR:** Well, a reminder would probably
8 really help because the only thing that I can attest
9 to -- you know, in these closure sites where clean-
10 up is really I mean robust and it's in full swing, I
11 will tell you that going through three contractors
12 over 21 years out there that the closer you go and
13 the faster the pace gets, it is a administrative
14 merry-go-round, and I mean it is really, really
15 hard, not only to find people that are responsible
16 in those areas to figure out what's going on and
17 where things are at that particular stage in time as
18 opposed to where things were just a few years
19 before.

20 So you know, what Robert had to say there,
21 there's a lot of validity in that. I mean it
22 becomes very difficult, so maybe a reminder like
23 that would really be good and we need to keep our
24 finger on the pulse of things.

25 **DR. ZIEMER:** Thank you, Bob, for a very

1 important point that you raised.

2 Now we have one more person who has
3 requested time, and that is Mark Lewis. Mark is
4 with PACE and from Waverly, Ohio. Mark?

5 **MR. LEWIS:** Thank you. Hi. First I want to
6 thank everyone for putting the time and effort that
7 you've been putting into this. It's very important
8 to all of us nuclear workers and other people
9 throughout the country at the weapons facilities and
10 I applaud your efforts for that.

11 I have some topics I'd like to talk about as
12 pertaining to site profiles, expert groups and
13 record keeping. They all tie in together, what
14 we're talking about.

15 First of all, the site profiles. I have the
16 privilege of being the coordinator of the local
17 worker health protection program in Piketon, Ohio --
18 dose screenings some of you guys were alluding to a
19 while ago, Larry was, and the thing we found out
20 about site profiles, a lot of the records that we
21 needed to get ahold of through the plant exposure
22 records, they were either incomplete or non-
23 existent. And by getting ahold of -- we called
24 expert groups of workers, former workers -- we got
25 ahold of some former workers and we put together a

1 risk-mapping session. This risk-mapping session and
2 focus groups. The risk-mapping session where I set
3 people down at tables, give them a map and have them
4 go back -- like taking a snapshot of the past of the
5 plant.

6 We found out, just like you mentioned, some
7 of the buildings used today for certain processes
8 that weren't used for that process years ago. A lot
9 of exposures -- you'd think a building would be
10 clean. For instance, at our site we have a building
11 we have shipping and receiving in. And years ago it
12 was where they sampled high grade uranium. So
13 within the walls of that building, inside with
14 people working there, they was drilling or something
15 in the walls, the maintenance man, they would be
16 going through a space and time with some of that
17 dust could have transuranics in it or whatever, you
18 know. So we found that the workers were our experts
19 at that time.

20 We got all the records we could from the
21 plant, but that, mixed in with the workers, led us
22 to know more of what to screen for today, you know,
23 in our screening program.

24 The risk-mapping part is very important. I
25 think, you know, if you went to a site to talk to

1 somebody, you know, they'd give you all the records
2 they'd have from the company, you know, that's
3 running the facility now. But don't forget to talk
4 to some of the retired people.

5 And the dynamics of this risk mapping, too,
6 is worthwhile because you get two or three people
7 together that worked together for a while. You
8 know, you want to get like with like people. You
9 get process operators, for instance, at one -- one
10 day. Get all the people who did welding at another
11 time, and these people could be retired now -- most
12 of them were. They'd see each other and their
13 memories would click more. And the collective
14 memory of those people was more valuable to us,
15 really, than any hard data that we had. I just
16 wanted to share that with you.

17 Also, pertaining to past -- I'm just going
18 to talk about neutron exposure at our Portsmouth
19 site. There was numerous studies done at the
20 Portsmouth site -- gaseous diffusion site pertaining
21 to, you know, exposures and all. But none of them
22 ever did come back and say there was neutron
23 exposures. Our own in-house -- the union activity,
24 our safety reps and stuff, suggested that hey, we
25 had some deposits in some lines and the potential

1 could be there for neutron exposure. And we asked
2 specifically for NIOSH to come in and just do
3 neutron exposure. And sure enough, that's what they
4 found, we had neutron exposure that we weren't
5 monitored before, see, before. So you know, just
6 going by your past histories of safety studies at
7 different sites may not clearly reflect what you
8 have. I can't emphasize enough about how workers
9 could be involved in it.

10 Now a lot of you may know that a gentleman,
11 Jeff Walburn*, works at our site. The company has
12 -- I heard was mentioning earlier yesterday
13 something about maybe somebody forgot to do
14 something or whatever, but there's cases -- in Jeff
15 Walburn's case, and it's in Congressional records
16 and the company's got letters, too -- where they
17 said yeah, we zeroed your dose for liability
18 purposes. And it's in Congressional records and in
19 memos, you know. So there's a lot of vidility (sic)
20 out there, you know, saying that it was done
21 intentionally in some cases, so --

22 In my own record, I started working at the
23 site when I was 21 years old in the fire department.
24 I got into a serious exposure situation where I had
25 high grade weapons material on top of my anti-C's*

1 from the fire department. And I ran out of air,
2 went outside to get some more air in my bottle. A
3 guy unzipped my suit, all the stuff fell down on top
4 of my head -- maybe that's why I am the way I am
5 today, I don't know -- but it all fell on me and
6 eventually I got exposed real bad, you know. I had
7 no skin left on my face for a long time and I went
8 through a lot of hassle.

9 Well, in '88 I had some heart trouble and I
10 thought I'm going to go get my records and just sit
11 down and see what I was exposed to. Well, guess
12 what? There's nothing there. Nothing happened that
13 day or for them weeks that followed.

14 So I thought I wanted to at least mention
15 those to you, and that's about all I had.
16 Especially when, you know, you go to do the site
17 profiles, don't forget the retired people -- all
18 right? The retired workers and the risk mapping.
19 That's all.

20 **DR. ZIEMER:** Thank you, Mark. Let me again
21 ask if anyone has questions for Mark.

22 (No responses.)

23 **DR. ZIEMER:** Okay. Thank you for your input
24 on that.

25 Now we need to return to the topic of

1 Special Exposure Cohort.

2 DR. MELIUS: Can I ask -- sort of figure
3 where we are procedurally, I guess. We spent a lot
4 of time this morning talking about this and I'm not
5 sure where we're going in terms of getting comments
6 in to NIOSH and how you want to proceed on that.

7 DR. ZIEMER: Well, what I'll do here is
8 summarize. The working group met during the noon
9 hour, and I'll summarize where we think we are and
10 get some feedback from the Board members.

11 Just for planning purposes, Mark, does your
12 working group have some further things that you're
13 going to want to present today, or are -- I mean
14 you're not under any pressure to come to a final
15 document. You got a lot of input this morning for
16 refining and --

17 MR. GRIFFON: Right. Not for today.

18 DR. ZIEMER: -- I think you can move forward
19 with what you have, so --

20 MR. GRIFFON: Yeah, and we did mention that
21 we might want to have a conference call in the near
22 future --

23 DR. ZIEMER: Right, but --

24 MR. GRIFFON: -- to probably --

25 DR. ZIEMER: -- in terms of today's meeting,

1 I think we're okay on that. I had planned -- I
2 thought we had put in the agenda, but I'm not seeing
3 it, to at least have a little discussion relating to
4 -- how can I describe it? Let me call it personnel
5 issues at NIOSH. Actually an issue that was raised
6 by Mr. Miller and perhaps we'll have time to at
7 least discuss -- I think -- it has to do with
8 whether or not the manpower is sufficient,
9 particularly in dose reconstruction and so on. This
10 is not an item that Larry has asked me to raise. It
11 can be very -- it can be a little ticklish for the
12 Board to get involved very deeply in hiring and
13 manpower levels at the Agency, but at least some on
14 this Board have raised concern about whether or not
15 there's enough staffing to get the job done. And
16 perhaps we can at least discuss that a little bit.

17 I do want to at least get us up to date on
18 where we are on the Special Exposure Cohort. We're
19 still shooting for having comments ready by the
20 25th, I think, of August. Is that the -- or 26th.

21 **MR. ELLIOTT:** The 26th is the last day.

22 **DR. ZIEMER:** The comment deadline. So let
23 me tell you what we've done so far, kind of taking
24 all of the input from this morning, Jim's comments,
25 Mark's comments and the ones that we had prior to

1 that.

2 What we're looking at now would be a letter
3 to the Secretary which included with it a series of
4 comments relating to specific parts of the 42 CFR
5 83. Some of those were ones I described this
6 morning.

7 That is, in section 83.1 to reformat the
8 wording in the manner that Tony had suggested. That
9 would be the first paragraph on that page. Plus
10 utilizing Wanda's word for proactive, the word
11 "diligent" in identifying and assisting employees;
12 adding a section 83.2 with the wording that Tony had
13 suggested for that section in his item two. That
14 wording is that a section would be added to state a
15 cancer claimant whose dose reconstruction was
16 completed, but whose claim did not qualify for
17 compensation, cannot reapply for or use the
18 procedures for designating classes of employees as
19 members of the special cohort as a route for
20 appealing a decision, that it is not an appeal
21 process. Section 83.10, as shown on the sheet,
22 83.13 as shown, 83.15 as shown.

23 Now we then looked toward dealing with
24 specific things, and let me refer to Jim's comments
25 -- and these overlap a bit with Mark's. First of

1 all, on the first comment where Jim has recommended
2 NIOSH should modify the approach envisioned by this
3 rule to place more emphasis on the group petitioning
4 process. We note that section 83.7 actually
5 identifies both the group petitioning process and
6 the individual, so our thought here was to use the
7 preamble -- and the preamble will be reformatted, is
8 our understanding, so that there will be descriptive
9 information pertaining to the various sections. So
10 there would be a preamble that would have a portion
11 relating to section 83.7. And our suggestion here
12 is that there be language in the preamble that would
13 sound something like this, and I'll give you the
14 rough draft that the committee came up with this
15 noon.

16 Quote, NIOSH should emphasize the group
17 petitioning process, parentheses, as opposed to the
18 individual petitions, and explain or describe
19 possible types of groups that might consider
20 petitioning; e.g., a group of workers who believe
21 they have been subject to an undocumented exposure
22 at a facility.

23 So basically then -- end of quote. So
24 basically the preamble would be used to sort of
25 emphasize the group petitioning process and give an

1 example, and that might be expanded on, but that at
2 least was our initial recommendation for dealing
3 with that.

4 On the second item --

5 **DR. ANDRADE:** Paul --

6 **DR. ZIEMER:** Yes. Oh, yeah, please -- and
7 any of the working group can help out here. Tony,
8 please.

9 **DR. ANDRADE:** Just a tiny suggestion. This
10 is word-smithing, but nevertheless I think it's
11 important in light of the fact that we're not trying
12 to give higher weight to one process versus the
13 other. Instead of using the words "as opposed to" I
14 would suggest something like "vis a vis" or
15 something along those lines.

16 **DR. ZIEMER:** NIOSH should emphasize the
17 group petitioning process vis a vis --

18 **DR. ANDRADE:** The individual.

19 **DR. ZIEMER:** Okay, I gotcha. This is not
20 final wording right now. This is our draft and we
21 may have to have a conference call and at least get
22 final wording out for -- and even do a phone vote
23 later this month.

24 Now on the issue of guidelines, we struggled
25 with that quite a bit. And where we landed on this

1 was to ask -- and our comment would suggest that the
2 -- ask the staff, in the preamble again 'cause the
3 preamble is more like a guide, to add some words to
4 section (e) under -- I guess it's section (e).
5 Section (e) on page 42964, that's the *Federal*
6 *Register* page. And this would come in in the
7 paragraph that says (reading) commenters asked HHS
8 to define the conditions under which NIOSH would not
9 have sufficient information.

10 And basically, Jim, I think your question
11 was when do we know we don't have sufficient
12 information.

13 Now as we read through the preamble, it was
14 our feeling that to some extent they have described
15 this, but it may be helpful to concisely put this
16 all up front and say that by sufficient information
17 we mean incomplete information on radiation source,
18 incomplete information on processes and practices,
19 incomplete information on source terms. So it would
20 spell out what it is that we're talking about when
21 we mean incomplete.

22 There was a feeling amongst our group that
23 it would be difficult to go beyond that. If you
24 drive down to the next question and say well, what
25 is incomplete source information or what is

1 incomplete dosimetry information, we can't say it's
2 one missing film badge or it's seven or it's 25 or
3 something. So at this point we're saying the
4 guidelines would have the nature of describing the
5 types of things where the judgment is that there's
6 not enough information in this category to complete
7 the dose reconstruction. And that -- it seemed to
8 us that that would allow sufficient flexibility so
9 that it was not completely proscriptive to those
10 doing the work, but still identified for those
11 petitioning what it is that we're looking for or
12 what it is that's missing. And one could even then
13 have -- if it were an application that said are
14 these pieces of information missing from your
15 records and therefore you are petitioning on that
16 basis. So that's where we landed on that one.

17 Item three we think now is being covered
18 already by our previous section one where we are --
19 is it previous section one? Where we are asking
20 NIOSH itself to be more aggressive, formerly known
21 as proactive, more diligent in identifying and
22 assisting employees. And again we ask the Board if
23 that will address the issue, but at least that's
24 where we landed on that.

25 And then finally -- of course your item five

1 we've already covered in a separate motion, and item
2 four I think we -- we think we ended up this morning
3 as realizing that probably we can't insert the time
4 limit into this. Was that --

5 **DR. MELIUS:** Yeah, I think it's --

6 **DR. ZIEMER:** -- everybody's understanding?
7 We discussed it and so our recommendation was not to
8 include anything on that. So what I've just
9 described now is the nature of what the
10 recommendation would be and I think we'd like some
11 feedback as to whether or not -- and it would have
12 to be worded and we would do that together with a
13 cover letter and distribute that for a final vote,
14 but I want to at least get an early measure of level
15 of comfort with such comments. Or if there are some
16 major issues that remain undealt-with, we need to
17 identify those.

18 I might also add, I believe that if
19 individuals have issues that they don't -- and the
20 Board is not able to, as a group, deal with, they
21 could always be submitted as an individual's. Is
22 that not the case, Larry? Nothing prevents Board
23 members, as individual citizens, to submit comments,
24 but -- and you may want to address that. Is that --

25 **MR. ELLIOTT:** No, you're absolutely correct,

1 an individual Board member may submit comments as an
2 individual.

3 **DR. ZIEMER:** Right. We don't lose our
4 citizen privileges.

5 **MR. GRIFFON:** Paul, did the working group
6 address my -- you know, the three -- I know one of
7 them overlapped Jim's, but the other two were --

8 **DR. ZIEMER:** Let me go back to yours here
9 and see what -- you know what?

10 **MR. GRIFFON:** Ran out of time.

11 **DR. ZIEMER:** We missed -- was it the
12 sufficient accuracy issue that you're asking --

13 **MR. GRIFFON:** No, that overlapped with
14 Jim's, I think, but especially the number three, I
15 guess the endangered health question.

16 **DR. ZIEMER:** Actually, we didn't. I'm
17 sorry, I think we ran out of time and so that --
18 that does not imply that this was not important.
19 What -- and maybe we can get some feedback right
20 now. How can we handle that one?

21 Is -- I want to start -- let me ask Ted
22 first. Ted -- or maybe Jim -- Jim's there?
23 Whoever. Is it the staff's feeling that they have
24 in fact defined endangered health in a manner that
25 is fully consistent with the law? That is, it's

1 based on the law. He obviously has to answer that
2 yes. Right?

3 **UNIDENTIFIED:** He'd better.

4 **DR. ZIEMER:** But you understand -- I need to
5 rephrase the question. Have you stopped beating
6 your wife, Ted?

7 (Laughter)

8 **DR. ZIEMER:** This says the current
9 definition of endangered health relies on an
10 estimate of potential dose and expresses some
11 concerns. Does the -- we need to consider whether
12 endangered health itself is fully and adequately
13 defined in the draft here.

14 **MS. MUNN:** Well, it certainly -- I'm
15 assuming that everyone is relying on the same
16 footnote that I am for that definition, where the
17 footnote says (reading) HHS interprets the statutory
18 language, endangered the health -- see 42 USC
19 4384q(b)(2)* -- to mean there is a reasonable
20 likelihood that the radiation dose may have caused a
21 specified cancer. That's a quote from the statute.

22 **DR. ZIEMER:** That's the definition here.

23 **MS. MUNN:** Right. Since claimants cannot be
24 compensated as members of the cohort for any adverse
25 health effects other than certain cancers under the

1 relevant portions of the law. It appears to me that
2 that's defined by the law already.

3 **DR. ZIEMER:** I believe this is how NIOSH has
4 defined it, based on the law.

5 **MS. MUNN:** Based on the law, uh-huh.

6 **DR. ZIEMER:** Those words may not be in the
7 law itself. Ted?

8 **MR. KATZ:** No, no, the law used the term
9 "endangered the health". HHS had to interpret what
10 that means, and what you're reading is -- it was
11 HHS's interpretation of that. And you know, of
12 course, as Dr. Ziemer said, we believe it's
13 consistent with the law or it wouldn't have gotten
14 out.

15 **DR. MELIUS:** But are you saying it's the
16 only -- it's not the only definition that's
17 consistent with the law.

18 **MR. KATZ:** It's --

19 **DR. MELIUS:** There are other ways of --
20 wouldn't you say there are other ways of
21 operationalizing that that would be consistent with
22 that, or are you saying that's the -- this is the
23 only one?

24 **MR. KATZ:** I'm not precluding that there's a
25 possibility of another way of operationalizing this.

1 I just -- we didn't come up with it. We didn't
2 imagine it.

3 **DR. ZIEMER:** I think you could argue to some
4 extent it is driven by the law itself. I mean I
5 suppose I could argue that you could say that it's
6 -- endangerment is 50 percent or more likely than
7 not at the 50 percent confidence level rather than
8 99. I mean it's a definitional thing.

9 **DR. MELIUS:** Correct. But I'm just saying I
10 don't believe that the -- the law is very vague on
11 this and what they mean by endangerment, and I don't
12 think this is necessarily the only way that that can
13 be interpreted. In fact, I personally think that
14 they're taking a relatively narrow interpretation of
15 what is in the law and what my understanding is in
16 the background, and it certainly contrasts with how
17 some of the other Special Exposure Cohorts were
18 designated. They were designated based on a
19 duration of exposure and a question of whether or
20 not they were monitored or should have been
21 monitored -- facility, which I think sort of begs
22 the question of a level of endangerment or level of
23 risk in that. So I think there certainly -- the law
24 implies some other approaches could be utilized.

25 **DR. ZIEMER:** At the end of the day, you

1 still -- you end up having to have some criteria,
2 and it's a little difficult for me to see that you
3 could use -- that it would be proper to use a
4 criteria that's different from the criteria that are
5 being used with the regular dose reconstruction
6 'cause that's --

7 **MR. GRIFFON:** Why? Explain your logic for
8 that. Why would you think that would be improper
9 since in one case you can estimate doses but in the
10 other case you already said that you cannot estimate
11 doses, so why would it be improper to use a
12 different --

13 **DR. ZIEMER:** Because the way that they're
14 doing it here does a group estimate and caps it and
15 makes a -- it's not an individual dose
16 reconstruction, but it makes a -- it makes what I
17 would call a reasonable estimate that their dose is
18 below the same bar. You're basically saying
19 everybody in that group is either over or under that
20 -- well, let's say if they're in the cohort, they're
21 over the bar, that same bar that you're using.

22 **DR. MELIUS:** I don't interpret the
23 calculation that's being done to necessarily -- in
24 that way -- probably 'cause we have very little
25 guidance for how that will be done. I mean what I

1 find to be illogical -- I don't know if that's the
2 right term -- is just the basic fact that you're
3 doing -- you've said you can't do a dose
4 reconstruction, yet you're basing endangerment on a
5 dose reconstruction of some sort, and the -- I'm not
6 saying that's not an approach that can't be used,
7 but I think it has some fundamental problems with it
8 that concern me, and I don't think it's the only
9 approach that's -- certainly not the only approach
10 that's prescribed by the legislation. I don't think
11 this is an easy issue, either, so I'm not trying to
12 trivialize or say that NIOSH's effort wasn't an
13 effort that should not be considered by -- I mean,
14 for example, for the other -- some of the other
15 Special Exposure Cohorts, it was working one year
16 and being badged or working a job that should have
17 been badged, I think is the terminology. Now
18 concern that was is well, would there be -- would we
19 encounter other situations where people may have
20 been badged as a precaution, even though recognizing
21 that very little likelihood they would have had
22 exposure and in case would we be allowing them into
23 the cohort inappropriately. I don't know whether it
24 would be the cafeteria workers, I don't know what
25 the right example is or -- Well, in that case, one

1 could argue that one would have enough information
2 to be able to do a dose reconstruction enough to say
3 that they wouldn't qualify. Are there situations
4 where that's -- they're going to fall in between or
5 be complicated from either of these approaches?

6 **UNIDENTIFIED:** Yeah, I think it's a --

7 **DR. ZIEMER:** So even the statement "should
8 have been badged" has certain implications on both
9 nuclides and doses and so on. I mean --

10 **DR. MELIUS:** Should have been monitored, I
11 mean. Excuse me.

12 **MR. GRIFFON:** Monitored or should have been
13 monitored.

14 **DR. ZIEMER:** Oh, should have been monitored.
15 Well, either one of those.

16 **MR. GRIFFON:** Either way, yeah.

17 **DR. ZIEMER:** Yeah, so there are certain
18 implications, as soon as you do that, that there are
19 some levels.

20 **DR. MELIUS:** Yeah.

21 **MR. GRIFFON:** Right, right.

22 **DR. ZIEMER:** Mark, you had --

23 **MR. GRIFFON:** That there's some significant
24 level, right. I mean I -- just to pick up on Jim's
25 point -- I wish Jim Neton were still here, but I

1 think that we heard NIOSH's efficiency process is
2 actually going to exclude those insignificant dose
3 cases from getting over that first hurdle of
4 sufficient accuracy. They're going to be able --
5 like Jim said, they're going to be able to do an
6 individual dose reconstruction 'cause they're going
7 to make all these worst-case assumptions and they're
8 likely not to -- even with all the worst-case
9 assumptions, they're not going to trip the 50
10 percentile, they're out of the potential class
11 automatically, so that to some extent addresses that
12 concern about just putting in -- potentially opening
13 up this class for people that had very little or
14 insignificant exposures.

15 And I think the other --

16 **DR. ZIEMER:** Well, but that still is
17 dependent on that bar being at that same level that
18 you talked about earlier. They're still comparing
19 it with the probability of causation of 50 percent
20 at the 99 level 'cause they're using the same --

21 **MR. GRIFFON:** But that's for individual dose
22 reconstructions.

23 **DR. ZIEMER:** Right.

24 **MR. GRIFFON:** That's the way they do that,
25 right.

1 **DR. ZIEMER:** Right.

2 **MR. GRIFFON:** Right. I'm not sure I
3 followed your point on that. But anyway, if -- you
4 know, the other reason for arguing for this
5 definition of endangerment that's not tied to -- and
6 I agree with Jim, this is a complicated issue, but
7 the other argument for not tying it to an IREP sort
8 of approach is just -- in addition to what I just
9 said, the hurdle should catch those low ones, but
10 also the secondary thing is that this sort of
11 counter-intuitive nature, especially to the
12 potential claimants, that they couldn't do my dose
13 reconstruction but then they were -- they had enough
14 data to reconstruct the class's dose and we still
15 got booting out, you know. I can see that sort of
16 scenario playing out. And then -- you know, so if
17 you had another sort of criteria for endangered
18 health, you may get to the same end as -- and in
19 fact if your efficiency process works and you have
20 another way of defining endangered health, we may
21 end up at the same end point, but I think it would
22 at least be more understandable to the public and
23 seem less sort of counter-intuitive. I mean I still
24 am concerned about that situation where you're
25 trying to -- you're doing a sort of worst-case dose

1 for a class when you're -- when we're clearly
2 concerned about the extent to which these site
3 profiles can be built up and -- you know.

4 **DR. ZIEMER:** Yeah, Roy.

5 **DR. DEHART:** Endangering to health is almost
6 a fatal error in this document. The definition --
7 many physicians would say radiation, per se, is
8 endangering to health if you believe in the linear
9 effects, so I think the definition is a poor choice
10 to begin with. And what we're trying to do is turn
11 a -- I guess a sow's ear into a silk purse with
12 trying to box that in. It's an unfortunate
13 definition to have to deal with.

14 **MR. GRIFFON:** Yeah, but I wonder if the
15 author is -- intended that language for that very
16 reason.

17 **DR. DEHART:** Politically, it may have been.

18 **DR. ZIEMER:** Other comments? Yeah, Larry.

19 **MR. ELLIOTT:** I think when we, within the
20 staff, dealt with trying to address this issue --
21 and you're absolutely right, Dr. DeHart, this is an
22 unfortunate piece of meat that we've been given
23 that's full of gristle to try to chew and swallow,
24 we were looking for a test of reasonableness.
25 What's the test of reasonableness here? Endangered

1 the health. What dose would it take to have
2 resulted in endangered the health? And achieve a
3 balance of parity with those that would not -- that
4 would have to go through dose reconstruction where
5 dose reconstruction could be done, and I think
6 that's how we approached this. So maybe -- I don't
7 know if that helps or hinders your thinking about
8 this or not, but perhaps if you had an alternative
9 suggestion on another option for -- to be considered
10 on how to define endangered the health in this
11 regard and achieve a balance of parity in a test of
12 reasonableness.

13 **DR. ZIEMER:** Tony?

14 **DR. ANDRADE:** After going through this
15 proposed rule several times -- and there are several
16 shortcomings and we are starting to deal with most
17 of them, but this is a tricky one. Every time I
18 tripped over this particular one, in my simple mind
19 I felt that because this legislation deals with
20 special circumstances under which somebody might be
21 considered -- again, and not as an appeal, but might
22 be considered again for compensation, given that new
23 information has come to light about a facility -- a
24 facility profile, if you will, whatever that may
25 mean at this particular point in time -- about an

1 undocumented exposure which one or many people claim
2 to have been subjected to, then my proposal would be
3 to try to tie this definition to this new event that
4 could potentially have caused additional dose to be
5 added to the person's original dose. It's a simple-
6 minded way of looking at things, but it is a way
7 that a special cohort could be formed, logically.
8 I'm struggling with this even as I speak, so if the
9 experts can rebut what I said or give reasons why
10 that would not make any sense, I'd appreciate it.

11 **DR. ZIEMER:** One possibility -- I think Mark
12 has suggested, and let me read the words 'cause
13 maybe this will help us. At the very least, this
14 needs to be explained further within the regulation,
15 and it's because of the counter-intuitive issue --

16 **MR. GRIFFON:** Right.

17 **DR. ZIEMER:** -- so it may be that we can
18 raise this in the comment and indicate the concern
19 that's reflected in the Board and ask the staff to
20 explain it further within the regulation. Now I
21 don't know what that would mean in terms of how that
22 would play out unless we're at a point where we can
23 suggest what those words might be.

24 **MR. GRIFFON:** I was just going to -- I was
25 actually going to ask Tony if he could restate -- I

1 think I understood what you were proposing, but
2 could you restate that? I'm sorry, I just want to
3 follow your...

4 **DR. ANDRADE:** I'm just saying that process-
5 wise, a person may end up with a, quote, incomplete
6 dose reconstruction. However, if new information
7 has come to light with respect to a situation that
8 the person may have been in or that NIOSH has
9 identified with respect to the facility that they
10 worked in, that in itself will result in an
11 additional dose than that that was originally
12 considered in the first dose reconstruction.

13 And maybe it'll take IREP again to calculate
14 what this additional dose is, but it may be that
15 which could be defined as the additional
16 endangerment or whatever this purports to be.

17 **DR. ZIEMER:** I'm not clear, though, how that
18 helps in the definition here.

19 **DR. MELIUS:** Actually when I first
20 interpreted what you said, it actually did help me
21 and let me tell you what I thought you said, which
22 is that if you -- if you think about this, it's
23 going to deal with I guess maybe two situations.
24 One is the unexpected has been found. Go back to
25 the enrichment plants, the transuranics, we just --

1 nobody thought or not enough people thought or
2 however you want to do that, and you have a surprise
3 and what do you do? And you can't go -- you know,
4 to go back and try to recreate and reconstruct, you
5 can't, so that's one situation this should cover.

6 The second situation this should cover is
7 when there just -- it's an old facility and they
8 just weren't monitoring and -- just 'cause the means
9 weren't available at the time and maybe all the
10 records on sources aren't as good as they would be
11 now and so forth and so on, and therefore we --
12 we're just totally befuddled in trying to do a dose
13 reconstruction.

14 When I worry about the current approach that
15 NIOSH uses to endangerment, I worry about the second
16 situation, where there's just very, very little
17 information and that they're just going to be making
18 a wild guess at what -- at what would -- what number
19 you put into that endangerment calculation that
20 they're going to do. I don't think, for the
21 surprise thing where you know it's a big exposure,
22 that it probably matters. But it could be
23 problematic when there's just very little
24 information and no monitoring and no records. And
25 we really are just going to be guessing at that.

1 The opposite situation we worry about is we
2 don't want to include the trivial or non-exposure in
3 this, so how do we come up with a definition that
4 would exclude that, but not I think rely on what
5 could be an arbitrary guesstimate at what their
6 exposure should be. And maybe there's just enough
7 different situations maybe there would be more than
8 one way of approaching this. I don't know, I -- and
9 we don't have all the examples, but I do think the
10 endangerment is -- the Special Exposure Cohort is
11 the surprise exposure and just the non-existent
12 monitoring and records. And maybe if we distinguish
13 those, it helps. Maybe it doesn't.

14 **DR. ZIEMER:** Wanda?

15 **MS. MUNN:** Well, I guess I still come back
16 to the footnote again, and to the original rule-
17 making where this term, endangered the health of the
18 members of the class, is used just as it's beginning
19 to identify what bases are necessary in order to
20 establish the finding of a special cohort. And it
21 includes a finding of short-term radiation health
22 effects for other members of that class and
23 identification of radioactive materials that they
24 didn't know about before, as Jim was just saying, a
25 description of shortcomings of radiation protection

1 measures. And all of the things we're talking
2 about, it seems to me, are in the rule. And since
3 this entire law is based only on radiation-induced
4 cancers, then I guess, to me, that -- with that
5 background and what's already here -- I understand
6 that there is some concern there may be other ways
7 of defining endangered the health, but this
8 definition that's given here that NIOSH has
9 developed, in this context, appears appropriate.
10 Because what they're saying is there's a reasonable
11 likelihood that this radiation dose may have induced
12 the cancer and under these certain circumstances.

13 I guess if we have better ways of
14 identifying exactly what that means, if it were --
15 if it were further unidentified, if these
16 descriptions were not given here below, then I would
17 have the same concerns that everyone else does, but
18 -- what does endangered the health mean -- but the
19 law says we're talking about only radiation-induced
20 cancers and here are very specifics about what that
21 endangerment might have resulted from. Are we
22 beating a dead horse? I mean can we get any -- if
23 we can get any better than this that would give our
24 potential claimants broader consideration, then what
25 is that?

1 **DR. MELIUS:** I think we're saying the
2 alternative -- an alternative is, 'cause I think
3 there are probably others, also, is that it would
4 apply to a situation where NIOSH is unable to
5 complete a -- it's not feasible to do a dose
6 reconstruction with sufficient accuracy and the
7 person has worked at least one year in a facility in
8 a area where they were monitored or should have been
9 monitored, and probably would need to flesh that out
10 with some definitions by -- what means by monitored
11 or should have been monitored.

12 **MR. GRIFFON:** And I mean I keep coming back
13 to this point, but this is a two-pronged test, and
14 sufficient accuracy is the first test. And if I
15 give in on having a more precise definition of
16 sufficient accuracy -- you know, the way NIOSH
17 defines sufficient accuracy right now is they can
18 complete a dose reconstruction and -- you know, an
19 individual dose reconstruction. And we know -- I
20 mean from our review of some of our cases, we know
21 that for these likely low/low situations, to use the
22 NIOSH efficiency process they likely have low
23 exposures to internal and low exposures to external.
24 They're going to take those through and give them
25 every possible -- given the data they have -- worst-

1 case scenarios, individually test that case against
2 IREP, as they should, and those are going to drop
3 out, the very low, insignificant exposures. The
4 ones that miss -- and that's why I'm focusing on
5 it's a two-pronged test, you know, it's not -- they
6 were just trying to define endangered health in
7 isolation where -- it's a two-pronged test. They
8 have to get over that first hurdle first.

9 **DR. ZIEMER:** But they're still testing it
10 against IREP.

11 **MR. GRIFFON:** They're still testing the
12 individual dose reconstruction against IREP.
13 Correct.

14 **DR. ZIEMER:** Right.

15 **MR. GRIFFON:** As they should, as they do all
16 the time. Correct. But the class against IREP is a
17 different question.

18 **DR. ZIEMER:** Right.

19 **MR. GRIFFON:** Right. And then I'm saying --
20 you know, so you get rid of these insignificant
21 cases by their own process by that definition of
22 sufficient accuracy -- I would argue by such a broad
23 definition of sufficient accuracy you're able to get
24 rid of those insignificant or lower doses, lower
25 dose cases. They won't be in that class. They

1 won't make that hurdle. And then since you're -- by
2 not being able to calculate a dose with sufficient
3 accuracy, can't -- I mean complete a dose
4 reconstruction for these folks, I think you have to
5 kind of say if they made that hurdle that far, he's
6 -- we're really -- the data we have left, can we
7 really use that data to kind of do the -- as Jim
8 said, to kind of do this worst-case estimate to
9 compare against that bar for the class in IREP or
10 should we have just another set of criteria similar
11 to the original SEC. And so I think of it as this
12 two-pronged test.

13 And I would also have problems if I thought
14 that a lot of the -- I mean I don't think it's
15 equitable if a lot of the -- just because you can't
16 reconstruct the doses but they likely had very
17 insignificant exposures and they make it into this
18 class, that's not equitable. That's not what we're
19 looking for here. But I think we're -- the NIOSH
20 efficiency process and that definition of sufficient
21 accuracy protects against that. I think Jim Neton
22 said that to me either on the record or on the side
23 here earlier, so that's how I'm trying to grapple
24 with this.

25 **DR. MELIUS:** If I can just add, I think with

1 the current approach they're using or proposing to
2 use, that I take comfort in the fact that we're
3 going to, as a committee, be reviewing those. Those
4 will be part of the petitions that come to us. I
5 worry about how we're going to make that assessment,
6 evaluate the decisions that they've made because I
7 -- again, we don't have much information and they're
8 making a guesstimate of some sort in order to fit it
9 into this -- to these IREP calculations that they're
10 proposing, and how are we going to assess whether
11 those are appropriate to do or how do we evaluate
12 those? And I think we're going to be hard-pressed
13 -- and particularly to keep them consistent from
14 situation to situation so that we're treating
15 everyone who would fall into a Special Exposure
16 Cohort, or potentially would, in a fair manner, that
17 we're making the same assessment for a cohort at
18 Hanford that we would at one at Oak Ridge or
19 wherever. And where we'll be dealing with some
20 very, very different situations. Your laboratory
21 example we talked about this morning as compared to
22 a production facility and so forth. Where
23 admittedly we don't have enough information to do a
24 very good sort of quantitative evaluation of that
25 risk.

1 **DR. ZIEMER:** I don't know what the process
2 was on the original cohorts. I wasn't involved.
3 But someone made a determination that there had to
4 be a certain length of time and perhaps there had to
5 be some -- there had to be some indication that
6 there were certain types of materials around, even
7 if it wasn't -- people weren't monitored. So there
8 must have been at least a kind of group estimate as
9 to what potential doses might have been, like the
10 screening process, that says it's very conceivable
11 somebody could have been there and gotten more than
12 a few millirem -- pick the number. I don't know
13 where -- somebody must -- in the thinking process,
14 somebody must have had a bar that says they could
15 easily have been up here somewhere. I don't know
16 what the process was. But I mean where did these
17 times come from? They can't be completely
18 arbitrary. I mean how would they -- well, maybe
19 they are. Congress did all this without any
20 scientific input. All right.

21 No, I mean rationally speaking, there's
22 still -- whether you explicitly say that there's
23 some test, dose test or you do it more indirectly
24 and say okay, even intuitively -- I mean I think I
25 could intuitively take a number of -- say if

1 somebody's working with these things for a year and
2 we weren't monitoring them, I can guess that there
3 could have been situations where they got pretty
4 high doses. I don't know how -- does anybody know
5 how that was done and -- okay, please.

6 **MR. MILLER:** Richard Miller. I will only
7 offer you this much, that this was an administration
8 proposal when it came forward as the one year, but
9 it had been based on discussions with the Justice
10 Department about the RECA model which uses a working
11 level month criteria for compensability. And so
12 what they did was -- and they looked at the RECA
13 amendments that were done in 2000, in fact, which
14 had been passed as part of what was then S-1515, and
15 in that legislation you will see actually
16 foreshortened periods of time compared to the old
17 RECA, so they -- the one year threshold was sort of
18 -- the whole concept of using a time period, Dr.
19 Ziemer, was derived from the RECA model of
20 compensability. They used time or duration in the
21 mines or in the mills or in the shipping and
22 transfer operations as the criteria.

23 **DR. ZIEMER:** All right. But see, in
24 general, that implies -- in the radon case it's a
25 concentration times the time and you get a -- an

1 intake value, but indirectly, somebody is measuring
2 that against some standard. But I'm at a loss as to
3 where we really go with this. It's -- whether we
4 specify it in terms of time or other parameters, we
5 are either directly or intuitively saying that
6 there's some point at which there's an endangerment.
7 And maybe my endangerment level is different than
8 somebody else's, but it's somewhere there.

9 And we're sort of -- we sort of end up, I
10 think, saying it's the way NIOSH has done it, is
11 that a reasonable -- is that one reasonable way to
12 do it or is that completely unreasonable?

13 **MS. MUNN:** No, it's reasonable.

14 **DR. ZIEMER:** Obviously there's other ways to
15 do it. Is there a better way? Is there -- or is
16 the issue simply one -- but yeah, people don't quite
17 understand this, or does it make sense intuitively,
18 and I'm trying to grapple a little bit with -- I
19 think, in principle, you end up doing the same
20 thing. Wherever is you do it and draw some lines,
21 you're doing sort of the same thing. So how do we
22 do it in a way that is reasonable and also does not
23 seem, for those out there, to be black magic.

24 **DR. MELIUS:** To reiterate the concerns on
25 this one, to both, one is that it -- the current

1 proposal is, one, it's counter-intuitive. Okay?
2 Which I think poses problems with people viewing it
3 from the outside, a claimant, a group of claimants.
4 Secondly is that I think it is quite arbitrary in
5 terms of how the dose will be selected, and that
6 also is going to cause problems -- again, from your
7 -- someone applying for this program or evaluating
8 this program or for us reviewing these decisions --
9 as to how it is being applied. I think the
10 advantage of a time frame, albeit an arbitrary one,
11 is that it's understandable, it's transparent, and
12 it can be applied and we're -- you know.

13 **DR. ZIEMER:** Yeah. I was going to say that
14 certainly the counter-intuitive issue -- I certainly
15 agree with that. The other, I think, is as much
16 arbitrary -- I mean whatever time interval you
17 choose obviously is as arbitrary as any other, so --
18 so in any -- it sort of gets down to what is a
19 reasonable way to approach it.

20 **DR. MELIUS:** Just one quick thing is that
21 the 250 days has the advantage of being consistent
22 with what's already being in the law. That's --

23 **DR. DEHART:** My question dealt more or less
24 with consistency, as well. Is this the first time
25 in a rule that this has been defined this way? This

1 is the proposed rule, so if there is to be a change,
2 this is where it would have to be since it doesn't
3 -- it isn't preceded by another...

4 **MR. ELLIOTT:** I'd consider that if you
5 establish 250 days as the requirement, that might go
6 counter, in some instances where the class may not
7 have spent 250 days, or you may need more than 250
8 days to reach whatever criteria you use for
9 endangerment of health, so that's why we stayed away
10 from that. And in fact, we felt that it was
11 appropriate to say that -- and here I would like to
12 speak to -- comment about the arbitrary nature of
13 what you were talking about, Dr. Melius. I think
14 once you -- what we have not done clearly, in my
15 mind, is articulate clear and well enough what we
16 see happening here, and that is that the class
17 definition that we bring forward for the Board's
18 review would establish what the class -- the time
19 frame that would be appropriate, in our mind, that
20 would support the test for endangerment of health
21 and is appropriate for the given situation that the
22 class experienced. And I think you would see all of
23 that laid out. We don't -- we should perhaps
24 prepare a mock-up example of a class definition. I
25 don't know if that would help or not.

1 And I think there's also a hang-up here -- I
2 think Jim tried to speak to this earlier this
3 morning, Jim Neton, about if the counter-
4 intuitiveness here is based upon we can't do a dose
5 reconstruction but we can put a dose in and
6 determine whether or not health was endangered,
7 you've got to come at that just the opposite way.
8 You've got to come in from IREP and say okay, what
9 is the most -- worst case likely scenario here this
10 class experienced, which is the radionuclide most of
11 concern, and what's the most likely answer that
12 would result from that -- from an exposure to that?
13 And so you don't plug in a dose number, you plug in
14 the demographics of the class as it's defined into
15 IREP and you see what the 50 percent at the 99th
16 percent probability -- credibility limit dose is,
17 and then that's the test of reasonableness that
18 we've been talking about.

19 If that, on the face of it, looks
20 reasonable, we're going to come forward and say we
21 recommend that this class be added. But if it's not
22 reasonable, we're going to say that, as well. So
23 maybe that's where we've lost you all, or maybe
24 where we're not understanding what you're talking
25 about, or maybe passing by each other.

1 **DR. ZIEMER:** Okay, Jim.

2 **DR. MELIUS:** Yeah, just back to one comment.
3 In trying to think through this -- and again, we
4 don't know all the potential situations involved,
5 but I don't think that there would be very many
6 where there would be exposure less than 250 days --
7 a situation where you wouldn't be able to do the
8 dose reconstruction in a way that -- have enough
9 information to do that that would still pass this
10 test, as you develop it. But I'm guessing, too, on
11 that. We just don't know. So I think -- I'm not
12 real worried about the false negatives in that
13 group, but it could occur with this situation.

14 I also don't want to be -- repeat my soap
15 box speech too many times, but I think this does go
16 back to this issue which I'm going to talk about
17 some more if I'm not satisfied with how we resolve
18 this, is this whole issue of defining when we can --
19 how we're going to do these dose reconstructions,
20 when we cannot do them, how it applies in different
21 situations. And I suspect if we spent some time
22 working on that issue and then came back and we're
23 talking about this regulation and this situation, I
24 think a lot of it would be easier to -- discussion
25 would be easier for all of us. But we are dealing

1 in a vacuum and -- to a large extent 'cause we
2 haven't really -- at least I haven't -- don't see
3 the criteria there for when you will and when you
4 will not be able to do dose reconstructions. I
5 think you're starting to get away from case by case
6 in terms of the presentation, but it's still, to me,
7 very arbitrary. And I think it makes this
8 discussion that much more difficult, also.

9 **DR. ZIEMER:** Any more comments?

10 **UNIDENTIFIED:** Why don't we take a break?

11 **MR. GRIFFON:** That's a good comment.

12 **DR. ZIEMER:** It's 3:15. Let's take a 15-
13 minute break and we'll reconvene.

14 **MR. ELLIOTT:** I remind you all I need your
15 preparation time.

16 (Whereupon, a recess was taken.)

17 **DR. ZIEMER:** In order to think about
18 reaching some level of closure today, one of the
19 ideas that has arisen during the break is to perhaps
20 do two things. One is, on this issue of clarifying
21 the definition on health endangerment would be to
22 have the document that we send to the Secretary
23 indicate that at least some of the Board members are
24 concerned about NIOSH's definition. The other
25 option would be to endorse the definition and vote

1 it up or down as far as the Board is concerned. My
2 personal feeling is that it would be useful to at
3 least have our document reflect the concern of those
4 members -- and it could be a majority, actually --
5 but reflect both of those views by indicating, for
6 example, that the definition that's being used in
7 the document is of concern to some of the Board
8 members. That doesn't address the issue of exactly
9 what a better definition would be, unless we were to
10 come up with something, or those who have expressed
11 the concerns would come up with some alternatives.

12 And then the other issue, and Jim indicated
13 just before the break that he was still somewhat
14 concerned about how the guidelines are defined for
15 the issue of determination of special exposure -- or
16 determination of when you can't do a dose
17 reconstruction. And I think has a potential way of
18 addressing that, also, in the document that might be
19 satisfactory to all concerned.

20 Jim, why don't you suggest that one first
21 and then we'll back up to the other one.

22 **DR. MELIUS:** Okay. What if the Board makes
23 a recommendation that NIOSH develop a set of
24 guidelines for how they will be making the
25 determination as to when a dose reconstruction

1 cannot be adequate -- completed with sufficient
2 accuracy, et cetera, the verbiage that's in the
3 regulation and so forth, and do that -- that would
4 be presented to the Board for review. So it would
5 not be part of the change in the regulation, per se,
6 but it would be something that would come back to us
7 as a Board to review so we would better understand,
8 provide better guidance on how they do that. So
9 similar to how we've done with the dose
10 reconstruction. We have a framework that's in the
11 regulations, and then we have a -- some
12 implementation documents that we have reviewed at
13 various points. Same with the IREP.

14 **DR. ZIEMER:** And so in the document itself,
15 are you suggesting that in the preamble where these
16 sort of broad guidelines are given that there simply
17 be some words that suggest that the staff would
18 develop operational guidelines for use, and they
19 wouldn't be part of the rule.

20 **DR. MELIUS:** They would then pin -- we ask
21 them -- I think we formally ask for that in our
22 recommendations and that they come back to the Board
23 for review.

24 **DR. ZIEMER:** And there could be a sentence
25 inserted here saying that such guidelines would

1 exist, and I would simply ask Jim to construct a few
2 sentences which we would insert in that section.

3 Okay. Now back to the other issue, the
4 definition of endangerment of health, Jim, what is
5 your feeling on having a statement in the -- I ask
6 Jim and maybe Mark 'cause I think the two of you
7 have this concern. What about having a statement in
8 the document -- it might actually be in the cover
9 letter, or it could be associated with the
10 definition where -- that footnote definition, to
11 indicate at least some of the Board members are
12 concerned with that operating definition. I don't
13 know what we would do with that at that point, other
14 than --

15 **DR. MELIUS:** Well, I think if we had a
16 statement that a number of Board members or some
17 Board members -- I can talk about the wording --
18 have concerns about this definition and this
19 approach that's being proposed by NIOSH and suggest
20 that NIOSH -- and carefully review this approach and
21 consider alternative approaches, and I think we've
22 talked about one approach -- such approach.

23 **DR. ZIEMER:** I just bounce that off the
24 group. We were trying during the break to see
25 whether we could find a kind of -- I don't know if I

1 want to call it middle ground, so much as a way to
2 comment and raise the issues, particularly --
3 including those which are of concern to maybe not
4 the full group, but at least some members of the
5 group. How do the others feel about that approach.
6 Roy?

7 **DR. DEHART:** I agree with both points, but I
8 would also add that there needs to be a sentence or
9 two -- some kind of explanation of why there was
10 concern on the definition.

11 **DR. ZIEMER:** Right, and you could even
12 reference the definitions used in the other
13 legislation or the statutes, yeah. And again, Jim,
14 would you be willing to draft a few lines that we
15 could insert there and -- yeah.

16 **DR. MELIUS:** Yeah, I'll draft Mark to pull
17 something off his computer. I think he's written
18 some of this.

19 **DR. ZIEMER:** Now let me ask the group
20 overall -- and again, we're not voting today, but I
21 wanted to see if we've -- have we covered -- with
22 those two methods of handling those two issues and
23 the other ones, have we covered everything that we
24 would need to address in this document?

25 **DR. MELIUS:** Can I ask one question of --

1 **DR. ZIEMER:** Sure.

2 **DR. MELIUS:** -- Larry and -- when people
3 write in to DOE requesting records -- I'm thinking
4 in terms of the class petitions, and you have a
5 requirement that people have one of two items, a
6 letter from DOE saying those records do not exist,
7 or a report from a health physicist or dose
8 reconstructionist, I'm concerned that the burden of
9 doing the second one is a lot for people to do. If
10 they want to do it, fine. I think -- and you have
11 it as an "or". I'm worried that -- I'd like to be
12 reassured that the DOE does respond when they don't
13 -- can't find the records and say they don't have
14 this. My personal experience with FOI's is when you
15 put them into an Agency and they don't find the
16 records, you never hear from them 'cause they don't
17 find them. And those are the most frustrating ones
18 to pin them down. And I don't want people having to
19 chase after a letter saying there aren't any
20 records. It's Wanda's proving the negative.

21 **MR. GRIFFON:** And you're asking the
22 petitioner to do that.

23 **DR. MELIUS:** Yeah, and in the petition
24 you're asking them to do that. If they do it
25 routinely, where we can assure that they routinely

1 -- fine, I'm not worried about it.

2 **MR. ELLIOTT:** I can't speak for DOE, but I
3 can speak about our experience in listening to
4 claimants and in public meetings, and it runs all
5 over the board. It runs over the board from -- I
6 got my information back, I didn't like what I got
7 and I asked for more; I got it back, I liked it --
8 to I haven't heard a word. And it seems to me that
9 it varies from site to site, for individual to
10 individual. But I would also add this in my
11 response to you, that our intent in putting that
12 there was not to force -- I don't believe, and Ted
13 can correct me if I'm wrong 'cause I wasn't privy to
14 all of the discussions among staff in crafting this
15 language -- was not to force an individual claimant
16 to do one or the other or either. But if they had
17 it, it certainly added credence to their petition.

18 **MR. GRIFFON:** That's not the way it's
19 worded.

20 **MR. KATZ:** No. I mean it's a requirement,
21 one or the other. Let me just clarify, the dose
22 reconstructionist report or whatever -- I mean we
23 especially had in mind, why that's there as an "or",
24 is not for someone to go out -- and we didn't think
25 -- we didn't imagine that happening, someone going

1 out and hiring themselves (sic) someone to review DOE
2 records, but really to address the situation -- some
3 of this sort of work has been done already and
4 someone could just grab, at hand, something off the
5 shelf to make their case. And then -- I mean -- and
6 you probably want to recall, too, you made a
7 suggestion for something in addition to this, which
8 is if there have been studies elsewhere, published
9 studies, whatever, that address this lack of records
10 for certain cohorts of workers or so on. That
11 should be a third alternative. That's not in there
12 right now so you probably want to comment on that,
13 as well.

14 **DR. MELIUS:** But I guess my concern is that
15 you've made it a -- the "or" is a requirement. Is
16 required either to have the health physicist's
17 report or -- we add a third one, or this outside
18 report, or a response from DOE saying the records
19 don't exist. And if they're unable to get that
20 response, they can't apply.

21 **MR. KATZ:** Right. And the assumption we
22 made is that DOE would have to respond to them when
23 they make the request. And another assumption we
24 made is that in cases where a petitioner is having
25 no luck getting a response, we'd hear about it and

1 then we could help them -- put pressure on DOE to
2 respond to their inquiry. 'Cause I mean most
3 government agencies I thought are bound under Foyle*
4 to respond, but -- so that's sort of a revelation to
5 me that they actually can ignore a Foyle request
6 'cause that's legally binding, I thought.

7 **DR. MELIUS:** I would then -- personally, I
8 guess I would suggest for that one that they have
9 documentation that they've made a good-faith effort
10 to obtain records and were unable to should suffice,
11 rather than having them have to wait six months to
12 get DOE -- I mean I don't argue with the need for
13 them to have tried to get records if they do exist
14 and not just to flood you with petitions for things,
15 but they ought to -- you know, if they can give you
16 the letter they sent and didn't get a response in 60
17 days or whatever.

18 **MR. KATZ:** Right, and let me -- Richard just
19 reminded me that in the case of the AWE's you're not
20 -- there's no government -- there's no government to
21 be, but -- so that's a case aside, as well.

22 **DR. MELIUS:** I think we can take care of
23 that specific language. I just want to --

24 **DR. ZIEMER:** Roy?

25 **DR. DEHART:** I haven't heard that we did

1 anything regarding the storage of records. We were
2 going to comment on it, I thought, perhaps in the
3 letter. Didn't we decide to do that with regard to
4 the letter that was to be written on the MOU? The
5 issue of record storage.

6 **DR. ZIEMER:** Actually when we did the MOU
7 resolution, we hadn't talked about the record
8 storage. The record storage came up today. I think
9 that -- I think I heard that the -- Larry was
10 talking about reissuing the reminder, but -- or --

11 **MR. ELLIOTT:** Well, it's not my job to
12 reissue the reminder; it's DOE's. And I would
13 encourage you in your letter about the MOU to speak
14 to this. The storage of records, the archival of
15 records, retention of records, the moratorium and
16 resubmitting -- re-notifying across the complex that
17 there is a moratorium and these records have
18 importance -- maybe this is the leverage you really
19 should apply is not only importance for
20 epidemiologic research, but importance for
21 compensation.

22 **MS. MUNN:** Yeah, that's easy.

23 **MS. GADOLA:** Can I just address that simply?

24 **DR. ZIEMER:** Yes.

25 **MS. GADOLA:** To reiterate the importance of

1 what Larry just said and of the Board addressing
2 that issue is from hearing what I've been hearing
3 from people who have been trying to obtain records
4 in Oak Ridge. Some of the problems they have
5 encountered is that due to the storage of different
6 contractors, records are stored in different ways.
7 Some were stored under people's last names, some
8 were stored under years. Some of them they have no
9 -- not been able to locate, but they know they must
10 be there someplace. They have also found folders
11 that have pages of medical records that have never
12 been put in files because they said well, the files
13 are here somewhere but we can't find them or we
14 don't have time to find them. Some of them they
15 discovered were put in with the personnel file in a
16 different file. Like the medical file is in with
17 about three other files that pertain to personnel
18 records, then -- and other ones are in a separate
19 box that has just medical records in it. So I
20 think the more that you emphasize the importance of
21 this, the better record-keeping we're going to have
22 and people are going to get reminded. And it has
23 changed hands because there are some people that do
24 know the rules, some people that are professionals.
25 As Bob knows, you encounter some people that

1 understand the whole process very well, and then you
2 get others that don't have a clue.

3 **DR. ZIEMER:** Thank you. I think actually
4 the memo to the Secretary will probably have to be
5 limited to asking DOE to re-issue or to remind
6 people about the storage issue. This is a whole
7 additional thing on how DOE keeps its records or --

8 **MR. PRESLEY:** Right now this will be a great
9 thing, too -- Bob Presley -- because DOE is in a
10 process of trying to either upgrade or redo what
11 they do with a lot of their records. They're right
12 now in the process of redoing this, so it would be
13 wonderful to get something out on this. This is the
14 time to do it.

15 **DR. ZIEMER:** Is there a particular past memo
16 that could be referenced to the Secretary that
17 covers that, and then we can reference that and say
18 the information that -- previously issued in
19 memorandum such-and-so should be reissued? Okay,
20 thank you. Staff will run that down.

21 **DR. MELIUS:** One other issue I think we
22 talked about before. I just wanted to make sure
23 everyone agrees it should be in our comments. That
24 was from Mark's set of comments and it was number
25 two, clarify the issue regarding SEC class applying

1 for non-SEC-listed cancers. I think what we were
2 going to recommend and NIOSH said they were going to
3 do was that they were going to work out procedures
4 for dealing with these different situations. And
5 then our recommendation for these -- for these set
6 of regulations is that NIOSH review those and make
7 sure that the current regulations would not preclude
8 any approaches that might be used to deal with these
9 situations. I think that's just sort of a technical
10 legal wording issue. I don't know of any verbiage
11 right now that might be a problem, but there -- I
12 haven't looked at it from that point of view, but I
13 think we ought to make sure that gets captured. And
14 I don't think there's any objection to that.

15 **DR. ZIEMER:** What -- can you -- just so I
16 have it in my record here, what section are we
17 talking about? Is it on the regulation on the -- or
18 the definition of the class and the listing of
19 the --

20 **DR. MELIUS:** I think so, I just -- I don't
21 want to pick on Ted, but I get worried if he
22 misinterpreted or mis-spoke or got misquoted on it
23 that -- was thinking of something and I'm just --
24 just want to make sure we're not -- I just hate to
25 have to reopen the reg. just to deal with some minor

1 thing.

2 DR. ZIEMER: I think it would be the section
3 that says the individual -- if they're determined to
4 be part of an SEC class defined -- let me see. It's
5 the issue of the non-SEC-listed cancers, is it not?

6 DR. MELIUS: Yeah.

7 DR. ZIEMER: And I'm looking for where that
8 appears.

9 MS. MUNN: Well, the specified ones are
10 listed in 83 -- is that --

11 DR. ZIEMER: Specified cancers, those
12 specified cancers I guess is what we're talking
13 about.

14 UNIDENTIFIED: Is it 83.11?

15 DR. ZIEMER: Section 83.11?

16 MR. KATZ: Can I make a suggestion? I think
17 you're not going to find -- I mean I'm not sure what
18 part of the rule we need to look at hard to make
19 certain this concern is addressed. I think that's a
20 real concern that Jim raised, and I think if you --
21 if it's enough that the Board specifies that --
22 their concern that classes of employees can be
23 defined in such a way as not to preclude that sort
24 of scenario, I think that'll handle it, and then we
25 -- I mean it's going to take some serious looking to

1 see what, in the construction of this rule right
2 now, might get in the way. But I don't think you're
3 going to solve it quickly, flipping through the
4 rule.

5 **DR. ZIEMER:** So this will be a general
6 comment, not referenced to a particular section
7 right now. Thank you.

8 Anything else?

9 (No responses.)

10 **DR. ZIEMER:** Now since all of this has been
11 developed in the public meeting, can we then
12 distribute the text to everyone and the web site
13 prior to having a conference call? This no longer
14 has to go through the working group, I believe would
15 be -- okay.

16 So what I will do is collate all this with
17 the additional verbiage that is provided and we'll
18 get this distributed to everyone in preparation for
19 a conference call, the time of which we will need to
20 designate yet today. Is that agreeable?

21 Let's look right now at calendars, if we
22 could, for that.

23 **MR. ELLIOTT:** And while you're looking for
24 your calendars and your time, let me explain what
25 will have to happen here. We'll have to announce in

1 the *Federal Register* that the Board will convene a
2 conference call to deliberate and vote upon the
3 language to present your comments on this notice of
4 proposed rule-making. And we need to know today
5 which day you want to have your conference call
6 'cause we're going to have to announce that early
7 next week in order for it to be out there in time.
8 And as we did the last -- the conference call back I
9 think in February, we will allow the public an
10 opportunity during that -- to listen in on that
11 conference that you have and provide any comment at
12 that point. Anything else, Cori, that I need to
13 share with them on this? I think we -- we have to
14 -- there are some things we have to put in place,
15 like *Federal Register* notice. We'll get everybody
16 lined up on a call-in number and get that out to
17 you. But this should be the only real business you
18 should take care of that particular day.

19 **DR. DEHART:** What's the earliest date, do
20 you think, from your perspective?

21 **MS. HOMER:** From my perspective? When does
22 this have to be placed by?

23 **DR. ZIEMER:** We need to have it by the 26th
24 of August, and that's very -- probably very close to
25 the earliest date that they can -- there's not a

1 whole lot of time. Today is --

2 MS. HOMER: Okay. Let's see if we can go
3 for the 21st --

4 DR. ZIEMER: As the earliest.

5 MS. HOMER: -- or the 22nd as the absolute
6 earliest.

7 DR. ZIEMER: Okay, let's just check timing,
8 'cause we need to also get stuff out to people for
9 them to look at. How's the 26th itself, Monday the
10 26th?

11 DR. DEHART: Can you get that turned around
12 to get it submitted then?

13 MS. MUNN: I don't think you can do that in
14 a day.

15 MS. HOMER: Yeah, is it possible to submit
16 it within a day?

17 DR. ZIEMER: If we agree on the telephone
18 call -- who has to have it that day?

19 MR. ELLIOTT: It has to be postmarked that
20 day. Postmark it to the Secretary and a copy that
21 goes to the regulatory docket.

22 DR. ZIEMER: Okay, so we're better if we
23 back it up a little bit, in case there's some
24 changes.

25 MS. HOMER: What about the 23rd?

1 DR. ZIEMER: 23rd, Friday the 23rd -- bad?
2 How many -- for whom is the 23rd not feasible? Not?
3 DR. MELIUS: Not. That's --
4 DR. ZIEMER: Not.
5 DR. MELIUS: -- good for me.
6 MR. GRIFFON: Not so good.
7 DR. ZIEMER: Not so good.
8 MR. GRIFFON: The 22nd is better, but I can
9 do it if I have to.
10 DR. ZIEMER: 22nd? Is the 22nd okay?
11 MR. ESPINOSA: What time frame?
12 DR. ZIEMER: Well, in terms of New Mexico
13 time -- we won't do it at 7:00 in the morning New
14 York time.
15 DR. ZIEMER: Late morning? East coast time,
16 late morning?
17 MS. HOMER: Late morning, early afternoon?
18 MR. PRESLEY: Early afternoon would be
19 better for me.
20 DR. ZIEMER: Early afternoon? How is say
21 1:00 p.m. eastern daylight time?
22 MR. PRESLEY: On the 22nd. Right?
23 MR. ELLIOTT: About a week from today.
24 DR. ZIEMER: Is that enough time, Cori, one
25 week?

1 MS. HOMER: Yes, that'll be enough time.

2 DR. ZIEMER: Can we get a recorder?

3 MS. HOMER: Ray?

4 THE COURT REPORTER: A week from today?

5 MS. HOMER: Yeah.

6 THE COURT REPORTER: Have this ready?

7 MS. HOMER: I'm sure we can get a reporter.

8 DR. ZIEMER: No, we don't need that ready.

9 MR. ELLIOTT: No, no, you don't --

10 The conference call, can you attend the

11 conference call.

12 THE COURT REPORTER: Oh, a week from today?

13 MS. HOMER: Marie, how's your schedule?

14 MS. MURRAY: Oh, you want me on it, too?

15 MS. HOMER: Uh-huh.

16 MS. MURRAY: Hold on.

17 MS. HOMER: 1:00 p.m., how long do you

18 expect the call --

19 DR. ZIEMER: One hour.

20 MS. HOMER: Just one hour?

21 DR. MELIUS: 1:00 p.m. eastern?

22 DR. ZIEMER: Is that okay for recorders?

23 THE COURT REPORTER: Yes -- well, she's

24 checking. It is for me.

25 MS. MURRAY: Thursday's good. The 23rd's

1 not good. Well done, y'all.

2 **DR. ZIEMER:** So ordered. Open your e-mail
3 just before the call. No, no, we'll try to get it
4 out early in the week.

5 **MR. ELLIOTT:** We'll send an e-mail. We'll
6 send it via e-mail and we'll also put it on the web
7 site, and if anybody's in travel status or needs us
8 to get it to them by Fed Ex or a hard copy somehow,
9 we'll do our very best to accomplish that.

10 **MS. HOMER:** If you know where you're going
11 to be ahead of time, I'm sure we can Fed Ex it to
12 you.

13 **DR. MELIUS:** Can I ask one other --

14 **DR. ZIEMER:** You bet.

15 **DR. MELIUS:** -- quick procedural question.
16 And this is something I don't understand at all, so
17 hopefully somebody does.

18 We're talking about a number of changes to
19 this document, and you're going to be developing a
20 number of other guidance documents. You're going to
21 be dealing with the issue of how to deal with the
22 non-SEC cancers and so forth. Is there advantage to
23 having this as a -- rather than as a final rule, as
24 an interim final rule? Does that give you more
25 flexibility in terms of being able to adopt some

1 other changes and sort of notify people that you're
2 going to be working on this -- 'cause there are some
3 things that aren't worked out here yet and...

4 **MR. ELLIOTT:** Go ahead, Ted, if you want to
5 answer that.

6 **MR. KATZ:** Let me just explain what an
7 interim final rule, issuing that would do. That
8 would mean that you could operate and you could deal
9 with petitions, but that at some point in the future
10 you can produce then a final rule that changes
11 things. Now I think you're still required -- if you
12 change things substantially beyond what the public
13 has had an opportunity to have input on, you would
14 have to actually issue another interim final rule
15 because you have to give the public opportunity.
16 But -- so what it would -- the difference is, I
17 guess, if we issue a final rule now and we want to
18 change things, what we would have to issue later is
19 a notice of proposed rule-making again and then go
20 to a final rule. And the problem with that is the
21 notice of proposed rule-making is not effective law.
22 But I guess it'd be a -- you'd still be operating
23 under your existing final rule while you were doing
24 that, so you'd be changing an existing rule. So I
25 -- I'm not entirely certain, you know, what the

1 difference would be, but certainly it would allow
2 you to make changes in the future. Whether you'd
3 have to issue another interim final rule or not
4 would depend on what those changes were.

5 **DR. MELIUS:** But it just seems to me we're
6 wrestling with a number of issues that we as --
7 being NIOSH, the Board here -- trying to determine
8 this endangerment issue, how we'll make
9 determinations in terms of there not being enough
10 information, the issue of how do you do the non-SEC
11 cancers and how we fit them into rule-making. And
12 if there are advantages to doing it that way -- and
13 plus at the same time we'll be gaining -- NIOSH will
14 be gaining experience, we'll be gaining experience
15 reviewing some of these situations. I think -- I
16 can certainly see better information, more
17 information coming from NIOSH as you're starting to
18 review more petitions and recognizing different
19 situations. Ted and I were talking at the break
20 about acute exposures and which is the best way of
21 handling them under -- in terms of looking at
22 endangerment and I just think -- if there are
23 advantages like that, I think it may be something
24 that ought to be considered. Maybe we ought to
25 recommend that it be considered as a way. And it

1 would also allow things to -- claims to be
2 processed. At the same time it would sort of notify
3 people that look, we're still looking at this and
4 aren't -- you know, may make some changes down the
5 road and are still considering changes to improve
6 this process.

7 **DR. ZIEMER:** Any comments or reactions?
8 It's -- Mark?

9 **MR. GRIFFON:** Yeah, I think that would also
10 be -- I mean just the case history alone I think
11 would be helpful to all the Board. You know, we're
12 playing a lot of what-if games with different
13 scenarios and how they're going to play out. I
14 think it'd be useful for NIOSH, too, to see how this
15 definition of endangerment is going to play out and
16 how -- versus the sufficient accuracy side of
17 things. So I would think that would be helpful to
18 have it as a interim.

19 **DR. ZIEMER:** Wanda?

20 **MS. MUNN:** I don't know how I got on this
21 see-saw with Jim and Mark on the other end. But
22 aren't we in real danger of running up against time
23 and energy limitations of both the staff and this
24 Board every time we say oh, good, let's have another
25 rule-making? Aren't we really creating some

1 potentially unsurmountable problems because of our
2 concern over one or two issues that we would like to
3 have very clearly delineated that possibly may never
4 be delineated? I understand the rationale behind
5 wouldn't it be nice if we could make this an
6 interim, but I also foresee an enormous amount of
7 time and public hearings and all that being done
8 repeatedly, at great cost of both time and effort of
9 everyone concerned. I don't want to shortchange
10 anybody, but I have some real hesitation of saying
11 oh, yeah, let's just make -- let's make this the in-
12 between time and we'll think of a lot of good things
13 in the meantime and have another rule-making. It
14 seems like we're stretching ourselves and staff when
15 we start thinking of not doing this in as crisp a
16 manner as we can now. I know we're time-constrained
17 now, but I can't imagine we'd be less so later.

18 **DR. MELIUS:** I guess I would -- if I
19 understood the explanation why, it's to the
20 contrary. This allows some changes to be made,
21 certain types of changes, without having to repeat
22 the whole rule-making process, so it should, if
23 anything, save time and effort on the part of the
24 staff and everyone else involved in looking at this,
25 that there could be adjustments of this rule --

1 would allow the work to go forward, which we all
2 want. We want this to go forward. At the same time
3 it would allow some adjustments without necessarily
4 requiring a full rule-making again. Now if they're
5 going to make major adjustments, yes, that requires
6 a full rule-making. But if they're going to make
7 non-major adjustments -- which I think they may very
8 well do --

9 **MS. MUNN:** Define non-major.

10 **DR. MELIUS:** Yeah, I know. It's sort of
11 like a negative, you know, proving the negative.

12 **DR. ZIEMER:** I wonder if we could ask Ted,
13 how difficult is it to make minor adjustments in a
14 final rule, as compared -- what is the real
15 advantage of an interim final rule, other than the
16 nomenclature is --

17 **MR. KATZ:** Well, the final rule -- I mean I
18 suppose it's not that hard if it's just a most minor
19 technical adjustment, you can issue that pretty
20 readily. But really otherwise, a final rule, you
21 can't make changes without giving public notice and
22 going through rule-making again. So again -- and I
23 can't -- sorry about this negative bit thing here,
24 but I can't tell you what the bright line is for
25 what is substantial changes to the rule that the

1 public would not have been able to foresee, but I
2 think there's language along those lines, really,
3 that the public has to be able to sort of foresee
4 how the changes arose out of what they were privy
5 to, so -- that would trip it otherwise. So if you
6 don't trip that line, then you can go from an
7 interim final rule to a final rule that has changes
8 in it, but they're just foreseeable changes, I think
9 -- changes that arose out of what the public had to
10 consider and the Agency had to consider previously.

11 **DR. ZIEMER:** It sounds like either way if
12 the changes are substantial, then you still go
13 through a much more extensive process. If the
14 changes are not substantial, you don't have much
15 process either way. So how does it differ?

16 **DR. MELIUS:** The advantage is -- I think the
17 advantages -- I mean the technical change to the
18 final rule are really minor things. You change the
19 name of the Agency, and even sometimes that's gone
20 to announced rule-making, but I think it's little
21 technical things like that, or the decimal point
22 missing or whatever -- you know, something like
23 that. What we're talking, if there's adjustments to
24 the rule that have been part of the public comment
25 and have just taken some more experience to be able

1 to decide which is the best way to go and then you
2 don't have to go through another process. So it has
3 advantages for -- I hate to use this -- moderate
4 changes as opposed to really minor.

5 **MR. ELLIOTT:** Well, I'm coming at this from
6 a perspective of having to talk to the Secretary's
7 office about this, and I know there's a considerable
8 interest in the Office of the Secretary to put this
9 in place to address the concerns of people across
10 the weapons complex about wanting to petition. I
11 would suggest to you that -- I don't know, I'm not
12 saying this is what the Secretary would do, but I
13 think the Secretary has some very conservative
14 counsel that would speak in his ear and say until
15 there is a final rule, you should not make a final
16 decision on a petition. So if you're operating
17 under an interim final rule and we need to be
18 careful and cautious here about adding a class that
19 we may wish we hadn't have added or it may not have
20 been -- we have to go back and revisit that each
21 time for everything that was -- every petition that
22 came forward under the interim final and we took
23 action upon.

24 I think that you have addressed this issue
25 by making the recommendation about operational

1 guidelines. I think that's where -- I'm enthused by
2 that. I think that's the appropriate place to
3 handle these different changes that come forward.
4 Those things -- those are the operational guidelines
5 that you would see, you'd react to, you'd work with
6 us on, and that's where we can -- I think we can
7 gain some ground. But if you go forward, you want
8 to go forward, that's certainly your prerogative as
9 a Board to go forward with a recommendation. But I
10 would just ask you to consider what you might be
11 facing with the Secretary making a decision on a
12 petition under an interim final.

13 **DR. ZIEMER:** I guess I would also be
14 concerned about the public perception of an interim
15 rule and what the implications of that might be with
16 respect to how claims are handled, that it's kind of
17 the picture that well, the system really isn't ready
18 to go yet so how do I know my claim is really going
19 to be handled the way it would or should be. I
20 don't know what the perception would be out there.
21 It may or may not be.

22 An interim final rule -- we're hearing a lot
23 of -- you know, people are dragging their feet
24 getting this system in place. It sounds like -- it
25 sounds like the Agency's dragging along again.

1 That's what I'd be concerned about.

2 **DR. DEHART:** Roy DeHart. I think the
3 potential downside from the political perspective
4 could be severe here if they decided not to start
5 allowing us to review petitions. We can't afford
6 that. We can't -- we can't be seen by the claimants
7 as being obstructive. We've got to move forward, I
8 think.

9 **DR. MELIUS:** I think we can couch our
10 recommendation -- we're making a recommendation.
11 They can consider it. They -- it can be outweighed
12 by counsel's advice that the Secretary shouldn't
13 make a designation until they've got a final rule in
14 place. We've gone from -- this was guidelines to
15 regulation, and I -- so who knows where the right
16 place to stop is and I think we put forward -- it
17 has some advantages. If it has a serious downside
18 like that, then I would hope that the Secretary
19 would not listen to us. I suspect the Secretary
20 wouldn't listen to us in that case. But we don't
21 know that and I think Larry's speculating, probably
22 on more facts than I have and more experience with
23 this, but let's -- if it would help. I don't think
24 it's -- if it's -- people see that things are being
25 processed, then it won't be a perception issue. If

1 it's -- holds up processing, yeah, obviously people
2 are going to be concerned. If anybody sat here and
3 listened to us today in trying to -- wrestling with
4 all this stuff, they'd probably be glad we get
5 anything recommended and out, so...

6 **DR. ZIEMER:** Further comments on this?

7 (No responses.)

8 **DR. ZIEMER:** Again, I think this is one
9 where there's a little bit of a split and the
10 possible solutions would be either, one, to vote it
11 up or down, or two, to indicate in the cover letter
12 that some of the members have suggested that the
13 interim final rule process be considered. Is
14 that --

15 **DR. MELIUS:** Yeah, I think that's proper.

16 **MS. MUNN:** I'd prefer to vote it up or down.

17 **UNIDENTIFIED:** Make the motion.

18 **MS. MUNN:** I move that we vote up or down.
19 I would prefer that this become a final rule.

20 **DR. ZIEMER:** That's sort of two motions.
21 Are you making a motion that we vote on this issue
22 or are you making a motion that -- what is your
23 motion?

24 **MS. MUNN:** I move that we vote on this
25 issue.

1 **DR. ZIEMER:** Okay. And is there a second to
2 that?

3 **DR. MELIUS:** Well, are we going to vote on
4 it today or at the telephone conference call?

5 **MS. MUNN:** No, now.

6 **DR. ZIEMER:** The motion is to vote on this
7 now as to whether or not it appear in the document.
8 Is there a second to that motion?

9 (No responses.)

10 **DR. ZIEMER:** I hear no second. So do I
11 interpret that to mean that the others -- I don't
12 know fully how to interpret that at this point.

13 Tony, did you -- are you making a motion?

14 **DR. ANDRADE:** Yeah, I'd like to make a
15 motion here. I'd like to be as specific as I
16 possibly can be. I'd like to move that we vote up
17 or down on whether the rule go forward.

18 **DR. ZIEMER:** As a rule?

19 **DR. ANDRADE:** As a rule, with
20 recommendations sent to the Secretary that have been
21 adopted today. However, and this may be a different
22 motion, with respect to the two -- I believe two
23 issues that exist, that those issues be taken care
24 of in language to be adopted in either guidelines or
25 a preamble to the rule that will go forward. It's

1 complicated. It's a complicated motion, but it's --
2 I think it handles everything all at once.

3 **DR. ZIEMER:** As I understand the motion,
4 which is not yet seconded, it's a motion to adopt
5 all of the items that we've previously discussed,
6 although we don't have the wording before us, which,
7 if adopted -- I'm not sure what that does and we
8 still are going to need the wording, right, for --
9 and we had already agreed to a meeting at which we
10 would vote on this, but nonetheless, your motion is
11 to adopt now those items that we had previously
12 discussed. Is that -- and that did not include this
13 issue of interim rule or was that part of that?

14 **DR. ANDRADE:** What is the best way to
15 proceed?

16 **DR. ZIEMER:** All you've covered is
17 everything but the interim rule, because the other
18 items I think we've agreed on how we're going
19 forward. We haven't agreed on the interim rule
20 issue, so your motion would be to basically adopt
21 the others. I think we still need to refine the
22 wording though.

23 **DR. ANDRADE:** Okay. Then let's take it step
24 by step. In which case, I move that we do not
25 pursue a path that includes an interim final rule.

1 **DR. ZIEMER:** Okay. The motion to not pursue
2 a path that includes an interim final rule is
3 essentially a motion not to say anything in the
4 document to the Secretary about an interim final
5 rule. Is that -- is that the motion?

6 **DR. ANDRADE:** That's the motion.

7 **MS. MUNN:** Second that.

8 **DR. ZIEMER:** And that's seconded. Now
9 discussion on that motion. Mark?

10 **MR. GRIFFON:** Well, I mean I think several
11 Board members have addressed this as a possible --
12 this sort of resolution -- potential resolution to
13 this problem of operating in a vacuum of how these
14 cases or how these petitions are going to fall out.
15 And I think that's -- that's part of the reason --
16 and actually Henry Anderson at the last meeting made
17 this as a recommendation -- or I don't know -- you
18 know, not a formalized recommendation, but he
19 brought this concept up of a possibility of an
20 interim final rule, so I think a number of us feel
21 that that might be -- and you know, understanding --
22 and I agree with what Jim pointed out, that you
23 know, these -- if there's downfalls, then the
24 Secretary's going to consider both sides and, you
25 know, make that decision. But there is at least

1 some up side to it. We feel there could be some
2 benefit to that, or some members feel there could be
3 some benefit to that.

4 **DR. ANDRADE:** That's precisely why I'm
5 calling for a vote.

6 **DR. ZIEMER:** The vote -- if you vote yes,
7 that will mean that the document does not say
8 anything about an interim rule. If you vote no,
9 that provides, if desirable, an opportunity to state
10 that some members have this concern.

11 **DR. MELIUS:** I have a -- yeah.

12 **DR. ZIEMER:** It would not necessarily have
13 to be a recommendation.

14 **DR. MELIUS:** I guess I have a procedural
15 concern about our committee. We've operated by
16 consensus and by adopting documents that reflect
17 that consensus and not by voting on individual
18 recommendations. And I think we're in a little
19 awkward spot here because we had -- led to believe
20 there would be a conference call -- a document
21 produced and that we'd be reviewing and voting on --
22 agreeing on -- or reaching -- trying to reach
23 agreement on particular language, and we really
24 haven't completed that process. And just sort of
25 changing our procedures and our approach and sort of

1 -- certainly has some implications for how long the
2 conference call will be a week from Thursday.

3 **DR. ZIEMER:** The Chair is going to call a
4 five-minute comfort break while you chat amongst
5 yourselves.

6 (Whereupon, a recess was taken.)

7 **DR. ZIEMER:** Are we all comfortable again?
8 Before we were so rudely interrupted by the Chair, I
9 think that -- I think to some extent, Jim, what I
10 heard you saying, through my discomfort, was that a
11 sort of plea for operating on this issue in a
12 similar manner to some of the others and maybe
13 allowing the document to the Secretary to suggest
14 that at least some members suggest that the
15 Secretary consider this as a possible path to take,
16 but if that were done, it would not have the weight
17 of being a recommendation of the full committee but
18 would at least raise the issue, I think is what you
19 --

20 **DR. MELIUS:** I think that's correct. That's
21 fair to --

22 **DR. ZIEMER:** And so I guess I'm interpreting
23 what the outcome of a vote, if a vote is yes, to
24 sustain the motion, then the note to the Secretary
25 would not mention this issue. A vote to defeat the

1 motion would keep the door open for what you're sort
2 of requesting, and that is to allow this to be
3 mentioned as a sort of -- I don't know, minority
4 report or something like that, or at least --

5 **DR. MELIUS:** Well, I'm trying to avoid
6 minority --

7 **DR. ZIEMER:** No, no, no, it wouldn't have
8 such words, just say some of the members have
9 suggested.

10 **DR. MELIUS:** Right. Much as we've tried to
11 make sure members who aren't here are available and
12 get to participate and review things, I think this
13 is similar to what's -- it should try to reflect
14 what the committee has talked about. And there may
15 be times when we do need to vote on these issues. I
16 don't want to preclude that 'cause that's a way of
17 evaluating how we -- what we believe and so forth.
18 But at the same time I think if we can deal with it
19 sort of through the wording and sort of reflecting
20 what we've recommended, I think -- I'd prefer that,
21 but --

22 **DR. ZIEMER:** If the motion were defeated,
23 the issue would arise in the final document again in
24 terms of the wording itself. Tony?

25 **DR. ANDRADE:** I just wanted to say that I

1 have no objection to continuing the discussion. And
2 what I'm proposing here is really a two or three-
3 step process that will be followed. Number one is
4 determining whether this body believes that there is
5 value-added in holding -- or standing up an interim
6 final rule. That's step number one.

7 Step number two is to have our telephone --
8 our teleconference, during which time we will
9 discuss the final language that we will be
10 suggesting for the final rule, whether it exists in
11 the preamble or in the body of the rule itself. And
12 perhaps at the same time people will have thought
13 through some of the questions that have been brought
14 to -- brought up on the floor and maybe we'll have
15 -- or somebody will have a clearer definition from
16 the staff or from among our body.

17 Or we will decide at that time -- which
18 might be step number three -- to address these I
19 think last two issues that we're grappling with,
20 which are difficult, but nevertheless I think
21 handleable in the long run. For example, in
22 guidelines that will be developed or some other
23 vehicle.

24 So again, I'm not proposing to break up the
25 way we've normally done business. It's just that

1 the only path forward that I can see at this
2 particular point so that we can move on, allow NIOSH
3 to begin its work as quickly as possible, and for us
4 to get as much of those things that we are in
5 consensus about into the rule as quickly as
6 possible, is to go down this path --

7 **DR. ZIEMER:** To the final rule.

8 **DR. ANDRADE:** -- to the final rule.

9 **DR. ZIEMER:** Okay. Are you ready to vote on
10 the motion?

11 **MS. MURRAY:** May I ask for clarification on
12 the two issues, whether it's an interim final rule
13 or not? Those are the two issues? What are the two
14 issues?

15 **DR. ZIEMER:** The motion is to whether or not
16 this committee would include in its recommendation
17 to the Secretary that he consider issuing this as an
18 interim final rule or not. The motion was that it
19 be issued as a final rule, so voting yes for the
20 motion is to preclude its being discussed in the
21 letter as an interim.

22 **MS. MURRAY:** Gotcha. Thank you.

23 **DR. ZIEMER:** Is that everybody's
24 understanding? So if you vote yes for the motion,
25 you are voting to identify it as the final rule, in

1 which case nothing is said to the Secretary. Voting
2 no doesn't -- it doesn't preclude stating that some
3 members suggest it be issued as a final rule. Okay.

4 All who favor the motion, say aye.

5 (Affirmative responses)

6 **DR. ZIEMER:** All who oppose the motion, say
7 no.

8 (Negative responses)

9 **DR. ZIEMER:** Okay, I'm going to call for a
10 show of hands, so all in favor, raise your hand.
11 One, two, three, four in favor.

12 All opposed, raise your hands. One, two,
13 three, four. The Chair votes against the motion.
14 The motion dies -- or is not carried.

15 Okay. Now I think we're back to where we
16 were. We will vote on the full document at the
17 telephone conference. I will ask Jim for an
18 additional sentence or two on that interim rule
19 issue. You still have an opportunity to wipe it
20 out, if his words aren't good enough, at the final
21 vote.

22 The time of the next meeting. Actually
23 there is one other item that -- there's housekeeping
24 issues. Maybe I will ask that we at least have on
25 the record this item that was raised by a member of

1 the public raising concern about the -- not by a
2 member of the public today, but by a member of the
3 public in an e-mail to me -- concern as to whether
4 NIOSH had sufficient staffing to actually handle the
5 workload that is before them. This is a little bit
6 difficult forum to discuss that because if you ask
7 any manager in a Federal facility if they need more
8 staff, that's an automatic yes. But on the other
9 hand, it could be discussed in the framework of what
10 the Board sees as the workload and a little bit of
11 feeling now, at least by the working group, is the
12 staffing level. And knowing that a contractor is to
13 come aboard soon and help with the real dose
14 reconstruction -- I guess I will only ask the Board,
15 are you concerned about the workload and the
16 staffing levels, from what you see?

17 **DR. MELIUS:** Yes.

18 **DR. DEHART:** Yes.

19 **MR. GRIFFON:** Yes.

20 **DR. ANDRADE:** Definitely.

21 **MR. PRESLEY:** Definitely.

22 **DR. ZIEMER:** Let the record show that
23 virtually all the Board members expressed some
24 concern about the staffing levels.

25 Now do I interpret that to mean that you all

1 feel that there's too many staff members?

2 (Laughter)

3 **DR. ZIEMER:** There is a general concern
4 amongst the Board that the staffing may be pretty
5 minimal for the job that's ahead. I'm not sure that
6 it's appropriate for us to raise this with the
7 Secretary as an issue at this point because I don't
8 know that we have all the facts in terms of what the
9 workload is. Perhaps when the contractor comes
10 aboard very soon, we will have a better feel for
11 this and can address it in the future. I at least,
12 as a starting point, wanted to have it on the
13 record. And perhaps we would even put it on our
14 little action item as something we want to look at
15 on an ongoing basis to make sure that the staffing
16 level is sufficient to carry out the mandate of what
17 is before you.

18 Again, I want to make it clear to everyone
19 that Larry has not had any contact with me on this
20 issue to ask me to raise this. This has come from a
21 completely different source, member of the public,
22 and I just wanted to at least see if that reflected
23 everyone else's sort of perception of the issue.
24 Anyone have any particular additional comments along
25 this --

1 **DR. MELIUS:** Given the hour, I will try to
2 make this very short, is that I think I would ask
3 for the agenda for the next meeting to include an
4 update on hopefully the contract's awarded, how that
5 contract's going to be managed, how we stand in the
6 claims process and what we foresee -- the staff
7 foresees down the future to -- in terms of handling
8 this program so that we can have some discussion.

9 **DR. ZIEMER:** Thank you. Okay,
10 administrative housekeeping. Cori, what items do
11 you have for us?

12 **MS. HOMER:** Well, most of you have at least
13 sent in a voucher and it's been prepared. Not all
14 of you have been reimbursed. I think there's one
15 that I received --

16 **DR. ZIEMER:** Previous meeting, right?

17 **MS. HOMER:** From the previous meeting.
18 There is one I received and was not able to get to,
19 as it got to my desk the day before I left.

20 Salary issues, if anybody has not been paid,
21 please let me know.

22 One more item 'cause the fiscal year is
23 closing. I need your vouchers mailed back to me as
24 soon as possible. I must have them on my desk
25 within two weeks. We have to file an annual report

1 and that has got to be compiled -- the costs of the
2 Board, including travel, has to be compiled prior to
3 that report being prepared.

4 Also, roster changes. If any of your
5 information has changed on the roster, if you would
6 like to switch addresses from your home to your
7 office or vice versa, please let me know so that I
8 can update the agenda.

9 And if you haven't already done so, please
10 let Larry know -- write down your time, preparation
11 time and outside time getting ready for either the
12 work group and/or the Board meeting, and let Larry
13 sign off on that and give it to me so I can submit
14 it for salary payment.

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

16 **MR. ELLIOTT:** I would like to add to Cori's
17 list that if your employment status changes or
18 anything on your OGE-450, you know what that thing
19 is; that's your declaration of conflict of interest
20 issues, we need to call for that again. So if any
21 employment change happens or anything changes that
22 would reflect upon that form, please file a new form
23 and call me and we need to discuss it. Thank you.

24 **DR. ZIEMER:** Now time of the next meeting.
25 We had blocked off -- at least according to my

1 calendar -- October 15 and 16 as a possible date. I
2 think we had a back-up date, also.

3 **MR. ELLIOTT:** I think we had 14, 15 and 16.

4 **DR. ZIEMER:** And November 18th and 19th was
5 also blocked off.

6 Okay, October 15th and 16th is basically two
7 months from now. We are assuming, I think, that the
8 dose reconstruction -- or the contractor will be up
9 and running by then. We have some items on our
10 master list to address. We have perhaps some dose
11 reconstruction groups to be underway, perhaps, and
12 test out the system and so on. Is October still
13 good?

14 I had a note in my book that we were
15 thinking about meeting in Santa Fe. Is that still
16 good for y'all? Richard say oh, yeah. And do we
17 know logistically, Cori, or staff, is that --

18 **MS. HOMER:** I actually have checked into a
19 couple of sites --

20 **DR. ZIEMER:** Okay, so that's --

21 **MS. HOMER:** -- independent contracts on that
22 basis.

23 **DR. DEHART:** Was there a holiday problem?

24 **MS. HOMER:** Yes, it was a government holiday
25 on the 14th.

1 DR. ZIEMER: On the 14th.

2 MS. MUNN: Columbus Day. It doesn't keep me
3 from traveling.

4 DR. ZIEMER: Is it a major problem?

5 MR. ELLIOTT: It's not a staff issue.

6 DR. ZIEMER: Right. Then we will proceed
7 with those dates for Santa Fe. It appears to be
8 still clear on everybody's calendar. I think we'll
9 have plenty of items to address at that point.

10 Do you anticipate, Mark, that any of the
11 working groups would meet ahead of that or --

12 MR. GRIFFON: The panels? No, we won't have
13 a -- I mean we're hoping that we -- at least by
14 conference call -- start to resolve and start the
15 procurement process --

16 DR. ZIEMER: The procurement process and
17 maybe --

18 MR. GRIFFON: I doubt that we'll have --

19 DR. ZIEMER: Okay, but you can work --

20 MR. GRIFFON: Right, right.

21 DR. ZIEMER: Okay. Any other comments on
22 that? Then we'll proceed with that schedule,
23 develop the --

24 UNIDENTIFIED: And the dates are?

25 DR. ZIEMER: The actual meeting dates would

1 be the 15th and the 16th, so many will have to allow
2 the 14th for travel and the 17th for travel.

3 We do have on the agenda one last
4 opportunity for any other public comments. I have
5 not received notes that there -- oh, Bob? Okay,
6 thank you. Bob, please proceed.

7 **MR. TABOR:** Can I do that from here?

8 **DR. ZIEMER:** Yes.

9 **MR. TABOR:** Bob Tabor again, for the record.
10 Folks, all's I wanted to say is one thing, and it's
11 not real specific upon me -- it's not real specific
12 about the fine detail which you're involved here.
13 It's kind of an over-arching comment. But at one of
14 the meetings I pointed out that -- do not forget
15 that we need to do the right thing right the first
16 time and do the right thing right for the right
17 reasons. If this stuff is not really clear and not
18 clean and it's not ready, I would beg you, don't do
19 it until it is. And if it requires extending or
20 whatever kind of process you go through to say hey,
21 we need more time, I think that from a worker
22 perspective I would rather wait to have something
23 right than to take and rush ahead just to show
24 progress. You know, for whatever those words are
25 worth. So if you need additional time, you know,

1 even in your public comment period, I know it's done
2 many times in the government stuff. They set a
3 date, but you find that there's a lot of interest
4 out there in a particular topic matter and people
5 will request -- we want more time to take in comment
6 on this and work through this. And I'm just saying
7 I know you're doing your very best. But you know,
8 from a worker perspective, please, do the right
9 thing right, as best you can the first time and for
10 the right reasons. And if you need more time, take
11 more time.

12 **DR. ZIEMER:** Thank you, Bob. That's
13 basically measure twice and cut once. Right? For
14 the tailors. Right? Thank you.

15 Any other items to come before us?

16 (No responses.)

17 **DR. ZIEMER:** Anything for the good of the
18 order?

19 (No responses.)

20 **DR. ZIEMER:** If not, we're adjourned.

21 (Meeting adjourned at 4:50 p.m.)
22
23
24
25

C E R T I F I C A T E

STATE OF GEORGIA :
 :
COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 14th and 15th day of August, 2002; and it is a true and accurate transcript of the proceedings captioned herein.

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

WITNESS my hand and official seal this the 14th day of September, 2002.

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