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CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes

MEETING 4

SUBCOMMITTEE FOR DOSE RECONSTRUCTION REVIEWS

The verbatim transcript of the 4th Meeting of the Subcommittee for Dose Reconstruction Reviews held at The Westin Westminster, Westminster, Colorado on May 2, 2007.

STEVEN RAY GREEN AND ASSOCIATES
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C O N T E N T S

May 2, 2007

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MAY 2, 2007

9:25 a.m.

P R O C E E D I N G S

WELCOME AND OPENING COMMENTS

DR. WADE: Good morning. We're a little bit late convening, but I think there's ample time for the subcommittee to do its work. Let me begin by introducing myself. My name is Lew Wade, and I have the privilege of serving as the Designated Federal Official for the Advisory Board. This is a meeting of the subcommittee of the Advisory Board, particularly the Subcommittee for Dose Reconstruction Reviews. This is the fourth meeting of that subcommittee. Those of you who have been with us for a while realize that there was a subcommittee that went before this subcommittee that looked at dose reconstructions and site profile reviews. This is a fairly newly-constituted subcommittee. The subcommittee is chaired by Mark Griffon. Members are Gibson, Poston and Munn. The alternates -- the first alternate is Brad Clawson, the second alternate Robert Presley. Dr. Poston is not with us and therefore Brad will serve as a memb-- a voting member of the subcommittee this morning.

Again, we're scheduled to meet until 11:30. The brief agenda items we're to deal with, in no particular order, are discussion of reviewed cases, selection of cases to be reviewed, and discussion of the overall review process.

With that, I'll turn it over to Mark, who is the most able chair of the subcommittee.

MR. GRIFFON: Good morning to everyone, also. And I -- I apologize for a little delay. We're getting some copies as I speak, and I want to move into the agenda, but I think the -- the items Lew read out, I think I'm going to go on and go in reverse order of that. And I wanted to start off with a discussion because often as we run out of time we haven't discussed these in depth and I think we need to sort of push forward on these fronts.

The first item is the -- which we did discuss at the last subcommittee meeting, which we held in -- in Cincinnati -- was the -- this idea of DR guidelines or DR instructions, and these -- for those of you who aren't as close to the process, these guidelines are basically templates that NIOSH and ORAU have developed over time to sort of -- they're -- they're guides for their dose reconstructors on how to do cases for certain sites. They don't have them for all sites, I don't believe, but -- especially for some of the bigger DOE sites, they certainly have these guidelines. And they're not -- we have not so far reviewed these. They're not procedures -- they're not standardized procedures, but they're more guides for their dose reconstructors, so we've been talking about -- as -- from our standpoint in reviewing individual cases, it'd be very useful to have these guidelines that were used when the case was developed so that we could determine if in fact the dose reconstructor was following, you know, these -- the internal guidance. And it would also help, from SC&A's standpoint, to follow -- you know, what mechanical steps was the dose reconstructor going through in developing the case. And -- and sometimes there's -- in some of these there's decision logic, like you know, you use TIB-whatever in this kind of situation, and if you have this kind of situation you use Procedure Number 6 or whatever. So there's sort of that -- that -- that sort of information is in these guidelines and we -- we have discussed this at the last subcommittee meeting. We felt that these things would be very useful, especially as we're auditing cases and we think they'd be useful to add to the administrative record of the cases, at least going forward. And I have a motion to -- to -- a draft motion, I should say, to put forward to my other subcommittee members and just see if we can bring this to -- to the full Board. And right on cue, she's bringing the copies in, so -- if you can give those to the Board members to -- oh, you did? Okay.

DR. WADE: Great. Oh, great, okay.

MR. GRIFFON: Thank you. So I'll -- I'll just -- that -- that's the first item I wanted to discuss.

Then I also drafted another motion on sort of conducting blind reviews. We had a slot in the original scope of work for SC&A involving blind reviews. We've yet to conduct any blind reviews, and I have a motion -- a draft again -- outlining maybe how -- I -- I think we had a number of questions that came up at the last full Board meeting, as well as the last subcommittee meeting. You know, what would be the purpose of this -- of the blind reviews, to what end are -- you know, are we doing these. And then there's the mechanical steps of -- you know, if they're blind reviews, how are we going to select the cases, since we do all our meetings in public, without giving away the identity of the case ahead of time. So -- and then there -- I think the other big question that we were trying to weigh was do we -- do we do this as a strictly blind case where SC&A gets the raw data only, or do we do it blind in the sense that SC&A gets the raw data but can use the NIOSH/ORAU-developed tools to -- to -- to determine the doses. It's just the steps in the middle that -- that might be different, the -- the assumptions and how they use the data within those tools. None of that will be available, so it'll be blind to that extent, but -- but they would still have the tools that exist. And -- and there -- there's good arguments on both sides of that, I guess, but I -- I think -- you know, so that's another thing we've been discussing. I have, again, a draft motion that I'll put before my colleagues on subcommittee --

DR. WADE: Mark, is it your sense then that the subcommittee would vote out on these motions and, if they voted positively, you would present them to the Board as the work product of the subcommittee?

MR. GRIFFON: Yes, that was the --

DR. WADE: Okay, would you like to do them just in turn?

MR. GRIFFON: Yeah, I was just going to -- since people are probably reading, I was going to go through the rest of -- of what I have to cover on our agenda --

DR. WADE: Okay Then we'll come back and --

MR. GRIFFON: -- give people time to --

DR. WADE: -- (unintelligible) in turn.

MR. GRIFFON: -- digest these.

DR. WADE: Okay?

MR. GRIFFON: Yeah. Af-- after we do those two items, an-- another item that -- that has come on our agenda in past meetings was the discussion of -- the original scope of work for our case reviews also included advanced reviews, and I just had asked everyone to reflect back on that scope and to sort of -- and I -- and this -- I don't have a motion developed on this. I think we're still at the discussion stage on this one. But you know, reflect back on that and determine to what extent we've covered -- I -- I think some of this -- in my opinion, anyway, some of the scope items within the advanced review we've not really touched on, so -- and on the other hand, I think that we might give a little bit different direction for SC&A on -- on some of the ways they have been doing their -- their case reviews. So I -- I think we want to sort of re-examine, you know, given our scope -- our original scope of work, you know, what subtasks within that scope have we been missing maybe, and maybe refocus our case reviews to make sure we capture some of those. I -- I guess the -- one example that has come up in previous discussions is, you know, I don't think it -- it's really at this point worth the -- the time of SC&A to go through -- sometimes in the -- in the analysis of a case there's the -- these input files that have annual doses by -- annual doses for -- for different types of radiation, and sometimes people worked there for 40 years, so you have sheets and sheets of this. And SC&A was -- was, by line item, checking each one of those numbers. And I'm not sure if they have to spend as much time on that, maybe randomly check some of those numbers, but there might be a -- more focus on -- on these other sort of what we would define as drill-down type activities, and that might involve making sure the interpretation from the raw data to those numbers was -- you know, was valid in -- in their -- in their view. So I think we might, you know, be able to modify sort of the way we go forward with some of the case reviews. And I think -- I think -- so that -- that's more of a discussion item I think today; not quite ready, I don't think, for a motion but I think we might discuss that.

Then after those three items, the -- the sort of mechanical items, I want to give an update on where we are with our -- our previous sets of reviews, the fourth set of cases, the fifth set of cases are both in the NIOSH resolution -- or comment resolution process, but I'll -- I'll give an update on that. And then finally we want to get to the eighth set of cases and I think we're hoping to make some preliminary identifications here of cases that we can at least ask NIOSH for more -- more specific parameter data on, and then to be able to bring that back to the full Board for selecting the eighth set of cases.

So that's kind of I think what I want to cover. Any -- any comments or questions on that?

MS. MUNN: No. I would observe that the statistical data that was just provided to us by SCA in graph form was very revealing for me in terms of where we are relative to our initial goals. And I'm hoping that in our discussion we'll remember to refer back to those, especially as we're choosing our blind reviews, to see whether our goals were realistic at the outset in regard to the different types of segments we were looking at and whether we need to -- now that we've seen where the claims are coming from and what the statistics are on those claims, whether the goals themselves need to be rethought.

MR. GRIFFON: Okay. Yeah, we -- that's definitely something we should discuss and I --

I assume you're referring to the overall percentage of cases or --

MS. MUNN: Yes, from the first 148 that we've done.

MR. GRIFFON: Right.

DR. WADE: And I just distributed hard copies of that and put some on the table.

DRAFT MOTIONS

MR. GRIFFON: Okay, so -- so maybe if we can start with those first two sort of draft motions, and I think the shorter one --

DR. WADE: Let's start with the first.

MR. GRIFFON: -- might -- might be the easier one, yeah.

DR. WADE: So there is a motion. We need someone to second.

MR. CLAWSON: Seconded.

DR. WADE: Okay. So this is the motion that says NIOSH should make DR guides, paren, guidelines, instructions or similar documents, close paren, available for all future cases, paren, included as part of the administrative record, close paren. Additionally, NIOSH should make appropriate versions of DR guides, paren, guidelines, comma, instructions, comma, or similar documents, close paren, available for all cases currently under review by the Board.

So we have a motion and a second. Now we can have discussion.

MR. GRIFFON: So -- go ahead, Wanda.

MS. MUNN: When the motion says available, do you mean available totally, publicly, on line, to SC&A, to the Board --

MR. GRIFFON: Yeah, and I think that's probably what Liz is commenting on, too, the -- the --

DR. WADE: Well, let Liz --

MR. GRIFFON: Well, available, I meant available on the -- on the O dr-- you know, to the Board.

MS. MUNN: Available to -- right.

MR. GRIFFON: To the reviewers, yeah.

MS. MUNN: Correct.

MR. GRIFFON: Yeah.

MS. MUNN: Okay. Perhaps we should stipulate that more clearly in the motion.

DR. WADE: Let's hear from Liz.

MS. HOMOKI-TITUS: That takes care of my second point, but my first point is if you could just change administrative record to the analysis reports. An administrative record is a legal document. An analysis record is what NIOSH puts out. Thanks.

MR. GRIFFON: Included as part of the analysis report?

MS. HOMOKI-TITUS: Analysis report.

UNIDENTIFIED: (Off microphone) (Unintelligible)

MS. HOMOKI-TITUS: Okay. Analysis record.

MR. GRIFFON: Analysis record, okay. That -- that would still be -- that's what we see on the O drive when we pull up a -- a case or whatever?

MR. HINNEFELD: Yes.

MR. GRIFFON: Okay. Okay.

DR. WADE: And then the second change was, Liz, to be formal?

MR. GRIFFON: Available -- do we need to put any words in there, available to the Board or available to Board and SC&A, you want to clarify that or --

MS. HOMOKI-TITUS: It would certainly be helpful if you would clarify that.

MS. MUNN: Yeah. Available to the Board and reviewers.

MS. HOMOKI-TITUS: Yeah -- well, I'm concerned about just using the word reviewers because petitioners may consider themselves reviewers of a final -- or --

MR. GRIFFON: Yeah, I think if we say available to the Board, that implies also SC&A since they're --

MS. HOMOKI-TITUS: Right.

DR. WADE: Correct.

MR. GRIFFON: -- our contractor. Right?

MS. HOMOKI-TITUS: We know that government employees -- government contractors can have it, the Board can have it, but if you'd just clarify that.

MS. MUNN: The language that's appropriate, yeah, would be then to the Board and --

MR. GRIFFON: Available to the Board.

MS. MUNN: Oh.

MR. GRIFFON: I think. Right? Does that cover us?

DR. WADE: Yes, that --

MS. MUNN: That -- that incorporates the contractor as well, yeah.

MR. GRIFFON: Okay. So -- and -- and to be clear here, I think there is one challenge, and

I don't know if NIOSH has a comment on this and I -- this appropriate versions, and -- and I did say for cases currently under review, so that would go back to the fourth set of cases. And I know that -- that -- you know, Stu might be able to talk to this, but I think so-- some of the old versions is -- it's -- you know, some of these cases were done in an early time period and I don't know if you've kept official versions by time, and how -- how difficult would this be to do, I -- we might even be able to say, you know, when -- when available or --

MR. HINNEFELD: When possible.

MR. GRIFFON: When possible, yeah.

MR. HINNEFELD: I think because, as you point out, there could very well be cases selected for review in the fourth and fifth and even from here on that were prepared some time ago, and the specific instructions just weren't retained. We -- you know, we frequently see cases in the review that used versions of procedures or Technical Information Bulletins that have been superseded by the time we review the case. And so very likely it will not in and of the -- if it's a controlled document, we can get the version that was used, but these are not controlled and I'm not 100 percent sure we'll be able to do it.

MR. GRIFFON: And -- and what if I said after the -- in the second sentence, Additionally, NIOSH should make appropriate versions of DR guides, parentheses/close parentheses, where possible?

MR. HINNEFELD: I think that --

MR. GRIFFON: Appropriate versions of DR guides, where possible --

MR. HINNEFELD: That works for us, yeah.

MS. MUNN: That sounds more reasonable to me.

MR. GRIFFON: Okay. 'Cause I do -- I do understand that challenge, but we do want to try to get those as -- okay.

MS. MUNN: Yeah, we have to deal in the real realm here.

MR. GRIFFON: Right. So that -- that's it, fairly succinct motion. I don't know if -- any further comments on it?

DR. WADE: I could read the -- the motion as modified then.

MR. GRIFFON: Yeah, you want to read it as edited?

DR. WADE: Okay, as edited, the motion: NIOSH should make DR guides, paren, guidelines, instructions or similar documents, close paren, available to the Board for all future cases, paren, included as part of the analysis record, close paren. Additionally, NIOSH should make appropriate versions of DR guidelines, where possible, paren, guidelines, instructions or similar documents, available to the Board for all cases currently under review by the Board.

MR. GRIFFON: Actually, just an editorial thing, I put the "where possible" after the parens there in the --

DR. WADE: Okay.

MR. GRIFFON: -- last, but --

DR. WADE: With that change.

MS. MUNN: Would you read that last sentence one more time, please, Dr. Wade?

DR. WADE: The last sentence one more time. Additionally, NIOSH should make appropriate versions of DR guidelines, paren --

MR. GRIFFON: DR guides.

DR. WADE: -- DR guides, paren --

MR. GRIFFON: Right.

DR. WADE: -- guidelines, comma, instructions, or similar documents, close paren, where possible, available to the Board for all cases currently under review by the Board.

MS. MUNN: Okay. Thank you.

MR. GRIFFON: Any further discussion on this motion?

(No responses)

I think we -- are we ready to vote on the motion?

DR. WADE: Okay. All in favor --

MR. GRIFFON: All in favor?

DR. WADE: -- signify?

MS. MUNN: Aye.

(Affirmative responses)

DR. WADE: Okay, it's unanimous, the four voting members.

Okay, the second motion.

MR. GRIFFON: All right. Second one is the motion regarding the blind reviews.

DR. WADE: We have a motion. Do we have a second?

MR. CLAWSON: Seconded.

MR. GRIFFON: Second?

DR. WADE: Brad seconds. Okay, discussion?

MR. GRIFFON: Did you -- did you want to read it in, Lew, like you did the other one, or --

DR. WADE: I could read it into the record.

MR. GRIFFON: You're so good at that, you know.

DR. WADE: Motion: The purpose of the blind reviews is to determine if required assumptions, comma, application of tools, comma, interpretation of data, comma, and treatment of data yield consistent results for the dose to the organ of interest.

New paragraph. The Board will select cases for blind review. Case ID will not be made available to SC&A. Further, comma, no information which could potentially be used to identify the case will be provided to SC&A until the blind review is complete.

New paragraph. The blind review will be conducted using available tools developed by NIOSH/ORAU, but without any case-specific analytical files. These blind reviews will be focused on best estimate cases.

MR. GRIFFON: So any -- and I -- I recognize that the -- I mean there's a mechanical step in here, the second paragraph, the mechanics of how to select the blind cases without doing it in a public forum, obviously -- I'm open for suggestions, I should say. I -- I would like to have a few blind reviews out of this eighth set of cases, and it might be -- at least for purposes here today, we might just select two less than we normally would out of the -- for the eighth set and -- and reserve a slot for two blind cases. And then -- I don't know if we can do -- select those in like a closed session format or something like that, but that may be a way to -- that -- that's a mechanical thing, though. I think --

MR. HINNEFELD: Well, there -- on the case selection list there is no identification on there of those cases.

MR. GRIFFON: But they have POC and --

MR. HINNEFELD: They do have POC, right.

MR. GRIFFON: I mean is there enough information to sort of infer -- yeah.

MR. HINNEFELD: There's POC on there.

MR. GRIFFON: Right. I think even that -- 'cause the POCs are -- you know.

MR. HINNEFELD: Because that's -- yeah, that (unintelligible) --

MR. GRIFFON: To a dec--

MR. HINNEFELD: -- gives you the answer to the

blind (unintelligible) --
MR. GRIFFON: Yeah, 40.7, you can find that pretty ea-- you know.
MR. HINNEFELD: Yeah, you're right, you're right. I -- that was actually not what I was going to comment about. We could -- what if we prepared that same list without that POC value in there to select from for blind cases?
MR. GRIFFON: Well, I --
MS. MUNN: But --
MR. GRIFFON: Yeah, I was thinking -- because we do want best estimate cases, so --
MR. HINNEFELD: Uh-huh.
MR. GRIFFON: I mean my -- my tendency would be to do -- to sort of have a -- a 15 or 20-minute segment of the subcommittee where we had a closed session --
MR. HINNEFELD: Okay.
MR. GRIFFON: -- and we just handled it that way.
MR. HINNEFELD: Okay.
MR. GRIFFON: I don't know if that's possible or...
DR. WADE: Well, it's possible.
MR. GRIFFON: Yeah.

DR. WADE: I'd rather explore other options, but if that's the option we -- would it be possible to have, for the Board, POC information and another list for the table that would include a POC between 40 and 50, for example. Is there a way we can demonstrate the fact that this is close to the margin, but without giving specific information? I guess the attorneys would have to advise. Again, I think it's always better to do business in the open if at all possible.

MR. GRIFFON: I agree.

MS. HOWELL: Well, I think the current list that we've been using for all of these selection cases does include the probability of causation number, so continuing to provide that isn't going to be a problem as long as, you know, we always review these to make sure there's not an aggregate of information that would allow --

DR. WADE: Okay.

MS. HOWELL: It's just a matter of -- if it's out there on the table, you know, SC&A's just going to have to wall themselves off from it, I guess, to make sure that they're performing blind reviews.

DR. WADE: Okay.

MR. HINNEFELD: We could take the list we have -- 'cause it's a Lotus -- it's an Excel file, rather, sort on POCs so that, you know, the POCs are the top; clip out the ones that are between 40 and 50, make that a file, and then delete out those POC numbers. In that case, we could generate a list that has all the same information that are on the selection lists now except for POCs, that would have the full internal and externals with POCs between 40 and 50 percent, but the POC would not be on the list.

MR. GRIFFON: But the cancer --

MR. HINNEFELD: We could do that.

MR. GRIFFON: -- cancer type would still be on there. Right?

MR. HINNEFELD: How can you do a dose reconstruction if you don't know the cancer type?

MS. MUNN: You can't.

MR. GRIFFON: Yeah, they need to know that, yeah.

MS. MUNN: Yeah, you really can't.

MR. GRIFFON: I'm just thinking through -- what are the parameters on there?

MR. HINNEFELD: There is the employment -- first employment decade, duration of employment, date that the draft DR was approved --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- whether -- there's the selection number, which is just an arbitrarily-assigned number, site --

DR. WADE: You're talking about this (unintelligible)?

MR. HINNEFELD: Yeah, you've got --

DR. WADE: Maybe I could give this out and you could look at it.

MS. MUNN: What is that?

(Pause)

MR. GRIFFON: Yeah, I -- I guess that may work if we just -- we sorted on the POC.

MR. HINNEFELD: We can do that.

MR. GRIFFON: That's the main identifying piece I think that --

MR. HINNEFELD: Right, that -- that would be -- that would be -- tip off the person who's going to do the blind --

MR. GRIFFON: Right.

MR. HINNEFELD: -- review to what the answer was --

MR. GRIFFON: Right.

MR. HINNEFELD: -- which is not -- which is what you want to avoid.

MR. GRIFFON: Right.

MR. HINNEFELD: Okay. So we can generate a list in that fashion.

MR. GRIFFON: Sort by -- sort --

MR. HINNEFELD: I don't know if I can do it this morning or not.

MR. GRIFFON: Sort with all POCs greater than 40 percent or whatever --

MR. HINNEFELD: Yeah, yeah, it's --

MR. GRIFFON: -- we --

MR. HINNEFELD: This is Excel. You can sort on POC and just clip out the ones --

MR. GRIFFON: And then --

MR. HINNEFELD: -- between 40 and 50.

MR. GRIFFON: -- and then find best estimate cases --

MR. HINNEFELD: If we work off this list, they'll be best estimates --

MR. GRIFFON: Right.

MR. HINNEFELD: -- full external and internal.

MR. GRIFFON: Right. What do people think? I think that's --

MR. CLAWSON: Sounds good to me.

MS. MUNN: It -- there's a question, I think, whether it's really possible to do this to the extent we would like to have it done without giving information which could in some way --

MR. GRIFFON: I know.

MS. MUNN: -- be traced back to the case. I just don't see how you can do that. There -- there may be some magic method out there, but --

MR. GRIFFON: Right. Well, and like --

MS. MUNN: -- and if --

MR. GRIFFON: -- Stu said, they eventually have to know the site and the --

MS. MUNN: Yes.

MR. GRIFFON: -- and the cancer type, so...

MS. MUNN: And if you know the site and the cancer type and the decade in which the person went to work --

MR. GRIFFON: You can narrow it down already, yeah.

MS. MUNN: -- then you're getting down to the point where it -- it could be identifiable.

MR. HINNEFELD: There's -- there's -- there's actually more of a problem with that. In order to do the dose reconstruction, if this person has an exposure record, that would be part of what the dose reconstructor would use to do the dose reconstruction. And those dose reconstruction records are identified, usually on every page. So what would -- we would be facing doing would be --

MR. GRIFFON: Yeah, yeah, redacting all -- yeah.

MR. HINNEFELD: -- printing this record -- printing this record, redacting it page by page, take off any identifier and then rescanning it to make it broadly available. And I'm just wondering, is it so critically important that SC&A not know which case it is, or is it just important they not know the outcome. And I don't know if there's a way to avoid, you know, having them -- the outcome available to them, if we can restrict access on a case by case -- I just don't know if we can restrict access or not just case by case, based on certain rights or not. I mean -- you know, or we could make it an honor system thing, you know --

MR. GRIFFON: Right, right, right.

MR. HINNEFELD: -- you're not allowed to look in NOCTS, you know, when you do this.

MR. GRIFFON: Yeah, I -- I was trying to make it a -- as clean as possible, but obviously we've got some -- some problems with that, yeah.

MR. HINNEFELD: To me, that's a very big deal because when you're doing a dose reconstruction, the -- the thing that, you know, you rely most on -- well, the CATI interview, again, would have to be redacted.

MS. MUNN: Yeah.

MR. HINNEFELD: The dose -- the exposure record that we receive for the individual would have to be redacted, quite possibly on every page, maybe several places on each page. And -- and so it really complicates getting the case available --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- for SC&A. We could generate for them -- as long as they can know who the case is, we can put all the information necessary that the dose reconstructor would have -- we can put all that information on the CD and provide that information on the CD and say then -- and during the blind review they must work from the CD --

MR. GRIFFON: Right.

MR. HINNEFELD: -- they're not allowed to consult NOCTS to help sort this thing out.

MR. GRIFFON: Right.

MR. HINNEFELD: They have to work from what's on that CD, I think we -- I think we can do that.

MR. GRIFFON: Right. Right, right.

MS. MUNN: This may be necessary, and it may be necessary for us to reword the second sentence in the second paragraph of the motion in order to clarify what the mechanics are going to be. We also may need to add "to the extent possible" at the very end of the motion. If we find, for example, when we get into what's available to us --

MR. GRIFFON: Yeah.

MS. MUNN: -- that best estimate cases don't give us the scope that we want to see covered in these blind reviews, then we may need to --

MR. GRIFFON: Yeah.

MS. MUNN: -- give ourselves a little space there.

MR. GRIFFON: How are you recommending changing the second paragraph, though? I --

MS. MUNN: The second paragraph, I think the wording --

MR. GRIFFON: Put more specifics in there or...

MS. MUNN: No, the wording of that second sentence needs to be worked on if we're --

MR. GRIFFON: Yeah.

MS. MUNN: -- if we're going to be realistic about this. The -- the addition to the end is easy, but we need to take a few minutes to consider the wording of that second --

MR. GRIFFON: I think we do, yeah. Yeah.

MS. MUNN: -- second sentence.

DR. WADE: John?

MR. GRIFFON: I mean --

DR. MAURO: If I may, in the first paragraph --

DR. WADE: Try to get very close to the microphone, please.

DR. MAURO: If I may, in the first paragraph reference is made to tools, and this goes back to the point that Mark had made regarding this business of do you use the tools or don't you use the tools. The way -- let me give you an example. When I review a dose reconstruction and one of these very sophisticated tools are before me to be used -- now it turns out Kathy Behling runs these tools all the time, took her quite some time to learn to use them, and she uses them. When I'm giving it, I use what I call -- give me all your data, I look at the data and I use my best knowledge and not the tool, the sophisticated tool, and in the -- because when I look at the tool, in some cases I don't especially feel that the tool is -- serves the process well. I don't -- I don't want to get into the specific -- it happens to be OTIB-18. So where -- where I'm going with this is that when I think about reconstructing a person's dose, I feel as if I don't necessarily want to be forced to use a tool that I do not necessarily like. I'd rather do it both ways. I'd rather say okay, John, you and whoever is going to do the best -- here -- 'cause when all is said and done, here's the data and this is what we've got. Here's the data from DOE. This is -- this is -- and now the fact that there might be a team of individuals over at NIOSH who put a lot of thought in building a sophisticated tool to really get -- sharpen the analysis, but in the end come out with a tool that perhaps other health physicists may say you know, I would not necessarily use that tool. I like the idea of saying what does that tool really buy you? Is it a tool that serves the process well? And so I guess what I would like to suggest is that if we're going to do the blind dose reconstruction, let's -- let's find out, let's use the tool and -- but also allow the dose reconstruc-- the auditor to use his own judgment and not feel as if he has to use the tool, and see what the tool buys us. Would it result in a better estimate, or perhaps a less robust estimate? And I have specific examples in mind where I feel the tool itself may not be the best way to come at the problem because of the way it's been conceived. So I'd -- I -- I think that insight into the value, power, validity of the tools that have been developed, and some of these are very sophisticated, needs to be understood and explored and disclosed to the Board because I think -- I know in several cases I feel as if the outcome, because we've used that tool, resulted in a dose reconstruction that I would not necessarily agree with, but I did follow all the rules. So I -- I sort of want to leave that --

MR. GRIFFON: Yeah, I -- I follow you, John. I guess -- the way I phrased that first part and -- and I don't think that restricts you from de-- from looking at that. I guess my point was that the purpose is to determine if these -- these -- you know -- I'm not sure it requires the word, but the assumptions, the application of the tools, et cetera, et cetera, yield to -- so if you're exploring whether they do yield a consistent result, you know, one -- I think one thing that you -- you should be allowed to do under this task would be to say, you know, we -- we -- you know, we looked at the -- you know, so you have the tools available, but you can certainly comment that we didn't -- you know, we did this both ways 'cause we don't think the tool's really appropriate in this case. We -- we chose this method. I think that it doesn't restrict you from looking at that. You're looking at whether the use of the tools makes sense, sort -- you know, also. So I don't think that restricts you from that.

DR. WADE: And you really have to distinguish --

MR. GRIFFON: Yeah.

DR. WADE: -- what you're trying to learn with a blind review versus a normal review. In a normal -- in a non-blind review, you are making those judgments all the time 'cause you're looking at what NIOSH has done and saying do we agree with that. Now here's a blind review. What are you trying to accomplish here different than what you're accomplishing with the normal review?

MR. GRIFFON: Well, that -- that is part -- but I think there is a different level. I think in these previous reviews a lot of the focus has been on if -- if a DR -- a dose reconstructor followed procedure and if they used the tool correctly and then, you know, sometimes it stopped there. You know, they used the tool as it was laid out to do, they used it in accordance with the appropriate procedures, they followed the site profile recommendations.

They didn't necessarily explore as to whether that tool was developed in a way that they -- that they felt -- you know.

DR. MAURO: That's correct.

MR. GRIFFON: Yeah, yeah. So -- now for the AWE sites we may get into this -- in our next discussion about advanced versus basic. For some of the AWE sites I think you did do that further probative questioning because, you know, we had the rationale when of-- oftentimes there's not -- you know, it -- it's one case, but all the cases for certain ones of these sites are done in the same manner, so you're basically reviewing the whole site in one -- in one case. So in those cases I think you did tend to do more of that probative analysis. But anyway, I -- I -- I don't think that first paragraph restricts you from -- from the -- you know, unless we need to edit it. I think Wanda has...

MS. MUNN: I'm wondering whether additional words are necessary in the actual motion, or whether our discussion here serves this purpose. Certainly we'd like to determine if the applications of the tool yielded consistent results. But by the same token, the question of whether in all cases the use of the tool provided the best reconstruction, the best notation of dose, is a different issue and that's the one that John really addressed here. It appears to me that if it's -- if we make it clear to our contractor that this statement with respect to the application of tools incorporates their judgment as to whether or not that was an appropriate use may suffice. Just don't want the record to --

MR. GRIFFON: Yeah. No, I think --

MS. MUNN: -- be misleading.

MR. GRIFFON: -- you're right. I think you're right. I -- I mean -- well, do -- do you have any proposed language addition to that or -- I -- I was thinking one thing we could add is yield consistent and scientifically defensible results for -- you know, get those words in there, the scientifically defensible thing. I think that's in our original charge, actually, so...

MS. MUNN: I think so, too.

MR. GRIFFON: Yeah.

MS. MUNN: John, would you find that --

DR. MAURO: Yes.

MR. GRIFFON: Would that --

MS. MUNN: -- reasonable for you (unintelligible) --

DR. MAURO: I was thinking those very same words.

MR. GRIFFON: -- work? Yeah, yeah.

DR. MAURO: That nails it.

MS. MUNN: Good.

MR. GRIFFON: All right. All right. So -- so getting back to that second paragraph now, the mechanics, I -- I tried to redraft a quick paragraph on that, so crossing out that entire second paragraph -- a friendly amendment to my own motion -- I -- I think maybe -- and this is pretty rough, as I was doing it real time, but perhaps this could work. The Board will select cases for blind reviews. NIOSH will put case information on a -- on a CD -- this is pretty crude here -- for SC&A to review. SC&A will not access the selected case via the NOCTS database. And -- and -- I mean if we really want to get restrictive about this, certainly NIOSH can even deny access to certain folders on NOCTS. I mean we -- we've seen this in the past. So they could even black -- block the Board's access and SC&A's access to certain, you know, selected case files and that way we -- you know, there'd be no indication that we were looking at the case information during the review, so...

MS. MUNN: That probably shouldn't be necessary.

MR. GRIFFON: I don't think it's necessary, but --

MS. MUNN: Certainly our -- our contractor is reliable enough to follow the instructions to use nothing except the data on the CD.

MR. GRIFFON: Absolutely, yeah.

MS. MUNN: And that's -- seems to be a reasonable method of -- of bounding what the -- what information is available in order to make it truly a blind review.

DR. WADE: Just again, Mark, NIOSH will select cases for blind review -- the Board will select cases for blind review. NIOSH will put what?

MR. GRIFFON: I -- I'm going to rephrase that second sentence. NIOSH will provide case information on a -- a CD for SC&A review. Or should I just say provide case information in electronic form or on a CD? I don't know.

MS. MUNN: CD is probably better.

MR. GRIFFON: On a CD, okay --

MS. MUNN: That puts it --

MR. GRIFFON: -- for SC&A review. And last sentence, SC&A will not access the selected case via the NOCTS database, just -- just so we're clear, you know, that -- you know. And then -- and -- does that make sense, Stu? I think that addresses what you were talking about.

MR. HINNEFELD: Right, I think that's -- that's quite doable.

MR. GRIFFON: Yeah.

MR. HINNEFELD: Presumably there will be a subcommittee member or members assigned -- normally there's a subcommittee member assigned to the review of each of the normally-reviewed cases. So rather than just say SC&A will not confer, it'd be SC&-- you know, subcommittee members or SC&A will not --

MR. GRIFFON: Okay. Yeah.

MR. HINNEFELD: -- you know, something like that.

MR. GRIFFON: Or -- or -- or the Board and SC&A

will not --

MR. HINNEFELD: Yeah, right.

MR. GRIFFON: -- yeah.

DR. WADE: You're saying the Board and SC&A will not access the NOCTS database?

MR. GRIFFON: Yeah. And in the first sentence I guess we -- NIOSH will provide information on a CD for the Board and SC&A review. Right?

MS. MUNN: Uh-huh.

MR. GRIFFON: I guess to be consistent.

MS. MUNN: Yes.

MR. GRIFFON: Should I read that whole paragraph back or I want to read the whole motion? I -- it --

MS. MUNN: Let's read the whole motion.

MR. GRIFFON: Yeah. I mean are there any other comments to any other parts, and then I'll try to piece this whole thing together in one read.

DR. WADE: Oh, I got it, if you want me --

MR. GRIFFON: Oh, you got it? Okay.

DR. WADE: I'll try.

MR. GRIFFON: All right, go ahead.

DR. WADE: Okay. Motion: The purpose of the blind reviews is to determine if required assumptions, comma, application of tools, comma, interpretation of data, comma, and the treatment of data yield consistent and scientifically -- ah, let me read it again.

MR. GRIFFON: Yeah.

DR. WADE: The purpose of the blind review is to determine if required assumptions, application of tools, interpretation of data and treatment of data yield consistent and scientifically defensible results for the purpose -- for the dose to the organ of interest.

Okay?

MR. GRIFFON: Yeah.

DR. WADE: The Board will select cases for blind review. NIOSH will provide case information to the Board and SC&A on a CD. The Board and SC&A will not access the NOCTS database for such cases.

MR. GRIFFON: That's it.

DR. WADE: And the third paragraph, the blind review will be conducted using available tools developed by NIOSH/ORAU, but without any case-specific analytical files. The blind reviews will be focused on best estimate cases, to the extent possible.

MS. MUNN: I would add one caveat. Following the NOCTS database, I would indicate NOCTS or any other available database, because we really don't want -- NOCTS is not the only source of information available.

MR. GRIFFON: And you -- you mean that regarding NIOSH databases or any other...

MS. MUNN: I mean --

MR. GRIFFON: I'm not sure exactly what you're referencing there, like the R drive versus the NOCTS system, is that what you're getting at?

MS. MUNN: Or original DOE files or original dose -- original badge reading contractors.

MR. GRIFFON: Oh, okay.

MS. MUNN: There's -- there's lots of other data out there that's accessible --

MR. GRIFFON: Yeah --

MS. MUNN: -- and -- and --

MR. GRIFFON: -- but I think the main --

MS. MUNN: -- that the -- isn't -- isn't the point we're trying to make don't use anything except what's on the CD for your review?

MR. GRIFFON: Yeah, I -- I -- I -- I've got to think about that one. You -- 'cause then we have to -- I mean are all the proced-- all the tools, procedures, site profi-- everything going to be put on that CD or -- or -- I guess they could be.

MS. MUNN: Well, then say any other claimant database, because procedures and things of that sort are --

MR. GRIFFON: Yeah.

MS. MUNN: -- are not the same as --

MR. GRIFFON: Maybe any other claimant database. I think --

MS. MUNN: Yeah, any other claimant --

MR. GRIFFON: -- the main thing we want to restrict SC&A from is looking at any analysis files that NIOSH has done, you know, if -- if, you know, raw records exist, I'm -- I'm not sure that's a problem, you know, but I -- I think any other claimant database is certainly --

MS. MUNN: Uh-huh, claimant database.

MR. GRIFFON: -- certainly appropriate, yeah.

MS. MUNN: Uh-huh.

MR. GRIFFON: Any other claimant database.

DR. WADE: Okay.

MR. GRIFFON: Okay.

DR. WADE: Okay. One more time then?

MS. MUNN: One more time.

MR. GRIFFON: One more time.

DR. WADE: Okay. Maybe I'll get it better this time.

The purpose of the blind reviews is to determine if required assumptions, application of tools, interpretation of data and treatment of data yield consistent and scientifically defensible results for the dose to the organ of interest.

Second paragraph. The Board will select cases for blind review. NIOSH will provide the Board and SC&A case information on a CD for review. The Board and SC&A will not access the NOCTS database or any other claimant databases for such reviews.

The blind reviews will be conducted using available tools developed by NIOSH/ORAU, but without any case-specific analytical files. These blind reviews will be focused on best estimate cases, to the extent possible.

MR. GRIFFON: Okay. Any other comments on the motion?

(No responses)

John, Stu, any other comments?

(No responses)

Okay. Ready to vote on the motion?

(No responses)

All in favor, aye?

MS. MUNN: Aye.

(Affirmative responses)

MR. GRIFFON: And I guess --

DR. WADE: (Unintelligible)

MR. GRIFFON: We got a unanimous vote?

DR. WADE: So the unanimous vote in favor of the motion.

MR. GRIFFON: So motion carries to the full Board.

TYPES OF REVIEWS

All right. The next item that I mentioned was at least a preliminary discussion of -- of the types of reviews that we're doing, blind versus advanced, and -- you know, how -- or whether we need to go back to our ori-- well, I was -- had asked that people look back at the original scope and consider the subtasks under the basic and advanced reviews and, to the extent we can, make sure that, going forward, we -- we haven't selected any -- we haven't really defined basic or advanced in the past case selections so far.

And I would argue that a lot of the cases have been basic, but certainly the AWE cases fall into an advanced review -- what I would say advanced review construct. And you know, I -- I just wondered if in our next sets of cases we need to specifically ask for basic and advanced. And if we do, just make that distinction. I think we need to have a more clear description of how that's going to affect SC&A's review. I think they need to know, you know, what -- what do you want beyond what we've done in the past to consider an advanced review. And -- and I -- the description I gave earlier, you know, might be one way we -- we ask them to modify their approach is that maybe we don't have to make sure every line item equals out so -- so that -- you know, therefore you have less -- less focus on that, but maybe more focus in the question of -- for example, if you have a raw dataset and -- and there's gaps in the individual's records, how were those gaps treated by NIOSH. And given the site dosimetry program, the history, you know, what went on at the site, the badging practices of the site, was that appropriate. And I don't think that -- that next step I don't think currently we take.

Now as I say this, also I realize that some of this falls into what we sometimes cover under our site profile reviews, so here we go with this, you know, sort of merging of the -- the two tasks. But I think that -- that -- that does become important because if -- if we stop the review at a point where we say, you know, they had gaps in the data and they -- they chose to assign it using this method and this method is prescribed in the TIB, that's one level of review, certainly. And if it's a -- you know, available method to the dose reconstructor in the TIB, that's certainly one method of review. They -- they've -- they, you know, check that they did it according to procedure.

The next step is, you know, is that -- is that application of that TIB appropriate for that site, given what we know about the dosimetry program and the, you know, the his-- you know, the history of -- of that site, or the individual's, you know, work and job history. I mean if someone has gaps and -- and they, you know -- I know that we've reviewed a lot of cases where we see, you know, very claim-- claimant favorable assumptions that -- that you'd say an individual had -- was monitored and never had a value over LOD and you're -- you're slapping on all this missed dose for several years where you -- you probably think --

MS. MUNN: Yeah.

MR. GRIFFON: -- you know, and rightly so, that that was very claimant favorable --

MS. MUNN: It's unreasonably --

MR. GRIFFON: -- so then -- then you get down to some cases where you might have small gaps, and did they -- did they use a different approach, did they use a coworker model to fill in that gap or did they still go with the LOD over two approach, when maybe the nearby doses were much higher than LOD over two -- you know, so that -- that's the kind of thing I'm -- I'm seeing as a more advanced probe -- just one example.

Other things that I've -- in -- in looking back at the scope and -- I didn't print out our initial -- it's in the original contract to

SC&A has the scope in. I don't know if we --

DR. WADE: (Unintelligible) get it?

MR. GRIFFON: I have it on disk, but -- I don't think we need it for this discussion really, but one other thing we brought up in there was -- was this question of whether -- whether the -- the -- it was the question of the interview being consistent with -- so the information provided in the interview was consistent with the -- the DR approach. And I think we've -- we've touched on that and -- and we do have one -- one obvious problem from the Board's working standpoint is that, you know, this -- this whole question of -- of can we -- can we, the Board, or SC&A approach the claimant and, you know, sort of re-interview them. And I think we've -- we've had a lot of, you know, dialogue about that in -- in past meetings, but we -- we certainly haven't explored -- usually -- and the other thing in the CATI interviews sometimes there's coworkers mentioned in there, and I don't think that our current reviews have said, you know, we've -- you know, certainly we haven't interviewed any of those coworkers, but you know, would -- would -- an advanced review could involve maybe looking at -- looking for those coworkers' radiation files. I mean they may not be claimants, but they might be within the DOE records system, looking at those coworkers' files and saying okay, you know, these people worked in the same operation. Thing-- you know, things look consistent with these workers, so comparing with like workers I guess was another option. That certainly is a more -- more advanced probative review.

So those are some things that -- that, you know, sort of jumped out to me as what would be considered advanced. You know, I think one -- even in the last subcommittee meeting we had the -- and it was an AWE case, actually, but it was the -- one of the AWE cases where they had an assumption on the -- the neptunium and -- and plutonium contamination in the recycled uranium that was used in the plant, and they had a baseline assumption for those percentages. But SC&A didn't go that next step to determine where -- how those were derived, you know, and if they seemed appropriate for that facility. I think that would be another example (unintelligible) --

DR. MAURO: Yeah, that -- that's a good example --

MR. GRIFFON: Yeah.

DR. MAURO: -- and where -- all we did in our review is point out that the justification for those ratios, those part per millions, was not provided --

MR. GRIFFON: Right.

DR. MAURO: -- or made reference to, and we stopped at that point.

MR. GRIFFON: Stopped there, right.

DR. MAURO: Yeah. A more advanced review would be dive into that --

MR. GRIFFON: Right.

DR. MAURO: -- and see if those numbers were in fact valid.

MR. GRIFFON: Right, right. So ju-- just some examples that I wanted to throw out there, and maybe -- you know, I'm not sure I'm ready to sort of make a motion to clarify what an advanced review should be, but I just wanted to maybe open some dialogue here today, and then maybe for our next subcommittee meeting we can, you know, flesh out what a advanced review is.

DR. MAURO: There may be another element of this type.

MR. GRIFFON: Yeah.

DR. MAURO: I notice that on many occasions I -- I'm just dying to pick up the phone and call up the person who did the dose reconstruction --

MR. GRIFFON: Right.

DR. MAURO: -- as oppo-- not -- not the claimant, but the dose reconstructor, and talk to them a little bit because sometimes the rationale or the explanation is very abbreviated and I know I'm going to spend a lot of time trying to figure out -- and in the end sometimes I'll simply write, you know, I just couldn't match this number and I'm not quite sure why.

MR. GRIFFON: Yeah.

DR. MAURO: A more in-depth review would be let me talk to the fir-- because it may be perfectly fine, but it's not self-evident to me as I read the DR report.

MR. GRIFFON: And we -- and we talked about that the last subcommittee meeting and I -- I think there's -- I'm not sure I like that option, actually, 'cause I think there's a benefit to not having that direct interaction because you can -- I think you can tend to be, you know, steered in the direction that -- that -- and I think a benefit of -- of this review is that you sort of attack a problem outside the box. You're not led down one path immediately. So I think there's trade-offs on that, yeah. I think -- I think the -- the middle ground there is to have these DR guides for each case, and then you sort of, without interviewing the dose reconstructor, you have some insight into what -- why they were going in the path of different decisions. I think that's a -- that's ground I'm more comfortable on, anyway. I can't speak for everyone, obviously.

MS. MUNN: There is another option, another possibility with regard to situations like that. I certainly have great understanding of the feeling that issues can be easily worked out if there's a direct dialogue between the people who are looking at the same information. But you're point's well taken, Mark.

Is there a possibility that in these few extreme cases that we're going to be looking at

-- and I'm only talking about these very best estimate, deep review issues -- perhaps a mechanism could be worked out similar to what we do in some of our working groups where the contractor looks at what has been done and states the question that comes to their mind. If we go one step further and allow the dose reconstructor to respond to that question, perhaps that could be done without having the interaction occur on a personal level.

MR. GRIFFON: Uh-huh.

MS. MUNN: And it might clear up the question very quickly.

MR. GRIFFON: I -- I mean the other -- yeah, the other -- and -- and you're saying sort of do that prior to any finding resolution process so that it's not -- is that what you're suggesting maybe?

MS. MUNN: I would think that you'd want -- if there's going to be a response --

MR. GRIFFON: Yeah.

MS. MUNN: If there's a question hanging in the air and there's someone who can answer that question, it would seem logical that we'd want that question answered before it came to us.

Would we not?

MR. GRIFFON: Yeah, I -- yeah, I think so. I -- I was just also thinking that -- how as we'd moved along here, we -- we've almost got a -- a few cases that I can point to, especially in the fourth set of cases, that -- that were sort of turning into advanced reviews, and these are these best estimate cases --

MS. MUNN: Uh-huh.

MR. GRIFFON: -- where, you know, NIOSH has come back and basically said, you know, we're going to provide you some, you know, further written analysis to -- you know, because these were very close and it was a question of whether the finding would result in a significantly different dose, you know --

MS. MUNN: Uh-huh.

MR. GRIFFON: -- so in tho-- you know, so then they -- there is more in-depth probing there. But that's sort of on the matrix level where we're asking, you know, here's what we -- you know, we have this question, and then -- I mean I'm assuming that in -- you know, Stu's bringing these back to the people that did the cases or people that, you know, reviewed them or whatever and asking them to provide more information or basically a response. But that's all in th-- in this formal level of the matrix. I mean maybe -- maybe you're right, maybe that step can be done prior to -- pri-- and then maybe it never gets on a finding level is maybe what you're saying, you know, to --

MS. MUNN: Worth considering --

MR. GRIFFON: Right, right.

MS. MUNN: -- as a possible mechanism.

MR. GRIFFON: Yeah. I -- yeah, I'm not sure there's an answer there, but it -- that -- that's an option, for sure. I -- I do think that -- my personal feeling is that I -- I like that separation of -- of, you know, the auditor from the people that were doing the dose reconstruction. And then if we do the response, I think it's best to have that response in the public for-- you know, on our subcommittee level and then, you know, there's no sense that there was sort of a -- a -- you know, a finding was taken off the table prematurely or whatever, without public scrutiny, I guess would be the word, so -- in my sense would be -- but -- but I certainly think that we have seen that in our -- in our review. In our resolution process we've seen where we've said, you know, we're not getting this number. We're not -- you know, we think there's an issue here and instead of just a verbal explanation, NIOSH has said let -- let's develop -- you know, let's -- let's give you a fleshed out, written response to this so you can see where we're coming from more -- you know, and we've got a bunch of those pending. Right, Stu? I mean right now we're in the process of that. So I think that -- that system works. Go ahead, John.

DR. MAURO: Another perspective on -- as you correctly pointed out, on -- on many occasions when we're doing a DR audit, very -- we're at the point now where on many of the cases that we're auditing there is an SC&A site profile review -- Hanford, Savannah River, there are a total of 21 right now.

MR. GRIFFON: Right.

DR. MAURO: So quite frankly, we've got now a backlog of knowledge regarding the site profile and -- you know, and into it in great depth. So we are the beneficiaries right now of being able to, while we're doing our DR, call up the lead on the site profile and say tell me a little bit more about how they did their neutron dosimetry or whatever.

MR. GRIFFON: Right.

DR. MAURO: So on that -- from that respect, we are in a position to go deeper into being -- providing the Board with some insight into the strengths and limitations of a given DR. But that's not the case for lots of DRs that we have not performed the dose -- the -- the site profile review. So in those cases I think a good question that needs to be asked is do -- does SC&A go into the original D-- do we perform what I would call a mini-site profile review and go into the -- the -- the records, the site profile, the documents that stand behind the site profile, as if part of our DR audit is to probe vertically into selected areas, as we see fit, the site profile and its supporting documentation for those that we haven't done already. And I -- to me, that is the -- the richest place for an advanced movement, by going down that road.

MR. GRIFFON: Yeah, I tend to agree with that.

Do -- do we have -- I mean I -- the other thing I haven't thought through really is -- is to what extent you do have the benefit of all those -- all those site profile reviews that you've done. And then I guess still, even for like Hanford and Savannah River, I'm not sure that you ever get down to like -- 'cause a couple of these came up in recent find-- and I think we're getting -- we're sort of getting at it in this resolution step, because questions are raised about whether someone should have had missed dose assigned for neutrons, and NIOSH's response is -- based on the job history and building history, they put together a compelling argument that, you know, their decision was correct. Well, SC&A hadn't, prior to that, gone to that depth. But maybe this reso-- you know, the resolution step's kind of getting us there anyway, so you know, I -- I don't know, you know. I think -- those were some of the things I was thinking about. Maybe some get covered in this resolution step. Maybe some need to be clarified in the original scope, you know.

DR. MAURO: But -- but you realize one of the line items in the matrix table, when we hit something like that, it's classif-- let's say we're doing a DR case, and we have a lot of these -- oh, this is a site profile issue; we'll deal with it then.

MR. GRIFFON: Right, right.

DR. MAURO: Now in the advanced review, the question -- you know, we're -- sort of like made a big circle now.

MR. GRIFFON: Yeah.

DR. MAURO: Are we going to deal with it right there as part of the DR, or are we going to put it off as a site profile issue, when the day comes when we do the site profile.

MR. GRIFFON: Right.

DR. MAURO: Yeah.

MR. GRIFFON: Yeah, and I've got -- I've got some of those currently. I was editing the fifth matrix on the plane out here and, you know, I have some questions in my mind on a few of those, which is -- you know, I -- I think some of them -- we said site profile issue, but I'm not even sure it's in the hopper for SC&A to review that -- that specific site profile, or some of them I think are -- are called exposure matrixes for the sites. They're not quite as big as a site profile, but -- and I -- my tendency is for those type of things we should handle it right, you know, in the DR process for those smaller sites. But yeah, it's open to discussion, too, so... I -- I -- go ahead.

MS. MUNN: It sounds as though you anticipate the end result to be the same whether this is done pre-matrix or post-matrix discussion.

MR. GRIFFON: Yeah, although -- although I think -- I think some clarification -- and I guess what I'd propose now is that before our -- for our next subcommittee meeting I'll try to circulate, before the day of the subcommittee meeting, some -- some draft language to clarify scope for an advanced review, 'cause there's some of these things that I think we might -- might want to touch on befo-- you know, some sort of flesh out in the resolution process, but some I think -- specifically the CATI elements and the coworker elements, and I know they're -- they're tricky ones to deal with, but I think we -- they're in our scope and I think we want to -- we need to -- to address them somehow.

DR. WADE: Is it your sense that we would look at some advanced reviews in the eighth set or hold for next year?

MR. GRIFFON: Well, I -- it'll probably -- since we're selecting the eighth set now, I -- I think it would probably hold off.

DR. WADE: To the -- to next year?

MR. GRIFFON: Yeah.

DR. WADE: Okay.

MR. GRIFFON: Although I think we're getting some -- I think we can retrospectively look back and say this was an advanced review, this is an advanced review. I'm not against that. I think some -- several of the AWE ones --

MS. MUNN: Uh-huh.

MR. GRIFFON: -- certainly fall into our classification as advanced reviews. Some of the Savannah River ones that we're asking for written responses back, I think at the end of the day we're going to consider those advanced reviews, you know, 'cause we're actually getting down to, in some of those cases, like I said, the work histories and how they match up with dosimetry and --

MS. MUNN: Uh-huh.

MR. GRIFFON: -- so we -- we -- I think we can assess our matrices backwards as to whether they were advanced or basic. But then for this -- this new criteria, I think for the nin-- ninth set, try to have it ready for the ninth set.

DR. WADE: Uh-huh.

MR. GRIFFON: If that's agreeable.

MS. MUNN: Seems reasonable, uh-huh.

MR. GRIFFON: Okay. Maybe -- so that -- that -- that's -- I guess the action is that I'll work with other subcommittee members and have a draft for the next subcommittee meeting of -- of a -- I guess clarification of -- of scope of advanced reviews. Right?

MS. MUNN: Be helpful.

MR. GRIFFON: And maybe -- I think this might be a good time to sort of insert Wanda's ite-- or I -- agenda item of looking at the SC&A data as far as the cases that we've covered. And then we'll go into the fourth, fifth and eighth case selection, if that's okay.

DR. WADE: Okay. Uh-huh.

MR. GRIFFON: We got ten -- 10:30 right now?

DR. WADE: Yeah.

MR. GRIFFON: We've got about another hour.

MS. MUNN: Are we going to take a break at any point?

MR. GRIFFON: Yeah, you want to -- I'm getting a look for a break. Let's -- let's take a ten-minute break and come back.

MS. MUNN: Just a quick one, thanks.

(Whereupon, a recess was taken from 10:30 a.m. to 10:50 a.m.)

DR. WADE: Okay, we're back in session.

DISCUSSION OF REVIEWED CASES

MR. GRIFFON: Okay, I think where we left it off, we were going to just have a discussion I think of -- SC&A provided us with a summary report -- statistics of the first 60 cases, and sort of a look at how many cases per site, different statistics like that. I think -- well, I -- I'll let Wanda take ov-- after she swallows, I'll let Wanda take over here.

DR. WADE: Well done, Wanda.

MR. GRIFFON: And I -- I'm just looking at these now. I actually -- I apologize, but I'll let Wanda take the floor.

MS. MUNN: And actually I was not looking at that printout. I was looking at the graphic display that covered the first 148 cases that gave us a better feel of -- for example, the cases that we've reviewed by years of employment, as opposed to our goal. Did you receive those?

DR. WADE: Yes, they were in that material that I gave you.

MS. MUNN: Yeah, uh-huh.

MR. GRIFFON: Are these available for everyone --

DR. WADE: Yes, they're on the table.

MR. GRIFFON: Okay, they are available.

MS. MUNN: Because those were so easily identifiable as to where we are, the printed list that was provided with this shows us very clearly that we have overestimated our requirements for some of the sites, and in other sites we still have quite a ways to go if we're going to meet our intended goal of 2.5 percent. Whether or not we actually have the kinds of cases in those particular sites that we feel needs the most attention, that are most problematical in our minds, is another issue. And perhaps we may not quite yet be ready to discuss that. But the breakdown of cases as reviewed by site is I think pretty indicative of where we have to go with a half-dozen of the sites and how we've overshot with others.

MR. GRIFFON: Yeah, I -- that --

MS. MUNN: Categories of POCs, we had originally expected to review about 40 percent in the zero to 44.9 percent area. We have 65 percent instead, of the current cases, which indicates that the 45 to 49.9 percent that we were looking at as 40 percent probably needs to be increased --

MR. GRIFFON: Yeah, I --

MS. MUNN: -- and --

MR. GRIFFON: I think to some extent that's been driven by our available cases --

MS. MUNN: Yeah, to some --

MR. GRIFFON: -- obviously.

MS. MUNN: -- to some, it has. But I think it would be wise for us to keep those clearly in mind as we --

MR. GRIFFON: All right. These are certainly helpful in our looking at the eighth set selection.

MS. MUNN: Very especially that 45 to 49.9

percent POC group. Clearly we only have eight percent of our currently-reviewed cases that fall into that category. That's pretty low.

MR. GRIFFON: Can I ask -- I think Kathy and Hans, are you on the line?

(No responses)

Kathy and Hans Behling, are you available on the phone line?

(No responses)

DR. WADE: Kathy and Hans, hopefully you're not muted.

MS. BEHLING: (Unintelligible)

DR. WADE: Yes, we're starting to hear you, Kathy. Speak up, please.

MS. BEHLING: Yes, we're on the line.

DR. WADE: All right.

MR. GRIFFON: All right. Thank you. I just had a -- a question in your table of the numbers of cases by site, the -- it -- the 2.5 percent, it says 2.5 percent of available cases, is that overall cases or is that -- that's not just final adjudicated cases, is it? That's --

MS. BEHLING: That number was actually provided to me by Stu Hinnefeld and I am under the impression -- and Stu, do correct me if I'm wrong -- that that is the number of cases with final decisions. I believe there is a number referred to OCAS by the DOL, minus ones that have been pulled, and then there is this number of final decisions. So I -- I believe that that number represents the number of cases with final decisions. Is that correct, Stu?

MR. HINNEFELD: That's my understanding. I sent, by site, essentially two numbers. I sent the number of cases available for review, meaning there's a final adjudication in place. And I also sent the total number of cases that had been referred to us for dose reconstruction, minus any cases that were pulled by DOL, which is the case -- that's the population which presum-- well, at some point will be available for review.

MR. GRIFFON: Right.

MR. HINNEFELD: So I sent both those numbers. This looks to me to be the numbers that are currently available for review.

MR. GRIFFON: The lower number then, so the--

MR. HINNEFELD: The lower number, that's what this looks like to me.

MR. GRIFFON: 'Cause I mean all of our scope was based on the projected totals, you know, sort of popu-- population of cases for each site.

MR. HINNEFELD: Presumably, all the cases --

MR. GRIFFON: And they look low to me, that's why I was wondering --

MR. HINNEFELD: Presumably, all the cases will someday be adjudicated --

MR. GRIFFON: Right.

MR. HINNEFELD: -- and if you want to review two and a half percent of everything that's done, then --

MR. GRIFFON: At some point it has to stop, I understa-- yeah.

MR. HINNEFELD: -- two and a half percent (unintelligible) -- okay.

MR. GRIFFON: But -- yeah, so I -- I think we -- when we look at these numbers, I don't know if this is possible, but it might be worthwhile also to update this table for -- to include that other denominator, all cases available by site. I don't know how quickly that can be provided, but might be useful.

Kathy, is that something you -- you could --

you have or...

MS. BEHLING: I'm sorry, ask me the question again -- I apologize.

MR. GRIFFON: Is -- that -- that 2.5 percent of available cases, I'd like to see the 2.5 percent of all referred cases or -- or is that the language, all referred cases?

MR. HINNEFELD: It's all referred cases minus pulls, is what it is. But if you just want to call it all referred cases --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- it's understood that a case that gets pulled, we're never going to do.

MR. GRIFFON: Right.

MR. HINNEFELD: You know, that's our expectation.

MR. GRIFFON: Right, right.

MS. MUNN: What are you calling referred cases, Stu?

MR. HINNEFELD: Cases that the Department of Labor sent to us to do a dose reconstruction on.

MR. GRIFFON: Now these are only --

MS. MUNN: Okay.

MR. GRIFFON: -- final adjudicated cases --

MS. MUNN: Right.

MR. GRIFFON: -- here, right.

MS. MUNN: Right, I understand that. We -- we've -- that's all we've had to work with from the outset.

MR. GRIFFON: Thus far --

MS. MUNN: Yeah.

MR. GRIFFON: -- but we're looking at our overall scope -- you know, when -- when we projected our initial numbers, we did it based -- and that -- and that database has obviously grown, but we based it on -- on the initial -- I know the spreadsheet I made we based it on all the sites that were in the NOCTS syst-- all the cases that were in the NOCTS system --

MR. HINNEFELD: I would suspect --

MR. GRIFFON: -- not -- not just the ones that had final dose reconstructions, obviously, 'cause we were just starting.

MR. HINNEFELD: Going back -- yeah, going back to when that was done, there were -- I would think -- very few finally adjudicated cases --

MR. GRIFFON: Right, right.

MR. HINNEFELD: -- so you almost surely worked from the ones --

MR. GRIFFON: Would not have --

MR. HINNEFELD: -- that had been referred to us for dose reconstruction.

MR. GRIFFON: Right.

DR. WADE: When the Board does its long-range planning, it needs to look at the -- the total population. When it does its selection, it has to look at what's available.

MR. HINNEFELD: What's available now.

MR. GRIFFON: That was my point. For our long-range projections more, we want to look at that other denominator.

DR. WADE: So -- so, Kathy --

MR. HINNEFELD: Kathy, I just wondered, did I -- did I in fact send you two numbers for each site?

MS. BEHLING: Yes, you did.

MR. HINNEFELD: Okay.

DR. WADE: And could you add to your table that looks at comparison of number of cases by site, add an additional column that would show 2.5 percent of the referred cases?

MS. BEHLING: I will do that, yes.

DR. WADE: Thank you.

MR. GRIFFON: Thank you. Anyway, I -- I think

Wanda's correct that this -- this -- we should certainly reflect on this as we select the eighth set and -- is there any other -- anything else you want to add to this?

MS. MUNN: No.

MR. GRIFFON: No? Okay. We're going to get to the eighth set really quickly here. I'm just -- I wanted to give a brief review of the fourth and fifth set of matrix (sic). We had a meeting in Cincinnati in between the last full Board meeting and -- a meeting of the subcommittee, and we did -- the main agenda items were discussing the fourth set. We're -- we're in, as I said, comment resolution phase for the fourth set and the fifth set. The fourth set -- you know, the -- the brief update is that we -- we're at a point where -- we have several best estimate cases, I'd say three or four, maybe five -- where NIOSH is coming back with some more in-depth written responses because these are -- you know, because they're best estimate and they're fairly high POCs, but they're not over 50, the -- the -- these findings could be significant enough to -- could have significant impact on the dose and -

- and, you know, have a significant effect on the case. So we -- we've asked for a more in-depth response on some of those cases and more -- that's sort of where we stand. Go ahead, Stu.

MR. HINNEFELD: Yeah, that -- the information's being compiled. We want to make sure it's, you know, complete and explanatory and then we'll share it with all the workgroup or --

DR. WADE: Stand a little closer to...

MR. HINNEFELD: -- the subcommittee members. The -- I had one question, though, is that in several cases the additional explanatory information is IMBA-filed -- an IMBA file that demonstrates the internal dosimetry -- you know, the bioassay that was there --

MR. GRIFFON: Right.

MR. HINNEFELD: -- what does the curve look like that is used in the dose reconstruction, you know --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- so I'm not sure, does -- do all the -- do all the Board -- or the subcommittee members have IMBA on their computer 'cause, you know, you have to have

IMBA to open this IMBA file and see it.

MR. GRIFFON: I think -- I think it -- it was made available. I'm not sure if everybody's loaded it on or whatever, but --

MR. HINNEFELD: Okay. And then --

MR. GRIFFON: Did everyone get copies of that early -- early on I know I got a copy.

MS. MUNN: That's --

MR. CLAWSON: I don't.

MS. MUNN: -- a lot of heavy-duty wading.

MR. GRIFFON: Yeah.

MR. HINNEFELD: The second part of it is just opening the IMBA file, so --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- in addition to providing the file, we need to make sure we have sufficient explanation to interpret what you're looking at because --

MR. GRIFFON: Right.

MR. HINNEFELD: -- it's -- even to a health physicist, it's not particularly intuitive --

MR. GRIFFON: No, I -- I --

MR. HINNEFELD: -- the program is not particularly intuitive --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- and so --

MR. GRIFFON: I agree, a narrative to go along with the IMBA file --

MR. HINNEFELD: -- so there's -- we want to make sure we have not just the file, but sufficient explanation that --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- you know, says this is what we're demonstrating here.

MR. GRIFFON: And I think it's more important that SC&A, you know -- we're probably not going to get down into the details of the IMBA model --

MR. HINNEFELD: Right.

MR. GRIFFON: -- but SC&A will probably do that, and if we have the narrative and --

MR. HINNEFELD: Right, okay.

MR. GRIFFON: -- you know, I think that -- that's the way that will proceed, I believe.

MR. HINNEFELD: Okay.

MR. GRIFFON: Yeah.

MS. MUNN: The IMBA model information is very high-level technical detail.

MR. HINNEFELD: Well, it's -- it's kind of esoteric. We keep the -- we keep it secret.

You know, we don't talk about the secrets --

MS. MUNN: Well --

MR. HINNEFELD: -- of the craft so that way we're more valuable as health physicists.

MS. MUNN: No, it -- it's really difficult to get through, for those of us who don't do it on a daily basis.

MR. HINNEFELD: And it's not really -- it's not really intuitive for those of us who do.

MS. MUNN: No, no, it isn't.

MR. GRIFFON: That's right. Okay. So anyway, that -- that -- the fourth set is -- you know, I'd say we've closed out many of the action-- many of the findings we've closed out, but we have several still on the table that -- that are requiring this more in-depth response and we'll -- we'll pull that up at our next subcommittee meeting, which I -- I do like to have these subcommittee meetings in between the Board meetings. I think we can get down into the details of those meetings, where it's a little harder at -- at this meeting.

The fifth set, we did go through the entire matrix at the last meeting and we have at least begun the -- the resolution process. I've actually edited the matrix, including a NIOSH resolution -- actually it's more -- more of a -- it should just be resolution, because in some cases the resolution was that SC&A was in agreement. In other cases, NIOSH is going to provide more information. But I have edited the matrix. I will -- that was done on the plane and last night when I got here at the hotel. I'll provide that. It -- it's -- I really -- at this stage of the game I think it's for the other subcommittee members and NIOSH and SC&A to look at and make sure that we -- that I accurately understood the -- where we stand. I do have some question -- remaining question marks on that, so the fourth and fifth I'm assuming when we reconvene this subcommittee, probably in Cincinnati, we'll take those up and try to clo-- you know, try to come to closure. And I -- I think we have a good shot at closing both those matrices at the next meeting, so that's sort of an update on the backlog.

And the six and seventh, I -- I don't know -- John, maybe you can just give us an update on where -- or Kathy and Hans, where we stand with the sixth and seventh ma-- or cases. We're not at the matrix level yet, I don't think -- or are we?

MS. MUNN: I don't have one.

MR. GRIFFON: No.

MS. BEHLING: This is Kathy. I believe -- I'm trying to remember if I have generated the matrix for the sixth set or not. I'm -- quite honestly, I'm not sure at the moment. The -- the issue with the eighth set is we're current-- or the seventh set, I'm sorry, we're currently in the progress of working on those and I'm hoping that possibly we will have a draft of those cases prepared maybe at the end of May, beginning of June, so that we can hold our conference calls at that point in time. And I apologize for not remembering that and sixth set matrix, put together or not, but I -- I will certainly do that within a day or two if I haven't.

MR. GRIFFON: Okay, that -- that's okay. You're not the only one that doesn't remember. Anyway, those sixth and seventh case -- sets of cases are in process, but they're in sort of the pre-resolution stage right now, but we're -

- we'll continue working on those.

SELECTION OF CASES TO BE REVIEWED

And then I think the remainder of our time I want to focus on the eighth set selection, and we've been provided -- Stu Hinnefeld, NIOSH, provided two spreadsheets for us --

DR. WADE: Stu, could you briefly --

MR. GRIFFON: Yeah, briefly describe these, Stu.

DR. WADE: -- what people have (unintelligible) have two.

MR. HINNEFELD: Okay, there -- there were two lists provided. One is -- at the heading it says "full internal and external". That is the list of all the finally-adjudicated cases that are identified in our database as being full internal and external dose reconstructions, which is essentially best estimate, or as close as we can identify best estimate case, based on -- that's -- that field in the database is populated by the HP reviewer when he or she reviews the case and -- and approves the draft dose reconstruction. They will indicate whether this is an overestimate or an underestimate, you know, in a particular component, or whether it seems to be pretty much, you know, that's just the best we can do and it's called full internal and external. So that is the one list. It has the normal selection information and I have sorted this list based on the date approved. Now that's the date the draft dose reconstruction is approved, so the newest cases are at the top, and that's why the selection numbers are kind of dis-- you know, a jumbled order, actually. They probably run kind of -- kind of backwards, but not exactly. So these are sorted based on date approved, thinking that the more recent cases -- if -- if you get into very old cases, sometimes procedures and OTIBs were used that have been superseded, so those are sorted in that fashion.

The second list is a random selection of some 200 cases, regardless of whether they're full internal or external or overestimates or underestimates. And so anything on this second list, the random selection list, that says full internal and external, you should -- you know, if you look real hard you can probably find it on the other list, as well. So if you --

MR. GRIFFON: And the -- also sorted by date approved I see. Right? Yeah.

MR. HINNEFELD: Yes, also sorted by date approved.

MR. GRIFFON: Okay.

MR. HINNEFELD: So those are the two lists here for --

MR. GRIFFON: Does the first list, the full internal/external, does that exclude ones we've already selected?

MR. HINNEFELD: Yes. Both lists exclude cases that are already selected for review. They also exclude cases that the Department of Labor has identified as having post-final adjudication activity on and therefore may be reopened. And so there are about maybe ten to 15 on each list that were removed by the Department of Labor because there's some post-final decision activity on the case.

MR. GRIFFON: Okay. Maybe -- I think it makes most sense, given the statistics we just looked at, that we want to focus on the best estimate cases to start with and -- and I -- I agree, I'm glad you sorted it this way, Stu, that we should try to focus on the most recently approved cases since a lot of our past reviews we've seen, you know -- NIOSH agrees, but a TIB's already been revised or whatever, so I think this would avoid some of those redundant findings that we've been coming up with. So maybe just -- I think we'll just throw this open as people look down the list.

DR. WADE: And John Mauro, for the record, how many cases are we trying to -- to find to give you your full year's --

DR. MAURO: The full year -- 32 -- if we could identify 32 cases today, we will have our full cadre cases for the fiscal year 2007.

DR. WADE: Okay, thank you.

MS. MUNN: (Off microphone) (Unintelligible) question?

MR. GRIFFON: No, I was going to ask that -- of these 32, we might consider two to be blind, given the way we defined it, our blind review criteria. Do we need to do that off of a separate list or we're going to get... I'm unclear on my own motion.

MR. HINNEFELD: I would suggest that we can -- you know, bef-- when we -- before we generate the list for blind selection --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- we can remove the ones selected for this --

MR. GRIFFON: Right.

MR. HINNEFELD: -- and then do our sort and re-prepare the lists. So the ones selected in this -- this arena would not be available on the selection for blinds.

MR. GRIFFON: Right.

MR. HINNEFELD: You know, that would be a way to not trip over ourselves, I guess is what --

MR. GRIFFON: No, I was going to propose to select -- try to shoot for 30 today and then save two for this blind review selection, if that's agreeable with folks.

MS. MUNN: We're not going to try to do two blind selections today?

MR. GRIFFON: Well, I -- I think we didn't want to have the exact POC number and stuff when we did the blind review selection. Is that still -- still correct?

DR. MAURO: Any hel-- maybe I can help out a little here. The 32 would cover all of the cases that we are obligated to perform that are considered basic and advanced. The blind reviews really are over and above that.

MR. GRIFFON: Oh, okay.

DR. MAURO: And I believe there is -- total of six, on that order --

MR. GRIFFON: Yeah.

DR. MAURO: -- I forget the -- I'd have to go back. So therefore the additional blinds are over and above the 32.

MR. GRIFFON: Okay, so -- so I guess we can do 32 today, if we find 32 reasonable cases here.

DR. WADE: And then when they're removed, we try to do the blinds at the next subcommittee meeting.

MR. GRIFFON: Right, right. Okay, that sounds good.

All right. So anybody -- we're all looking at this real time, so going page by page.

MS. MUNN: I'd suggest the fourth -- the first one might be the one, two, three, four, five, six -- oh, 05289. That's one that falls in -- recall that we were really short, if we're looking at the same goal, on cases between 45 and 49.99 --

MR. GRIFFON: Yeah.

MS. MUNN: -- percent. That one falls there and --

MR. GRIFFON: 289 looks good to me.

MS. MUNN: INE--

MR. GRIFFON: Okay, people?

MS. MUNN: Yeah, INEL, our goal of available cases was 13; we've only looked at five so far, so that seems a logical fit.

MR. GRIFFON: I als-- also think the second one on the list, which is K-25 and Mound, 48.38 percent.

DR. WADE: That's 295?

MR. GRIFFON: 295, people, agree, disagree?

(No responses)

DR. WADE: Okay.

MR. GRIFFON: Okay? Going down the list, any...

(Pause)

MS. MUNN: 48 dot 649 on page 2.

MR. GRIFFON: What's that number again, Wanda?

MS. MUNN: 48.689 (sic) --

MR. GRIFFON: Oh, POC 48.649?

MS. MUNN: Uh-huh.

DR. WADE: That's case 260.

MR. GRIFFON: 260?

DR. WADE: Paducah Gaseous Diffusion.

MS. MUNN: (Off microphone) (Unintelligible)

MR. GRIFFON: Yeah, okay.

DR. WADE: Okay, it's down.

MR. GRIFFON: That's down.

MS. MUNN: And then --

MR. GRIFFON: Two down from that, number 257?

MS. MUNN: Right.

MR. GRIFFON: Y-12 case.

DR. WADE: Okay.

MS. MUNN: It fits.

(Pause)

MR. GRIFFON: And then we got 254 is a Mound case.

MS. MUNN: We already have one from that site, don't we -- or did we?

DR. WADE: You had a mix, Wanda.

MR. GRIFFON: Yeah, we have five -- well, six available, but...

DR. WADE: So what say you, 254 then -- number 254?

MR. GRIFFON: I'm asking Wanda, Mike, that Mound case, 254?

MS. MUNN: Let's look at the cancer types for a minute.

MR. GRIFFON: I think it looks okay, unless I hear --

MS. MUNN: I think so.

MR. GRIFFON: Okay.

DR. WADE: I've got it.

MR. GRIFFON: That's number five, right, Lew?

DR. WADE: Right, number five.

MR. GRIFFON: Okay. What about -- you -- Bob, you were saying 249?

MR. PRESLEY: As an outsider.

DR. WADE: You can say that.

MR. GRIFFON: Yeah, okay.

DR. WADE: 249?

MR. GRIFFON: 249, Portsmouth.

MR. PRESLEY: Yeah, that kind of gives us a -- a look at two sites on that type of cancer.

DR. WADE: Okay.

MR. GRIFFON: Okay.

(Pause)

MR. CLAWSON: 240?

MR. GRIFFON: 240, yeah.

MR. CLAWSON: (Off microphone) (Unintelligible)

MR. GRIFFON: Yeah, 240 looks good.

MR. CLAWSON: How about 239?

MR. GRIFFON: 239, Hanford? We've done a lot of Hanfords and Savannah Rivers, but that's --

that is -- does look like a decent case.

DR. WADE: Uh-huh.

MS. MUNN: But we're still -- if I'm -- if I'm looking at the number of cases that we've looked at as opposed to the ones that we had for our goal --

MR. GRIFFON: Yeah.

MS. MUNN: -- we're still --

MR. GRIFFON: Yeah, we could still do --

MS. MUNN: -- we're still low on those.

MR. GRIFFON: Yeah, I say add that one, number 239, that is.

DR. WADE: Okay.

MR. GRIFFON: That's eight cases total?

DR. WADE: Right.

MR. GRIFFON: That first Savannah River one on the third page looks good to me.

MS. MUNN: Number?

MR. GRIFFON: 236.

MS. MUNN: That's -- that's in that POC range where we have a surplus of --

MR. GRIFFON: Oh, where we have a lot, yeah.

MS. MUNN: Yeah.

MR. GRIFFON: I'll put a star by that one, Wanda, given your comment that number -- that

236 --

MS. MUNN: Yeah.

DR. WADE: Okay.

MR. GRIFFON: It's still over 40, but we did say 45 to 50 was what we were targeting.

MS. MUNN: Yeah.

MR. GRIFFON: Yeah.

DR. WADE: We can go -- we can go back.

MR. GRIFFON: Yeah, we -- yeah.

MS. MUNN: That's Savannah River...

MR. GRIFFON: Yeah -- I mean we do have other criteria we've got to remember, too, and the -- a lot of these are best --

MS. MUNN: Yeah.

MR. GRIFFON: -- estimate cases, which we certainly want to look at, you know.

MS. MUNN: Yeah, we do.

MR. GRIFFON: So we don't want to be driven completely by the POC.

MS. MUNN: No, but my feeling is that the small number that we're going to have that falls in between that -- that guideline that we've established is going to be so small that we're still going to have room for whatever we want to do to fill in with that --

MR. HINNEFELD: Mark, I just might offer that I recall the last time we did a selection we did a large group to get more specific dose reconstruction information about --

MS. MUNN: Uh-huh.

MR. HINNEFELD: -- and bring that back for the ultimate selection. So could be -- you might want to do this in two phases. Pick some that you're cer-- pretty certain you want to look at --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- and then pick a larger group the addi-- you know, another group for the additional information maybe. You know what I'm saying? Last time you picked more than what was ultimately going to be selected --

MR. GRIFFON: Right.

MR. HINNEFELD: -- to get additional information about how the dose reconstruction was done.

MR. GRIFFON: Yeah.

MR. HINNEFELD: And so just a -- a thought to keep in mind is there may be more --

MR. GRIFFON: Yeah, we talked about doing the same phase --

MS. MUNN: (Unintelligible) go back.

MR. GRIFFON: -- here --

MR. HINNEFELD: Okay.

MR. GRIFFON: -- but I don't know if that would be...

MR. HINNEFELD: Well, you can apply it where you want. I just occurs to me that, you know, we're really focusing on 45 to 50 percenters here, grabbing the majority of those -- not every one but, you know, the majority --

MR. GRIFFON: Right.

MR. HINNEFELD: -- and the ones -- the ones that we're picking seem like they're going to be -- you know, they're not dose model. They're going to be full internal and externals, the ones we're picking.

MR. GRIFFON: Right.

MR. HINNEFELD: But at some point you may want to, you know, pick more cases for us to go get the additional data on.

MR. GRIFFON: Right, right, and that -- and we did talk about doing those. I mean what -- what are the logistics of that, Stu? We probably can't expect to have that like overnight for the Board --

MR. HINNEFELD: No.
MR. GRIFFON: -- to consider tomorrow or --
MR. HINNEFELD: No, not for the remainder of this meeting --
MR. GRIFFON: Right, right, right.
MR. HINNEFELD: -- because there's at least a partially manual search or --
MR. GRIFFON: Right.
MR. HINNEFELD: -- you know, kind of a laborious search to find that information.
MR. GRIFFON: So we did talk about picking this eighth set in a similar way that we did --
MR. HINNEFELD: Right.
MR. GRIFFON: -- the seventh set.
MR. HINNEFELD: Right.
MR. GRIFFON: We -- we could probably do that on a phone -- a Board phone call, though. Right?
MR. HINNEFELD: Yes.
DR. WADE: We could.
MR. GRIFFON: So I -- I -- 'cause I don't want to delay this three months, you know, but I think we could --
DR. WADE: Right.
MR. HINNEFELD: Right.

MR. GRIFFON: -- have a mid step and then make a vote on a Board phone call, like we did last time, so --

DR. WADE: Right.

MR. GRIFFON: -- so I think we still want to do the same thing, give you these, maybe shoot for 40 or 45 --

MR. HINNEFELD: Okay.

MR. GRIFFON: -- broaden our -- our lens a little bit here --

MR. HINNEFELD: Uh-huh.

MR. GRIFFON: -- and then have Stu get more information on those, come back and then we can cull it down to 32. Right?

DR. WADE: Okay.

MR. HINNEFELD: Right.

MS. MUNN: Since we're --

MR. GRIFFON: I'm --

MS. MUNN: -- since we're --

DR. WADE: On the top of -- on the top of page 4 there's a number of 45-pluses.

MR. GRIFFON: Yeah.

MR. PRESLEY: Got that.

MR. GRIFFON: Right. I was still back on page 3, actually -- 224, halfway down. It's an X-10 case, it's 42.6. It's not 45, but it's fairly high POC.

DR. WADE: Okay.

MR. GRIFFON: Colon cancer's supposed to be best estimate, so...

MR. CLAWSON: What was the number on that?

MR. GRIFFON: 224. And I'm on to page 4. I'm sorry, I was a little behind everyone. Bob mentioned 209, the fourth one down.

MS. MUNN: And actually there's 210, just above it, as well.

MR. GRIFFON: And 210, right above it? Yeah, I actually think they're both -- both reasonable selections -- 209 is a multiple cancer with pancreatic cancer and -- and so I think -- okay, so 210 and 209.

MS. MUNN: 195.

MR. GRIFFON: Where's that at, Wanda, one --

MS. MUNN: Down near the bottom.

MR. GRIFFON: Got it.

DR. WADE: 195?

MR. GRIFFON: Yeah, multiple site. Looks like a good -- good one to look at.

MS. MUNN: And I would -- I would not do 191, simply because we have three cases already reviewed from there and --

MR. GRIFFON: Yeah.

MS. MUNN: -- only one --

MR. GRIFFON: My sense is --

MS. MUNN: -- required.

MR. GRIFFON: -- that -- we're in the middle of reviewing Bridgeport on one of our matrices right now, I think, and --

MS. MUNN: Yeah.

MR. GRIFFON: -- is that a site-wide model, John, do you recall -- or Stu? Or is it a --

MS. MUNN: I thought it was.

MR. GRIFFON: Is there individual data or is more of a site --

DR. MAURO: I think it has an exposure matrix specific for it.

MS. MUNN: Yeah.

DR. MAURO: Yeah, so there is a --

MR. GRIFFON: Yeah, so I think if we reviewed some cases, they're all going to use the same --

DR. MAURO: They're all going to look that way.

MR. GRIFFON: Yeah.

MS. MUNN: Yeah, and we've already done three.

MR. GRIFFON: I think we've got that covered.

Yeah.

MS. MUNN: Okay.

MR. GRIFFON: I'm on to page 5.

MS. MUNN: Yeah, that first one, another Paducah -- yeah, 185.

DR. WADE: 185?

MS. MUNN: Uh-huh.

MR. GRIFFON: When -- when we looked at Bridgeport Brass, did we combine Havens Lab and Adrian? Are those...

MR. HINNEFELD: I don't -- I don't recall right off hand, and I don't even recall right off hand whether the profile describes them both or if it's specific --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- to one or the other, so I -- I don't remember right now.

MR. GRIFFON: Kathy or Hans, do you know if -- if the three cases you mention on your matrix here in your presentation -- or in your table there, if they were Havens Lab or Adrian or -- or you don't know?

MS. BEHLING: This is Kathy. I believe that one of the Bridgeport Brass cases, the most recent one we had looked at, was only the

Havens Lab. And the exposure matrix does discuss both the Havens Lab and the Adrian Plant. But the current one that we're working on, that we (unintelligible) just worked on, only discussed the Havens Lab.

MR. GRIFFON: So the cases we reviewed only cover Havens Lab right now?

MS. BEHLING: (Broken transmission) previous (unintelligible) cases have (unintelligible) exposure matrix was not available at the time we reviewed (unintelligible) were actually done under the OTIB-4 and so we've only had I believe one case where we've actually reviewed Bridgeport Brass using the exposure matrix.

MR. GRIFFON: So I think it might be worth getting a Bridgeport Brass Adrian -- although this one may not be the one, it's number 184, stomach cancer at 21 percent. With these type of cases I'm not sure the -- the POC is as important because we're really reviewing the exposure matrix, in a sense, so -- I don't know what people think about that one, 184.

MS. MUNN: Well, but if you're going to look at Adrian, we have 187, as well.

MR. GRIFFON: Is there a better one? Okay.

DR. WADE: That's 52 percent.

MS. MUNN: Compensated.

DR. WADE: Bottom of page 4.

MR. GRIFFON: Bottom of page 4? Oh, I missed it. Yeah, either -- that's fine with me.

DR. WADE: 187 it is then?

MR. GRIFFON: So that'll give is 14 total, Lew, or...

MS. MUNN: That'll bring us up --

DR. WADE: Now we're at 14.

MR. GRIFFON: Fourteen, that gives us a --

DR. WADE: You haven't decided on 185 yet.

MR. CLAWSON: (Off microphone) (Unintelligible) on page 5.

MR. GRIFFON: Page 5 we have a recommendation of 172, which is halfway down the page. This is Mound and Rocky combined.

MR. CLAWSON: Yeah.

MR. GRIFFON: Almost at 45. Looks okay to me. Again, we -- we're broadening our lens here so we're shooting for maybe 40 or 45 cases.

DR. WADE: Right.

MR. GRIFFON: So that's 15.

MS. MUNN: Another -- 157.

MR. GRIFFON: Oh, where's that at -- oh, at the bottom of the page, page 5?

MS. MUNN: Yeah.

MR. GRIFFON: Paducah?

MS. MUNN: Bottom of page 5.

MR. GRIFFON: Okay, that looks all right.

MS. MUNN: Three in a row, Paducah we need more, Y-12 we can use more, Savannah we can use more, so --

DR. WADE: So 156 and 155 as well?

MS. MUNN: 157, 156 and 155 all fall in the range we're looking at.

DR. WADE: Proposal for the last three --

MR. GRIFFON: Last three?

DR. WADE: -- on page 5.

MR. GRIFFON: And I agree, yes, so 16, 17, 18 that gives us.

MS. MUNN: 153 on page 6?

MR. GRIFFON: That's okay, yeah. We have a lot of Savannahs, but we need a lot more. Right? So yeah.

MS. MUNN: Yeah, we can use a bunch.

MR. GRIFFON: That's 19.

MS. MUNN: At least eight or ten.

MR. GRIFFON: Right.

(Pause)

We've got an awful lot of Savannah on the next couple of pages here.

MS. MUNN: Yeah.

MR. GRIFFON: Yeah.

MS. MUNN: On page 7 --

MR. GRIFFON: Page 7, that's where I'm at, too.

MS. MUNN: -- the next -- 120 up there is the first one that falls in the --

MR. GRIFFON: 120 works, yep.

MS. MUNN: -- category.

MR. GRIFFON: That's number 20.

MS. MUNN: And 101.

DR. WADE: 101 is proposed?

MR. GRIFFON: 101? Where is that, Wanda -- oh, yeah. Again Savannah River, 46,37 percent? Anybody at -- think it's okay?

UNIDENTIFIED: Yeah.

MR. GRIFFON: Going on to page 8, unless I hear otherwise.

MR. CLAWSON: That doesn't look like a very good page.

MS. MUNN: No, but if we are going to broaden our -- our view there, we might consider 083.

DR. WADE: 083 has been asked for.

MS. MUNN: That site, we don't have very many.

MR. GRIFFON: Where is that at, on --

MS. MUNN: Top of the page --

MR. GRIFFON: -- up top, okay.

Oh, Iowa, though, that -- I think we've avoided that, didn't we, 'cause it was an SEC -- but is this -- is this non-SEC? I don't understand, Stu. Can you help me out with this one? Was that a non-SEC ti-- I thought an SEC was proposed for the entire...

MR. HINNEFELD: There may be some people who worked at Iowa Ordnance who didn't have enough time on the AEC portion of Iowa Ordnance and therefore didn't qualify for the class.

MR. GRIFFON: 'Cause bladder's a listed cancer.

MR. HINNEFELD: Bladder's a listed cancer, I believe.

MR. GRIFFON: Yeah.

MR. HINNEFELD: An SEC cancer, so from a time frame, I don't think any part of Iowa Ordnance is excluded. You know, I think it's the entire period of operation is included in the class, so it must be that this person was determined not to have sufficient time in the AEC -- AEC portion of the -- of the plant.

MR. GRIFFON: I guess we can look at it. I'd be curious how this would be a --

MR. HINNEFELD: Yeah.

MR. GRIFFON: -- best estimate case, but --

DR. WADE: We can find out. So 083 --

MR. GRIFFON: Yeah.

DR. WADE: -- is that it?

UNIDENTIFIED: (Unintelligible) 083?

MR. GRIFFON: Yeah. That's 22, Lew, is -- are we in agreement there?

DR. WADE: Yes, 22.

MR. GRIFFON: Okay.

MS. MUNN: (Unintelligible) anything else in there. Everything else is very low or compensable.

MR. GRIFFON: I'm on page 9, unless I hear otherwise.

MS. MUNN: Uh-huh.

MR. GRIFFON: Close to our time to close the meeting, too.

DR. WADE: It's okay.

MS. MUNN: Nothing there.

MR. GRIFFON: We're okay, we're okay.

MS. MUNN: Nothing inside the box. There's nothing to the end of the list that's inside --

MR. GRIFFON: Yeah, where's this Anaconda

Company, Stu, do you know? Is that a uranium type facility or...

MR. HINNEFELD: I don't recall off the top of my head. Most AWEs are uranium-forming --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- you know, of some sort.

MR. GRIFFON: I -- it might be worth just pulling at least additional information and seeing what that case is all about.

DR. WADE: That's 045?

MR. PRESLEY: 045?

MR. GRIFFON: Yeah. Number 22, right?

DR. WADE: 23.

MR. GRIFFON: 23? Uh-oh -- oh, yeah. I think we might be moving into our random cases.

MS. MUNN: Yeah.

MR. GRIFFON: Anyone have anything else on these full external/internal?

(No responses)

And so we're at -- we're at 23. If we can get up to 40, that would be great, I think.

Let's look at the random list.

MS. MUNN: Well, if we shift our criterion to the decades first employed, our original goal for persons in the '60s was 25 percent. Right now we have only 17 percent. And for the '70s was 25 percent; we have only 14 percent. So perhaps -- perhaps the '60s and '70s might be --

DR. WADE: Question?

MR. HINNEFELD: I was just --

MS. MUNN: -- criterion.

MR. HINNEFELD: I was just going to mention that it would be probably pretty rare to see a POC in the 45 to 50 percent range that's an overestimate. You shouldn't see any that are an underestimate, and if you find something on this list that is in the 45 to 50 percent range, more than likely it's a full internal and external, in which case you may have selected it off the list we just looked at. It would have had a different tracking number on the -- selection number on the other list. So I think -- I don't think you'll find any in the 45 to 50 percent range --

MR. GRIFFON: Right.

MR. HINNEFELD: -- on this list.

MR. GRIFFON: If you did an overestimate and it fell into 45 to 50, you would then do -- go back to doing a best estimate. Right? You wouldn't --

MR. HINNEFELD: For some time now we've not accepted them.

MR. GRIFFON: Yeah.

MR. HINNEFELD: There may be some early-on ones that were done that way --

MR. GRIFFON: Right.

MR. HINNEFELD: -- but for the --

MS. MUNN: Yeah.

MR. HINNEFELD: -- lately it's -- they're not really accepted that way or --

MR. GRIFFON: Okay.

MR. HINNEFELD: -- only on very rare occasions.

MR. GRIFFON: All right. So Wanda -- I'm sorry, my attention drifted there. Did you have a proposed case or did I miss a --

MS. MUNN: No.

MR. GRIFFON: No, not --

MS. MUNN: You heard what I was saying about the years?

MR. GRIFFON: Yes.

MS. MUNN: Yeah.

MR. GRIFFON: 1960 -- yeah.

MS. MUNN: Other than that, I was just agreeing with what Stu was saying.

MR. CLAWSON: Mark, what about 690?

MR. GIBSON: (Off microphone) (Unintelligible) comment about the years, Mark?

MR. GRIFFON: 690 is on the table. Where's that at? Give me other --

MR. CLAWSON: First page.

MR. GRIFFON: Yeah, that's one that I flagged. Lawrence Livermore?

MR. CLAWSON: Yeah.

MR. GRIFFON: 44 percent, it might have just been under that 45 cusp. I think that looks pretty good, number 24.

(Pause)

687 looks interesting, just 'cause the guy worked for 120 years. I'd like to see that individual.

684, Fernald bone cancer, 1950 decade. I think that looks --

MS. MUNN: We're back in the '50s.

MR. GRIFFON: Any objections to that one?

MS. MUNN: Well, we have all these '50s.

MR. GRIFFON: 25, yeah, I know.

MS. MUNN: We've got way over the number that we need from the '50s decades.

MR. GRIFFON: Oh, okay.

MR. GIBSON: Mark?

MR. GRIFFON: Yeah.

MR. GIBSON: It doesn't seem like we have a lot of cases that they maybe started their work careers in like the '70s and they worked through the cleanup phase.

MR. GRIFFON: Right.

MR. GIBSON: And even though the ones that are listed have a -- most of them have a low probability of causation, I just --

MR. GRIFFON: I think you're right, it's another period we want to examine. Wanda's point, too, that the '60s we're missing -- you know, so we should keep that in mind. We're getting a lot of the early start dates, the '50s.

MS. MUNN: I'm sorry, where --

MR. GRIFFON: If you see some of those, you know, ma-- make sure we get them.

MS. MUNN: We're -- we're working on random now. Right?

MR. GRIFFON: Random, yeah.

MS. MUNN: And we have chosen one?

MR. GRIFFON: Two of them, 690 --

DR. WADE: And 684.

MR. GRIFFON: -- and 684, and both of these were 1950, unfortunately, but we -- you know, I think you're right, we should look at that decade worked or --

MR. GIBSON: Mark?

MR. GRIFFON: -- you know, carefully.

MR. GIBSON: What about case 227 on page 3?

MR. GRIFFON: Page 3 of the random?

MR. GIBSON: The person started work in the '80s and worked 22 years, so that'd put them up to 2002.

MR. GRIFFON: I'm not sure I find the number, Mike.

MR. CLAWSON: What number was that?

DR. WADE: Was this on the first list, Mike?

MR. GIBSON: 227 is the case. It's on page 3.

MS. MUNN: Oh --

MR. GRIFFON: Oh, of the first list? Okay.

DR. WADE: Okay.

MR. GRIFFON: Of the first full estimate list?

MS. MUNN: Yeah.

MR. GRIFFON: Okay.

DR. WADE: 227, 41.

MS. MUNN: Uh-huh.

MR. GRIFFON: Yeah, and I think your point is a start date of 1980, too, so that is different.

MR. GIBSON: (Off microphone) (Unintelligible) through the cleanup phase.

MR. GRIFFON: Okay, let's add that on. That'll be number 26. Thank you.

MS. MUNN: 26?

DR. WADE: 26.

MR. GRIFFON: Did you find that one, Wanda?

MS. MUNN: 27.

MR. PRESLEY: You got another one there (unintelligible) Savannah River.

MR. GRIFFON: That's the 26th one we selected. Right?

DR. WADE: Right.

MS. MUNN: But we could -- we could actually do both of them, they both fall in the category we're --

MR. GRIFFON: Which -- which -- which is both?

MS. MUNN: -- looking at.

MR. GIBSON: 27.

MS. MUNN: 27 and 26.

MR. GRIFFON: Oh, and 26, the next one's --

MS. MUNN: Yeah.

MR. GRIFFON: -- starts in 1970?

MS. MUNN: Right.

MR. GRIFFON: Yep, yep, that's okay. That'll be the number -- this 27th case selected. The numbers are confusing me.

DR. WADE: Only briefly.

MR. GRIFFON: Okay. I'm looking back at -- I'll -- I'll take offers from any -- any list, but I'm back on the random list at this point.

DR. WADE: No reasonable offer refused.

MR. GRIFFON: Yeah.

MS. MUNN: There's -- on the first page there's 678 from NTS, a 1960s case.

MR. GRIFFON: What --

DR. WADE: 678, first page of random.

MR. GRIFFON: First page of random.

DR. WADE: 678, Nevada Test Site.

MR. GRIFFON: Yeah, I was just looking at that, starting in 1960s, three years -- at least worth looking at to -- yep. Number -- how many is that?

DR. WADE: 28.

MR. GRIFFON: Twenty-eight?

MS. MUNN: On the next page -- no, that's a --

UNIDENTIFIED: No.

MR. GRIFFON: What page, Wanda? Page 2 --

MS. MUNN: Page 2 --

MR. GRIFFON: -- on the random --

MS. MUNN: -- of the randoms. We have several from the '60s in there. How about 649?

MR. GRIFFON: At the bot-- near the bottom --

MS. MUNN: Yeah.

MR. GRIFFON: -- Paducah?

DR. WADE: Right.

MS. MUNN: Uh-huh, Paducah.

MR. GRIFFON: This is another skin cancer case, you realize.

MS. MUNN: Yeah, we've had a number of them in this batch.

MR. GRIFFON: People want that one?

MS. MUNN: There's 644.

DR. WADE: 649, yes or no?

MR. GRIFFON: 649, yes or no, anybody object to that one?

UNIDENTIFIED: (Off microphone) (Unintelligible)

MR. GRIFFON: Yeah, it's in an SEC, but this is a non-listed cancer --

DR. WADE: Non-covered cancer.

MR. GRIFFON: -- non-covered cancer.

DR. WADE: So say yes to it?

MR. GRIFFON: Yeah, for now.

DR. WADE: Okay.
MR. GRIFFON: -- first -- first list, anyway.
DR. WADE: And then, Wanda, you said 6...
MS. MUNN: Somebody said 649. I'm trying to have a -- trying to find 649.
MR. GRIFFON: We haven't done (unintelligible) at Simonds?
MS. MUNN: And I'm not seeing it.
MR. GRIFFON: We can probably do another one.
MS. MUNN: There it is.
MR. GRIFFON: Wanda, which one did you say?
MS. MUNN: 649 is what I was looking at.
DR. WADE: We got it.
MR. GRIFFON: Okay. I would go back up the list, maybe 666, 17.36 POC, breast cancer, Savannah River. The only reason -- particular interest -- back to what Mike was pointing out, the decade worked is 1980, so a later case.
MS. MUNN: Okay.
DR. WADE: 666?
MR. GRIFFON: Might be an overestimating approach, but at least we can look at it.
DR. WADE: All right.
MS. MUNN: Evil number.
DR. WADE: That's 30.

MR. GRIFFON: And then Bob brought up 661, a few down from there, Simonds Saw, starting in the '60s.

MS. MUNN: Oh, I think we have --

MR. GRIFFON: We've done one case from there.

MS. MUNN: -- an awful lot of those. Don't we have a lot of those? Oh, we'll do it.

MR. GRIFFON: Any objections to that one?

MS. MUNN: No, that'll do.

DR. WADE: Okay, I'll put it down.

MR. GRIFFON: Thirty-one?

MS. MUNN: That will fulfill our requirement for that site.

MR. GRIFFON: Yeah.

MS. MUNN: What number did you say, Mark?

DR. WADE: 661.

MR. GRIFFON: 661.

MS. MUNN: Oh, I thought you gave a number --

MR. GRIFFON: Oh, no, I didn't --

MS. MUNN: -- another one after that.

MR. GRIFFON: -- give another one, no.

MS. MUNN: Okay.

(Pause)

MR. GRIFFON: There is one toward the bottom, a Brookhaven National Lab one. I don't think we've --

MS. MUNN: I saw that.

DR. WADE: What number?

MR. GRIFFON: We've got one case from there alr-- done out of -- well, one based on available cases. I don't know --

MS. MUNN: Yeah.

MR. GRIFFON: This is number 644.

MS. MUNN: We had one in --

MR. GRIFFON: At the bottom of page 2.

DR. WADE: Okay.

MS. MUNN: We had one and one already.

DR. WADE: Put it down?

MR. CLAWSON: How about on page 3, 6--

MR. GRIFFON: I'd say at least initially put it down.

DR. WADE: Okay.

MR. GRIFFON: Yeah. Hold on now, let me -- Brad had one, or --

MR. CLAWSON: 632.

MR. GRIFFON: 632, same thing, okay. Where's that at?

MR. CLAWSON: It's on page 3.

MR. GRIFFON: Page 3.

MR. CLAWSON: Los Alamos.

MS. MUNN: That's a good one.

MR. GRIFFON: Yeah, that looks good, 1970s start date.

MS. MUNN: Yeah.

MR. GRIFFON: That'll be 34?

DR. WADE: 33, I have.

MR. GRIFFON: 33? Okay.

MS. MUNN: And --

MR. PRESLEY: The other one was (unintelligible) --

MR. GRIFFON: And again, we're shooting for 40 and anticipating we'll lose a few.

MR. PRESLEY: (Off microphone) (Unintelligible) is 1970 at the Nevada Test Site, which is a nervous system (unintelligible) low POC but still (unintelligible).

MR. GRIFFON: 1970, yeah.

DR. WADE: 627?

MR. PRESLEY: Yeah.

MR. GRIFFON: Any objections?

DR. WADE: No? Okay.

MR. CLAWSON: Robert, let's look at 623, too, that's --

DR. WADE: 623 is asked to be looked at.

MR. GRIFFON: 623?

MR. CLAWSON: Nevada Test Site.

MR. GRIFFON: Nevada Test site, four years, 1960.

DR. WADE: Okay?

MR. GRIFFON: That's okay for first cut.

DR. WADE: All right.

MR. GRIFFON: Now we've got several more pages. Let's not limit ourselves here.

MS. MUNN: Well, there's --

UNIDENTIFIED: -- page 4?

MS. MUNN: -- the very bottom one on page 3, though, 613, is also --

MR. GRIFFON: Lawrence Livermore, we haven't done that many from there. We just picked one today.

DR. WADE: Okay, 613?

MR. GRIFFON: 613, yeah, put that on the list.

DR. WADE: Okay.

MR. GRIFFON: Thirty-six -- page 4, Bob has something.

MR. PRESLEY: Yeah, it's 588, Mound, 1980, breast cancer, (unintelligible) point six.

MR. GRIFFON: From the 1980s. Any objections to that?

MS. MUNN: Isn't that -- isn't that pretty much like the -- didn't we have one --

MR. GRIFFON: Did we have one like that before?

MS. MUNN: -- almost -- yeah.

MR. GRIFFON: We had a 1980 breast cancer. I can't remember if it was --

MS. MUNN: Yeah.

DR. WADE: 588?

MS. MUNN: With about the same POC, as I recall. Different site, I think.

DR. WADE: Different site.

MR. GRIFFON: Well, let's say yes for now on that one.

DR. WADE: Okay.

MR. GRIFFON: Thirty-seven? I'm going on to page 5 on the random list.

MS. MUNN: Well, that's '70s and '80s. 562, down toward the bottom.

MR. GRIFFON: 562, what -- where's that at?

DR. WADE: Towards the bottom of page 5.

MS. MUNN: Near the bottom.

DR. WADE: 562?

MR. GRIFFON: That looks okay, yeah. That gives us 38.

(Pause)

On to page 6 of 7.

MR. PRESLEY: (Off microphone) (Unintelligible) bladder, Los Alamos, (unintelligible).

MR. GRIFFON: Is that on page 6?

MR. PRESLEY: Six.

MR. GRIFFON: At the bottom, yeah, okay.

DR. WADE: What number?

MR. GRIFFON: 528, POC 30.2, Los Alamos.

DR. WADE: Okay.

MR. GRIFFON: That's number 40, ri-- or no --

DR. WADE: No --

MR. GRIFFON: -- 3--

DR. WADE: -- 39.

MR. GRIFFON: -- 39.

DR. WADE: One more.

MR. CLAWSON: What about 52-- 525? I know it's breast, but we've got Y-12, Pantex --

MR. GRIFFON: Where is that at, Brad?

MR. CLAWSON: Very bottom of --

DR. WADE: Very bottom of the page.

MR. CLAWSON: -- page 6.

MR. GRIFFON: Okay.

MR. PRESLEY: (Off microphone) (Unintelligible) site.

MR. GRIFFON: Yeah, Y-12 and Pantex, 1980s.

MR. PRESLEY: (Off microphone) (Unintelligible)

MR. GRIFFON: Looks okay.
DR. WADE: Might as well just do the last page.
MR. GRIFFON: That's 40, why don't we just go through the last page and get a couple extra if we need them.
MR. GIBSON: Mark, what about 551, Hanford?
MS. MUNN: Yeah, I looked at that.
MR. GRIFFON: 551?
MR. GIBSON: (Off microphone) (Unintelligible) '70 (unintelligible).
MR. GRIFFON: 1970s, yep, yep.
MS. MUNN: Yeah.
DR. WADE: Doesn't hurt.
MR. GRIFFON: Okay.
MS. MUNN: Looks good.
MR. GRIFFON: That's 41.
DR. WADE: And on the last page.
MR. GRIFFON: Going to the last page --
MR. PRESLEY: Livermore, look at 545, 1970. It's a Lawrence Livermore breast cancer.
MR. GRIFFON: That looks okay, 42.
DR. WADE: Five -- is that 545 or --
MR. GRIFFON: 545 on page 6 of 7.
DR. WADE: 545, okay.
MR. GRIFFON: Yeah.

DR. WADE: Okay.

MR. GRIFFON: On the last page, just to -- might as well go through, for completeness.

(Pause)

MR. GRIFFON: Yeah, nothing -- I don't see anything there. We don't have to add any more.

MS. MUNN: No.

DR. WADE: We have 42.

MR. GRIFFON: We have enough to get our 32.

MS. MUNN: There --

MR. GRIFFON: We have 42 pre-selected cases here to bring back to the Board. Is everybody happy with that list? Mike, do you have a --

MR. GIBSON: 514.

MR. GRIFFON: What page?

MR. GIBSON: The last page, page 7.

MR. GRIFFON: 514, 16.95, Idaho National Lab?

MR. GIBSON: POCs low, but we can compare it to Wanda's.

MR. GRIFFON: Yeah.

MR. GIBSON: It's in that -- same decades.

MR. GRIFFON: In that time period, 1980.

DR. WADE: Okay.

MR. GRIFFON: We can certainly add that one on. That gives us 43.

DR. WADE: 43.

MR. PRESLEY: (Off microphone) (Unintelligible) look at (unintelligible). That's low all the way around.

MR. GRIFFON: Yeah, I bet that's an overestimating approach, yeah, yeah. Okay.

DR. WADE: So we've got 43.

MR. GRIFFON: Anything else? I think we got -- we got enough to get our 32.

DR. WADE: I can report them to the Board then this afternoon.

MR. GRIFFON: All right, so we'll report that. That'll be part of our subcommittee report back to the Board, and then we'll get more detailed data and we'll probably vote on this on a phone call meeting, is my assumption. That's how we'll move this forward.

So I think that's all of our business on the subcommittee. Anybody have anything else?

(No responses)

I'll do the report back on our motions and the eighth set.

DR. WADE: I'll get them typed up nice for you.

MR. GRIFFON: And -- okay.

DR. WADE: Thank you all very much.

MR. GRIFFON: Thank you. Meeting adjourned on the subcommittee.

(Whereupon, the meeting was concluded at 11:55 a.m.)

CERTIFICATE OF COURT REPORTER

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 day of May 2, 2007; and it is a true and accurate transcript of the testimony captioned herein.

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

WITNESS my hand and official seal this the 26th day of July, 2007.

____

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