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

convenes the

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ADVISORY BOARD ON

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VOL. III

DAY TWO

ABRWH BOARD MEETING

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the Knoxville Marriott, Knoxville, Tennessee, on October 18, 2005.

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P R O C E E D I N G S
(8:45 a.m.)

WELCOME AND OPENING COMMENTS

DR. ZIEMER: Good morning, everyone. I'd like to call the meeting to order. This is the official opening of the 33rd meeting of the Advisory Board on Radiation and Worker Health. Let the record show that we have a quorum. Mr. Griffon is also going to join us in a few minutes. Dr. Melius will be joining us later today. But there is a quorum and we will proceed.

Some general information and announcements again. My usual reminder to you, to please register your attendance in the registration book out in the foyer. Also, those members of the public wishing to address the assembly at the session this evening, please sign up on -- in the booklet out in the foyer, as well.

There are a number of handouts, copies of the agenda and related materials, on the table in the back of this room. If you have not already done so, please avail yourselves of those.

We will try to follow the agenda as it's set forth. However, the times may be adjusted accordingly as various discussions occur and

things take longer or not as long as planned for, so there will be some flexibility in terms of when certain things begin and end. But we will plan to follow the agenda as it's set forth.

This is, as I said, our 33rd meeting. It's actually the second time that this Board has met in east Tennessee. We had a previous meeting in Oak Ridge, but we're pleased to be back in Knoxville and an opportunity to interact with some of the local folks here, as well as others who have joined us.

Let me ask our Designated Federal Official, Lewis Wade, to make a few remarks, as well.

DR. WADE: Thank you, Paul. I'd like to welcome you all to this meeting, and bring you welcome from Secretary Leavitt and the Director of CDC, Dr. Gerberding, and also from my boss, John Howard, the Director of NIOSH.

The subcommittee met yesterday, had a very productive day, and I'm looking forward to a very productive meeting of the full committee.

Just to keep you up on things, on Friday of last week Secretary Leavitt signed the determination of adding Mallinckrodt as a class

to the SEC, following your recommendation, and has sent that on to Congress. I join the Secretary and John in thanking you for your deliberations on a very difficult issue, and I'm pleased that the Secretary has acted consistent with your recommendation.

I'd like to remind you of some things in your immediate future that I think sort of flow from lessons we've learned with regard to Mallinckrodt. It is quite likely that at the scheduled meeting at the end of January the Board will have to consider SEC petitions for Rocky Flats and the later years of Y-12.

As you know, we're now working actively on site profiles related to those two facilities. I think it's terribly important that the Board considers its actions leading up to the January meeting to see that you are ready to vote on the site prof-- on the SEC petitions. We have available subcommittee and working group and other opportunities for the Board's -- the Board to get together.

There is no requirement that we look at those petitions at the end of January, although I think it is right for us to do work in a timely

fashion. If for any reason we find we would not be ready to give full consideration to those SEC petitions at the end of January, we could consider moving them to a later meeting, although I wouldn't hold that out as the first option. I think the important thing to do is to complete all work on the site profiles for Y-12 and Rocky Flats so that we can look at the SEC petitions in a timely way in January. But again, we learned a lesson in Mallinckrodt that it is very difficult to juggle a site profile and an SEC petition at the same time, so I think it's important that we keep our eye on future activities and take actions consistent with prudent action on the SEC petitions. Hopefully that's not too confusing. I think we have the opportunity to do it right, and I think we're wiser by the Mallinckrodt experience, so thank you.

DR. ZIEMER: Okay. Thank you very much, Lew, for those comments and general direction as to upcoming events for this particular Board. We have on our agenda the approval of minutes. Those minutes were distributed to the Board yesterday. Some of the Board members have just

joined us this morning and have not had the opportunity to review those minutes, so without objection, I'm going to defer action on these minutes until tomorrow, so those who joined us today will have a chance to read through them before we take formal action. But Leon and Rich, particularly, make sure that you got copies of those minutes that were distributed.

CONFLICT OF INTEREST

One other thing that we did yesterday, and I think I'm going to, in a sense, repeat it for the benefit of those who were not with us. We had brief discussion from counsel about conflict of interest and participation in discussions involving site profiles, as well as SEC petitions. And Liz, would you be willing to -- oh, okay, this is -- yeah. Liz's co-counsel here, and for the record, introduce yourself also, please.

MS. HOWELL: I'm Emily Howell. I'm with HHS OGC, as well. We just wanted to make everyone on the Board aware that as the Board discusses site profiles you are free to discuss a site profile where you may have a conflict of interest. However, if the Board does take any

official action, you will need to -- not necessarily move away from the table, as we ask you to do when approving or disapproving SEC petitions, but avoid voting on that issue. Any site prof-- any site where you have a conflict that's in your memo waiver that you received from CDC, you will need to do that with -- regardless of the length of time that you worked at that site. And if you have any questions, please approach Liz or I.

DR. ZIEMER: Thank you. So the real difference is that you can enter into debate on site profile issues, even though it's a site where you have worked. Okay. But have to abstain from voting.

REPORT FROM SUBCOMMITTEE:

BETHLEHEM STEEL SITE PROFILE

Now we'll move into the issues relating to Bethlehem Steel site profile, and as we lead off here I'm going to call on Jason -- Jason, I have trouble pronouncing your last name, so you'll have to -- I can spell it, but I can't pronounce it, so --

MR. BROEHM: Okay. Well, you're in good company. It's -- it's pronounced Breem (ph.).

DR. ZIEMER: Okay, B-r-o-c-h--

MR. BROEHM: e-h-m.
DR. ZIEMER: -- e-h-m. And Jason is Congressional liaison for CDC, and he did read into the record yesterday one letter, and we have some additional ones, and I think they relate to Bethlehem. Is that not correct?
MR. BROEHM: Yes, all three do.
DR. ZIEMER: So this would be an appropriate time for you to read those.
MR. BROEHM: Okay. Well, yesterday I read the statement that we had from Senator Charles Schumer from New York. And since then I have also received letters -- or statements from Representative Louise Slaughter and Representative Brian Higgins, also both from New York.
So I'll start off with Senator Schumer's statement. (Reading) Mr. Chairman, thank you for allowing me to submit testimony to the Board regarding Bethlehem Steel. Thousands of New Yorkers labored during the late 1940's and early 1950's in ultra-hazardous conditions at Department of Energy and contractor facilities while being unaware of the health risks. Workers at these facilities handled high levels

of radioactive materials and were responsible for helping to create the huge nuclear arsenal that served as a deterrent to the Soviet Union during the Cold War. Although government scientists knew of the dangers posed by the radiation, workers were given little or no protection, and many have been diagnosed with cancer.

Despite having one of the greatest concentrations of facilities involved in nuclear weapons production-related activities in the nation, western New York continues to be severely under-served by the Energy Employees Occupational Illness Compensation Program. I'm aware that many positive steps have been taken in the past few months regarding the Bethlehem Steel site profiles, but I do not feel that worker concerns are being adequately addressed, or that workers are going to be adequately compensated.

Eddie Walker has been a tireless advocate for former Bethlehem Steel workers, and I share many of his concerns. For example, has residual radiation between rollings and after rollings been evaluated to the fullest? I have

a hard time believing that such a large steel mill could be completely cleaned of uranium dust simply by using a vacuum. Without proper decontamination after a rolling, it is likely that uranium dust would still be present throughout a plant of this size, therefore making residual radiation a hazard for all workers.

In the latest S. Cohen & Associates report on Bethlehem air data released on October 14th, 2005, an interview with a former worker states just this, quote, The repair and machine of the rollers, which would carry residual dust from the rolling area, was done in the machine shop according to the schedule of the shop. Which means that it was likely that it was done on days which uranium was not being rolled, unquote.

In meetings I've had with former workers, they tell me that they were surrounded by uranium billets and/or dust all day long. Some even told me that they had to remove uranium flakes from inside their coffee mugs. Has site expert information and worker interviews truly been taken into account? S. Cohen & Associates has

repeatedly stated that airborne dust was unlikely to be the main contributor to ingestion dose, both in the first review in October, 2004 and in the last -- the latest document on October 14th, 2005. Worker interviews done by S. Cohen & Associates also state that workers were required to be at the rolling stand all day, even during lunch. Many workers ate their lunch in the rolling area because adjustments to rollers were constantly necessary.

I cannot stress how important it is to speak with former workers and site experts to come up with a proper ingestion model. The bottom line is, this latest document from S. Cohen & Associates clearly supports what Mr. Walker and other former workers have been saying from day one. If an accurate dose reconstruction model cannot be formulated from Bethlehem Steel information, then these workers should be awarded a Special Exposure Cohort, plain and simple. Using air sample data from Simonds Saw and Steel in place of Bethlehem Steel data is based on assumptions rather than on sound science.

On July 27th, 2005 Senator Clinton and I, along with our colleagues in the House of Representatives, introduced S. 1506, which would amend the Energy Employees Occupational Illness Compensation Program Act of 2000 to include certain former nuclear weapons program workers in a Special Exposure Cohort under the Energy Employees Occupational Illness Compensation Program. Our bill would correct years of injustice for western New York's nuclear workers. After the sacrifice these Cold War heroes made for our country, they have waited far too long. Being added to the cohort means that these former employees do not have to go through a dose reconstruction process. Instead, if a person has an eligible cancer and worked at a facility where weapons work was performed, their cancer is presumed to have been caused by workplace exposure and the person's claim is paid. This bill would finally put the former workers on the path to getting the recognition and compensation they deserve, and this is how we should correct this wrongdoing, not by endless bureaucratic red tape.

Again, I thank the Chairman and the Board members for allowing me to submit testimony on behalf of the former nuclear workers of New York.

Next I will read a letter from Representative Louise Slaughter. (Reading) Dear Members of the Advisory Board, as you consider the Bethlehem Steel site profile I respectfully request that before you finalize this important document you satisfactorily investigate the following concerns and consider designating Bethlehem Steel as a Special Exposure Cohort.

The site profile relies on data that we believe is flawed. Data used to measure the air quality was approximately 500 feet away from where the rolling of uranium actually took place, therefore it does not accurately reflect the air quality breathed by the workers rolling uranium; hence the air data samples are inaccurate measures for a dose reconstruction formula and must be recalculated.

Moreover, the data reflected in the site profile was not taken from Bethlehem Steel, but rather from the nearby Simonds Saw facility.

To compare a small, out-dated facility, Simonds

Saw, to the state-of-the-art Bethlehem facility, quote, a high-speed continuous rolling mill, unquote, is grossly negligent and unacceptable. At the time of the uranium rollings, Bethlehem Steel was the only site in the country with a continuous rolling mill. Therefore, no other facility can provide a fair comparison to Bethlehem Steel, nor should data from other facilities suffice to reflect the conditions at Bethlehem Steel.

I understand that recently air concentration data from Bethlehem Steel has become available, and I respectfully request that the National Institute for Occupational Safety and Health (NIOSH) review and utilize this information in the site profile.

Another failing in this process is that prior to drafting the Bethlehem Steel Corporation Technical Base (sic) Document, NIOSH had not interviewed any site experts from the company. Despite neglecting to gather the complete data and interviewing former workers and experts, NIOSH began denying claims nearly 16 months prior to the July 1st, 2004 site expert meeting in Hamburg, New York. Furthermore, at the

July, 2004 meeting NIOSH showed little interest or desire to pursue any of the information offered by former Bethlehem Steel workers. These workers could have been instrumental in recreating the conditions under which they worked. Thusly, the basic technical facts of the rolling procedure at Bethlehem Steel were not known by NIOSH prior to the Technical Base (sic) Document approval.

Therefore, I believe an accurate formula for dose reconstruction cannot be reflected in the site profile. With the inconsistencies and inaccuracies, despite four years of research, clearly NIOSH has not demonstrated that the dose reconstruction formula will accurately reflect the conditions at Bethlehem Steel.

Four governmental sites have already been designated as Special Exposure Cohorts. While none of these sites had to go through a dose reconstruction phase, many workers from these sites suffering from cancers identical to those manifesting in Bethlehem Steel workers are already being compensated for their illness.

Bethlehem Steel employees worked unprotected, unmonitored, for the duration of the uranium

rollings. They and their families have waited far too long to be compensated for their important service to their country. I urge you as Advisory Board members to recommend a Special Exposure Cohort for Bethlehem Steel and give them the compensation these dedicated workers rightly deserve without further delay. Thank you.

And finally, I have a statement from Representative Brian Higgins. (Reading) It has been brought to my attention that the Presidential Advisory Board will meet in Knoxville, Tennessee on October 17th and 18th. Among the topics to be discussed is the site profile dose reconstruction for the Bethlehem Steel site in Lackawanna, New York.

Many western New Yorker claimants are concerned that the data used to develop the Bethlehem dose reconstruction is flawed. I was told that the copies of the air sampling reports initially used were illegible, and that only within the past few weeks the original records were made available. This actual data for rollings completed in 1951 and 1952 are now exact but the actual dose reconstruction

remains largely incomplete.

Please remember that the Bethlehem site was enormous, three times the size of a football field, and it is essential that significant adjustments be made to accurately reflect the air quality in the breathing zone as opposed to the tested areas. My friend and constituent, Ed Walker, indicated to me that Sanford Cohen & Associates will be filing a report for your review that clearly makes the case that adjustments to the actual records have to be made to fairly establish the breathing zone. The inconsistencies and lack of accurate data in developing the Bethlehem site profile and dose reconstruction are the primary reasons my colleagues and I introduced legislation that provides Special Exposure Cohort status to this site.

Please understand that we will not rest until justice is received on behalf of the workers who served this nation without questioning any ill effects to their health. I'm unable to be in attendance next week, but I would appreciate having my concerns read into the record of the proceedings.

Thank you.

DR. ZIEMER: Thank you very much, Jason. Now before we get into our own deliberations on Bethlehem Steel, I want to give an opportunity for Mr. Walker also to address the assembly. Ed has -- as I indicated yesterday, Ed drove out here from New York to be with us for this session. He does have to return soon and will not be here for the public comment session this evening, so we're going to give -- without objection, give Mr. Walker an opportunity to make some remarks relating to that facility. Ed, welcome.

MR. WALKER: Thank you, Dr. Ziemer and the Board, and I really appreciate you letting me speak early because I'm going to shuffle off to Buffalo shortly and I get a good start with this nice weather that you're having down here. Again, I -- I appreciate and I -- I thoroughly understand the complex (unintelligible) of this program, and I really -- I was a builder all my life. I didn't experience anything like this. My life was simple. Build me a house or build me a garage, a dealership somewhere, and it was simple. I took the plans, I went and I built

it and listened to the complaints and went home -- with little money, by the way. But to get involved in all these issues that NIOSH and the Board -- for as long as it's been going on and not being able to come to a conclusion is -- to me, is mind-boggling. I don't know how any of you do it, going through the records. My wife hasn't seen her dining room table in two years, and I'm just worried about Bethlehem Steel. So I really appreciate what you're all doing. No matter how it turns out, I really respect everyone in this room for it.

Most of the issues you heard were -- by these Congressional people who I've obviously listened to them and listened to me -- they listened to me -- and -- and they feel that we do deserve a Special Exposure Cohort. And it's not by chance. It's not because I paid them off. It's because they listened to what I had to say and they believed that we were mistreated. And no matter how this scientific program goes and whether there was a (unintelligible) or whether I stuck my head over a salt bath and how much did I breathe in, or how much did every day -- what degree did we

lose this uranium in the air that it wouldn't affect me anymore, and to tell me I only received it the hours I worked there and if I was there during the week there was none there, to me is just unbelievable. I know they've tried hard and they've got all these things from somewhere else, but nobody came to Bethlehem Steel. Nobody knows. I have videotapes showing the conditions and I almost was going to call and ask if we could -- I could just show some of these film clips from the time that these people worked down at Bethlehem Steel, because you couldn't see 30 to 50 feet. And there's actually -- there's actually photographs of rollings where men were standing there in coats and goggles was all they had on and was heating stuff and the dust and everything was coming up that you couldn't see. I -- and maybe it'll have to come to that. Maybe I'll have to request that. I don't know where the next meeting is -- I hope it's in Buffalo -- but I would like you people to actually see it, to really understand that these air samples -- it just isn't -- it isn't right. I mean it's so obvious when you look at

it. When you can't see -- and this was quoted by one of our expert witnesses that worked there. He was a super at the plant. He scheduled everybody, the 60 men, where they were going to be. And he said you couldn't -- there's times -- and not only just in the steel rollings but in the uranium, which should be less -- I've heard that mentioned yesterday. How much less? Where's the line? Is there enough dust there or wasn't there enough dust there. Where's the line that you draw on what we've sucked in? Where -- where are the actual data that they say we went to the salt bath and if you were bending over and it's 130 degrees or 150, that you didn't take in big gulps of air? Where's the logic in it?

I hope this program doesn't turn out to be like the food pyramid. We all lived off information we got that the government said this was fact, this was gospel, live by this, eat by this and you'll live a long time. Where are these scientists today that were completely wrong? The food pyramid is no more. I didn't see any of them coming up saying I said it was good. This -- this is the type of stuff that upsets

me. After four years -- after four year-- it may be longer -- is there reasonable doubt at Bethlehem Steel? Is there -- if there's a document and I come down and I present it to you and it says this is what happened, this -- there are no records. There was -- there was stuff done there, but there are no records. So we arbitrarily take air samples or something and we allow you this because we know if we give you all these (unintelligible) where there are no records, you're still not going to get compensated. So why don't -- just like in the other facilities, (unintelligible) say lookit, there's not enough records. When I bring this up to certain people, they say well, that isn't really -- that really isn't representative that what was going on. That fella was really -- didn't know everything that was going on. That's the record I've got to live by. The government themselves in their own documentation says there was experimental work going on there before the rollings, and there's no -- no records and they say themselves they were destroyed. Where's the fairness in that program? I'm asking -- (unintelligible) I

don't expect an answer now because I haven't found one in four years so I don't expect you're going to come up with it. But I think it should be taken into consideration when you're dealing with this.

Here -- again, here we are, four years later, and I can't go back to my chair and -- and really say well, they've treated us fair -- all my issues aren't going to be resolved, but at least I think they've made a effort really to be fair about this to Bethlehem Steel. I don't know about (unintelligible). I don't know their layout and I wouldn't come up here and say a thing about it 'cause I don't know enough about it unless I studied it, unless I went there, talked to the men and really dug into it. And -- and in NIOSH's case, I don't feel that was done. And if that isn't done, then information can't be accurate. And I hope you consider this.

I believe it's -- it's really time to close this. I really think -- is -- has this whole program for four or five years been hinging on whether we find somebody in New York City that can come up and say I took those air samples

and here's what I done? Well, I furnished information and that's what I've done, but we're going to listen to him. We're not going to listen to you, Ed, because who are you? You didn't take an air sample. I worked there. I worked with these guys that came back from the second World War, that put their lives on the line and -- good friends of mine, and in good faith made all this possible, where we're living here in this country. This, to me, cannot be overlooked. These men -- kids, like your kids, your fathers, your children -- and it may happen to you again, went and put -- I was in the Army, and when I had to be put on alert that I didn't know if I was going to live next week or not, I -- it's a hell of a feeling. These poor kids went over -- some of them were lucky enough to come back. And I won't go into it, but you knew about the fella that was captured for two years and living in the jungle, come back -- I worked with him at the plant. He -- he was shell-shocked bad. He died. He left I think four kids. His diagnosis with the doctor -- the best they could say was that he died probable lung

cancer.
This report went down to NIOSH, probable lung cancer. We're giving you the benefit of the doubt, probable. Okay? She -- children get a letter back -- they lost their father. Their mother isn't alive anymore. They get a letter back saying that's not enough proof. I asked the girl, I says Cindy, what -- what did you do? Didn't you have an autopsy? She says no, my dad went through so much, he started out as an orphan, he went through that capturing, he come back, he was shell-shocked, he worked at the plant, he died a miserable death of cancer. And NIOSH says huh, not enough proof. You can't dig this man up. We can't dig it up and find all this Bethlehem Steel dust in him, but common sense would say benefit of the doubt, claimant favorable. That's what I've been hearing for four years and that certainly isn't claimant favorable. You wouldn't want it to happen to anybody in this room who'd want their child to go out tomorrow, have the government expose -- and not even -- let's not go through the war part of it. Let's just talk about doing your job or going to college, and you

come up in 20, 30 years and your child was exposed and lied to by our government and -- and dies and leaves a family, maybe young kids. In one case, 15 kids in the family, the mother had to raise them -- denied, because we think our information says your father -- he worked there all his life -- didn't have enough uranium dust. What a crying shame. And I know you people listening to this unders-- I would hope that you all understand where I'm coming from. And I know it's a hard job for you people to make a decision, but I really hope that you really consider and take what I say as gospel. I'm not up here -- I apologized to Mr. Elliott yesterday and I think he warranted it. I'm not -- what was -- has been done to us for the last 50 years has been lying, and more than once, right up to this day -- and I don't want to get into that -- and I wouldn't want to come up here and tell you something that didn't come straight from my heart. And I felt Larry Elliott deserved an apology because that's the kind of guy I am. And anyone in here I would support because I think you're all doing your job, you're listening and for that I'm very

appreciative.
So I won't take up too much -- I won't take up any more of your time. I know you've got a lot to go through, and at that I want to thank you for the opportunity to get up and talk and I hope you'll listen and take this into consideration when you make your decisions.
Thank you very much again, everybody.
DR. ZIEMER: Thank you very much, Ed. Now we're going to, in essence, review some materials from yesterday. Most of the folks here at the table were in the session yesterday so they've heard the presentations by our contractor. They heard the presentations by NIOSH. I want to give both SC&A and NIOSH an opportunity here at the front end of this discussion to make any additional comments that they may wish, or any overall summary comments. And John, you or your staff, do you have any additional words for us on Bethlehem that you want to make as we get underway here? And again, you've given us your formal presentation yesterday.
And incidentally, for Board members who weren't here in the subcommittee session, the

presentations by SC&A and by NIOSH are in your book, so...

DR. MAURO: There was one thought I had yesterday that I thought I'd want to pass on, and that is something that I didn't have a chance to say, is that we're talking about a -- a one size fits all, whether it's by year, but it's -- really we're going to apply this concentration of dust, the max, to all the claimants. And one of the things that I think I have to always continue to remind myself is that that means that -- it's not the average claimant we're trying to protect or -- we're trying to make sure that -- there's some people out there that might have had some unusual jobs for some periods of time, and we have to strike that balance where we pick that concentration that we think captures that high-end individual. So it's very easy to think in terms of averages. But no, we're not talking about averages. We're looking at catching that elusive, high-end number that we think fairly represents the high-end workers. Perhaps not every single worker under every single circumstance, and that's where the difficult

judgments come in, where do you pick that number that you think is -- is claimant-favorable, scientifically plausible and reasonable. So I just wanted to -- so in all -- all our thinking tries to capture that point, and that's a real tough number to find.

DR. ZIEMER: Thank you. And Jim, do you have any additional comments? Okay -- does not. One thing we heard from -- yesterday both from NIOSH and from SC&A was that beyond the differences in some assumptions and methodologies, the actual endpoints for both groups appear to be coming fairly close together. Did we understand that correctly? Are we -- are we fairly close or -- or not?

DR. NETON: I guess it depends on your definition of fairly close, but I think --

DR. ZIEMER: Well, both of you were --

DR. NETON: We've come a long way since our -- since the first review and now we're on Rev. 2. If anyone looks at the total picture, the difference is not that substantial. For 1949 and '50 I think we're in agreement for the exposure model. For 1951 and -- in 1952 I think we're fair-- we're very close; '51 we

have some disagreement with the use of GA versus BZ. I think SC&A's -- at a minimum I think their position is 550 MAC air or something like that, and we're substantially lower. But within a factor of two or so, so that's -- that's the main difference.

But these other issues with ingestion and resuspension are -- are important. I mean they're important to the individual claimants, but they are -- represent fairly minor tweaks on the individual doses themselves.

DR. ZIEMER: Now we also heard yesterday that you had learned that Mr. Breslin from the Health and Safety Lab had been involved in the design of the air sampling programs, both for Simonds Saw and Bethlehem Steel, and that the possibility of speaking to him and gathering additional information might be helpful. And I do want to add this comment. I don't think that the idea is that we would, for example, believe him above Mr. Walker, but it might be an additional piece of information that I thought both groups felt might be useful. Did I characterize that correctly? Is that --

DR. NETON: I think that's true. I mean we --

we have to look at a total picture, what the workers are telling us, what the people who actually took the measurement are telling us. We put that into a complete package and come to some type of a conclusion.

DR. ZIEMER: Okay. Mark?

MR. GRIFFON: Yeah, just to respond to your first question, I think that we are close, especially on many of the findings. I think Jim -- Jim pointed it out, too, that the -- the first finding with a question of the representativeness of the air sampling and the GA versus breathing zone sampling, I think that remains really -- really needs some resolution for Bethlehem Steel. I think several of the other findings, even though there were different approaches, which I think we -- we may want to explore further from a program standpoint, I think the -- the endpoints were similar for ingestion, for resuspension, for oro-nasal -- they were off by similar factors, actually a factor of two, but the dose consequence was much lower on those items. The first item, they're still around a factor of two or three apart, those -- the dose

consequence is much -- much higher, I believe, so I think we need to explore that one a little further. And -- and the other ones I think we're pretty close on, especially for Bethlehem Steel. I think they remain -- I think we as a -- for the program, need to -- to come to some resolution on those items because they're going to come up again and again. We've already seen that, so I think those remain important items for the program.

DR. ZIEMER: Items such as the oro-nasal breathing issue, which may have less consequence here but in another situation might be significant.

MR. GRIFFON: Right.

DR. ZIEMER: So that simply because one says that it has very little impact here does not necessarily carry over to other situations. Is that what you're saying? Yeah.

MR. GRIFFON: Yeah, yeah.

DR. ZIEMER: Now one of the -- I think one of the things we have to do here as a Board is to make a determination of just where we are on the Bethlehem Steel site profile. We can -- we can in fact instruct NIOSH and our contractor

to proceed and gather the information from the Health and Safety Lab person, or we can say well, we have enough information now to make a decision on this site profile and don't bother, or -- in other words, what -- what do we want to instruct our -- our contractor and what do we want to instruct NIOSH, or are -- are there issues that we want either or both to pursue -- and Ed, did you have a question on this also?

MR. WALKER: It's not really pertaining to what you're asking right now but it was just brought up about when you were drinking and what is -- what did -- our intake, what was our intake. I can honestly and truthfully stand here and say our mindset -- my mindset when I worked there and this -- chips flew down like -- like snow, chips of -- we didn't know what it was. It wasn't -- it wasn't harmful to our system. If it was steel, you could dip it out, you could take your spoon -- you could shake it off, however you wanted to take it out, but -- as far as your ingestion, and -- and not just one chip. I'm -- I'm talking -- we would take them out and you would drink it because the government had not told us and we had no

protection, we had no idea that this was uranium in -- in the air. How much (unintelligible) small stuff, I don't know, but I can tell you I seen chips in the air, very -- very large chips where we would take out (unintelligible) at the mindset that we don't know what it is, it's not going to hurt you. If it was steel, it's clean, it's steel, it was just (unintelligible) and we drank it. So I really question them on air samples and your data and really whether that should really come into play and I think should be a big part of it, and that's just the mindset of the people working there at that time. Not just me, but all the workers (unintelligible). Thank you.

DR. ZIEMER: Uh-huh.

DR. WADE: Maybe I could offer a -- oh, sorry, Henry?

DR. ZIEMER: Henry.

DR. ANDERSON: I was just going to say I think we ought to instruct NIOSH and our contractor to meet with the fellow and see whether that helps with additional information since they've identified him and, you know, if you're hopeful you say maybe this will resolve the

differences. But if the differences aren't resolved, I think we need to instruct the two to work further together and see, you know, how they can resolve their differences further. They seem to have made considerable progress, and the question is can more progress be made or do we need to just move forward on the --

DR. ZIEMER: Right, exactly, okay.

DR. ANDERSON: Yeah. I think we need to get that additional information. We need to -- hopefully that'll be there by our phone call so we can get an update on the phone call.

DR. ZIEMER: It's not clear to me whether you're expressing just an idea or making a motion.

DR. ANDERSON: Well, I would make a motion that that would be part of the instruction, unless somebody says we have all we need and we want to vote on it at this point. I'd like to hear what the fellow has to say.

DR. ZIEMER: Okay. Would you -- we're going to continue discussing for a moment. Would you craft that in some very concise words that we can use for a motion and we'll get some other comments. Dr. Wade, I think you had a comment.

DR. WADE: Yes, and my comments don't go to the issue that Henry just raised of contacting this fellow. I'd just like to remind the Board that there is this -- there will always be this tension between getting the last bit of information collected to resolve an issue and the fact that there's much work for this Board to do, and you have to decide how you want to spend your time. There's no question in my mind that good has come of the review of the Bethlehem site profile. I think we have a better document. I think we're in a better position to serve claimants based upon the work that's been done to this point. We feel we're very close and maybe we need to take that next step, but I would -- I would ask you to always keep in mind the fact that there's only so much resource in terms of the time of these good people to spend on this, and if we're doing Bethlehem we're not doing Hanford or the Nevada Test Site, and we have to keep that in mind. So I'd ask you to bring that tension and understanding of that tension to -- to your deliberations.

DR. ZIEMER: And the fact that it's always a

sort of elusive endpoint, the feeling that there's some additional bit of information out there which if we had would shed additional light on something, and at some point you have to stop and say we've done what we can do and we have to make a decision of some sort. Is the site profile as complete as it's going to be and that's it, and we will proceed from there. And it either will be adequate to do dose reconstruction or, if it is not, then we have some other options.

Other comments on this issue? Roy DeHart.

DR. DEHART: I think the Board -- I think -- I think the Board needs to make sure that --

DR. ZIEMER: I'm not sure your mike is on.

DR. WADE: No, it's not.

DR. DEHART: Thank you. I think we as a Board need to make it clear to the audience that we're dealing with the site profile. We are not dealing with a qualifying application for special cohort.

DR. ZIEMER: That's correct, there is not a special cohort petition before us to act on.

Wanda Munn.

MS. MUNN: There's another concern. The

feeling, and I think misinformation, has been expressed from several sources with respect to all individuals who were involved in this work suffering potential harm from it. And one of the things we as a Board are required to do is to help ascertain whether in fact there was harm, and that's easy to forget in light of the individual pain of the claimants. These types of outcomes are painful for people, whether they have been a part of a U.S. government program or whether they've never been on a site or had anything to do with these types of activities that we have to -- to try to define. And we spend a great deal of time talking about issues which may in all probability be very small in the overall context of the amount of dose that might have been received or the dose that might have been harmful. And it's necessary for us to try to parse the fact out of what transpired, and would be helpful, I believe, if we all were able to remember that we are going for a fact but not absolute precision. I don't believe there's anyone on the Board who believes that we can absolutely and precisely calculate the kinds of doses that

were involved in these early, early plants. But we can certainly put a bounding reference on how far that consideration must go, for example. If we're dealing with low enrichments of uranium, which we are in this case, and we are dealing with limited numbers of exposures, which we are in this case, then the total dose that is possible is also limited in cases like these. It's hard I think for claimants to understand that we're not trying to say we can -- we're not asking our agencies to say we can identify precisely what your dose is. What we're attempting to do is identify -- I believe, and correct me if I'm wrong. I believe we're attempting to identify what the worst case might be for an individual in that condition, and that's why we're asking both our contractor and the agency who works with us to do the kind of thorough investigation they're doing.

DR. ZIEMER: Thank you. And I think that -- and perhaps amplifies the remark made by John Mauro that it's trying to identify that -- not the average, but that sort of worst-case scenario.

Yes, Ed, did you have another question?

MR. WALKER: In response to your statement that we can't -- we -- we can find the exact -- if you don't have the information from '49 to '51 of what went on in that facility -- and we're guessing. We're mixing general air samples with breathing zone samples. I cannot believe, if you don't have the information, that you can do an accurate dose reconstruction. I just cannot rationalize how that can be done.

DR. ZIEMER: That's basically what was said, that you can't. That's what she was saying.

MR. WALKER: Maybe I misunderstood. But how can you accept something as a Board who hired the audit team to see if NIOSH was treating these claimants fair, and they went out and done a magnificent job of information. And -- and now you ask them to see if we were being treated fair and after all these years there's still no decision except there's -- there's no agreement, so obviously -- obviously you can't make a dose reconstruction after this length of time if -- if with all the power -- the brain power that we have has not been able to come to a conclusion, why should the Bethlehem Steel

claims pay for this -- or other claimants in the country, not just Bethlehem, when in return -- and I'll throw this out and I know it'll just maybe not go far -- but the government already has -- has given awards, compensation, to people with no information at all because they couldn't -- they couldn't have -- they didn't have information enough to do a dose reconstruction. And if the money is there, as it was brought out yesterday, and it can be replenished, what is the big fight not to pay Bethlehem Steel when you've paid four sites, you've -- I don't know how many more you've got on Special Exposure Cohort. We just heard down at Mallinckrodt and Iowa Ordnance, you're going to pay them because you don't have enough information. Why, with the information that's brought in front of you people that there's a black hole in this information, are we fighting Bethlehem Steel tooth and nail? The first group that had dose reconstruction, the first group that had supposedly a site profile -- which was questionable -- and the first group that had dose reconst-- we're fighting tooth and nail, spending thousands of dollars. I

don't see the rationale in this. I really don't. Just -- think of these things that I said and -- well, that's all I've got to say.

DR. ZIEMER: We understand your point, Ed.

MR. WALKER: Okay.

DR. ZIEMER: Thanks.

MR. WALKER: Thank you.

DR. ZIEMER: Yeah. Gen Roessler.

DR. ROESSLER: I just want to make sure I'm clear on the motion. We are --

DR. ZIEMER: Yeah, we don't have it yet.

DR. ROESSLER: Oh, okay, well -- if we have the motion that I think Henry made, we're deciding whether to recommend to NIOSH that they bring in Breslin to provide information on the air sampling. If we do this, does this actually delay then our vote on the site profile? And then the next follow-on question, if it does, then does that delay anything on the SEC petition? Are we in essence -- I guess to put it out bluntly -- taking this step and then it -- it does delay.

DR. ZIEMER: I'm not aware that we have an SEC petition.

DR. WADE: We don't have an SEC petition.

DR. ROESSLER: Okay.
DR. WADE: There is no SEC --
DR. ZIEMER: There is no SEC petition.
DR. ROESSLER: Okay.
DR. ZIEMER: Does it delay -- the issue of delay is one that we define ourselves. If you wish to have some final action today, that's the privilege of the Board. If you believe that you have enough information to instruct both NIOSH and the contractor to take what they have and that's it, that's one option the Board has. If you believe that this additional information will be helpful to both NIOSH and the contractor in coming to closure, that's another option.
Yeah, Rich.
MR. ESPINOSA: Yeah --
DR. ZIEMER: Is your mike on?
MR. ESPINOSA: This is probably a question for Larry. We just heard that there's no SEC petition before the Board. Right? But has there been one filed for Bethlehem?
MR. ELLIOTT: No, there's not been a petition submitted for Bethlehem Steel.
DR. WADE: If I might --

DR. ZIEMER: Thank you.

DR. WADE: -- just to -- to pick up on Gen's point as to what's at stake, you know, dose reconstructions are being done. If the Board delays its decision to talk to Mr. Breslin and then makes a recommendation further on downstream that is then -- causes NIOSH to react, NIOSH would always then reconsider dose reconstructions in light of that information. So I think really what's at stake here is just the resource of the Board and the resource of those serving the Board in terms of putting their energy to this or to something else, and the desire of the Board to be complete. And I think that's the tension. But there's not an SEC petition. There is nothing there, if the Board does it subsequent to this next meeting, that won't have the same impact.

DR. ZIEMER: Mark.

MR. GRIFFON: (Unintelligible)

DR. ZIEMER: Go ahead, Larry -- Larry Elliott.

MR. ELLIOTT: Just for the Board's information, I want to add this for your consideration. I believe the -- the number's right now about 94 percent of the claims for Bethlehem Steel have

gone through dose reconstruction. A little greater than 45 percent of those claims have been found to be compensable. As Dr. Neton has presented to the Board before, we see a bi-modal distribution of the POCs, the probability of causation for those claims. There's a -- there's a blip on the right-hand side of that spectrum close to the 50 percent mark or above it, very few claims perhaps will be affected by any change at this point, whether it's ingestion, inhalation or a -- coming up with a higher maximum point estimate to calculate by. And then the blip that's on the left-hand side of the spectrum, those aren't going to be affected at all by any change, we believe. Typically in an SEC class experience, we see a 60/40 split. The 22 cancers yield 60 percent of cases being compensable, 40 percent not being compensable. So just add that for your deliberation.

DR. ZIEMER: Yeah, I think there often is a common belief there -- out there, just in general, that an SEC means that everybody that gets cancer gets compensated, and that's not the case.

MR. ELLIOTT: I think -- my point is is that we haven't stopped processing cases. Anything you do at this point in time to revise the site profile, typically and traditionally our practice has been to go back and look at all the cases conducted and dose reconstructed under a prior document, evaluating those cases, determining if any change has been made. And if so, we'd make that change and pass it on to the Department of Labor.

DR. ZIEMER: Okay. Okay. Yes, Mark.

MR. GRIFFON: Notwithstanding what Larry said, I still think that that one item -- and what I would say is -- is let's -- let's -- Henry has a motion, but let's carry it through the interview process and try to come to some resolution on that issue.

For the other findings, I would offer maybe to take -- take these back to the workgroup and have -- have us develop a Board action for those and -- and what I'm thinking -- as we're talking here out loud, I'm thinking that many of those actions are going to be, you know, acceptable for Bethlehem Steel site profile, program-wide policy should be developed by

NIOSH and reviewed by SC&A, something like that, but I would offer that we could -- we could do that and not have them -- not have SC&A or NIOSH spend much more time on --

DR. ZIEMER: On the other --

MR. GRIFFON: -- on those other items. I think we've -- we're -- we're fairly close on those items. I think this one outstanding one is a big enough difference that I think we need to sort of hash it out a little further, and the interview might help that process.

DR. ZIEMER: Wanda, you have a comment?

MS. MUNN: Just to agree and to re-emphasize what Mark has to say with respect to the really -- need that we should see as acute to help both our contractor and NIOSH come to some agreement about process in future claims. We're not going to be able to expedite any of these things unless we agree that the appropriate process for approaching this type of issue is generally agreed upon.

DR. WADE: Just for the record, I -- I mean I find Henry's pending motion to be quite reasonable. I don't want you to misinterpret my comments in any way.

DR. ZIEMER: You haven't heard that motion. It sounded reasonable when he talked about it.

DR. ANDERSON: Let me put it (unintelligible) move on. I think it's pretty -- NIOSH and SC&A should continue to review the representativeness of air sampling data for use in dose reconstruction at Bethlehem Steel, specifically clarifying the issue of general air versus breathing zone samples. In part, this should include interviewing Mr. Breslin.

DR. ZIEMER: Is there a second?

MR. ESPINOSA: Second.

DR. ZIEMER: Okay. Discussion? So it -- the intent of the motion -- and I assume we don't have to go through the Secretary of HHS for this. This would be some guidance for our contractor and hopefully for NIOSH to proceed on that issue and --

DR. WADE: Right, you don't need to go to the Secretary with this motion.

DR. ZIEMER: And Larry, a comment?

MR. ELLIOTT: I would like to suggest that Mr. Walker be included in any conversation that incurs.

DR. ZIEMER: I think the intent there would be

-- in fact, we talked a little about it yesterday -- that the interview with Mr. Breslin would include someone from NIOSH, our contractor, Mr. Walker and the Board.

MR. GRIFFON: Without -- without maybe overwhelming him with a large --

DR. ZIEMER: No, no, but --

DR. NETON: I think that's a great recommendation, but we do have to favor Mr. Breslin's wishes and we're not sure how overwhelmed he would like to be by an interrogating style of committee. At least it would be his discretion, so --

DR. ANDERSON: No kleig lights.

DR. NETON: No kleig light.

DR. ZIEMER: No, we do want the opportunity for those four groups somehow to be represented, if possible.

DR. NETON: If possible.

DR. ZIEMER: Otherwise, I think for the Board -- and we can ask Ed -- we could stipulate that a record be kept and the information be provided.

DR. NETON: Yeah, I'm --

DR. ZIEMER: Where would the interview with Mr.

Breslin occur?

DR. NETON: I don't know. I sort of liked John Mauro's suggestion yesterday. He lives close. I suspect he's within an hour's drive of Mr. Breslin's home. I thought that we would do at least an initial interview at his home, if he was agreeable to that, to get him -- I get the impression his health is not tremendous at this point. So if we could do it in the convenience of his house, maybe with SC&A represented, that -- that's kind of what I had in mind at this point, but we're open to other --

DR. ZIEMER: I think the Board would be agreeable that we not necessarily have someone there as long as a record is kept and SC&A will be our representative. Ed, I don't know whether you want to be there or not, but we'd certainly let you know -- and it'll be up to Mr. Breslin also as to whether or not he can handle a large crowd, but we'll keep you informed and then work it out.

MR. WALKER: I was just going to mention Buffalo's half-way if there's any consideration --

DR. ZIEMER: Well, I think Mr. Breslin's health

is going to be the deciding factor, but -- or he might hop at the opportunity to go to Buffalo. I understand that.

UNIDENTIFIED: (Off microphone) In the winter, yes.

DR. ZIEMER: In the winter. Okay, Wanda, comment on the motion?

MS. MUNN: Just commenting on the potential for the interview. Perhaps he would not be averse to the idea of having a conference call spider in -- during the interview so that (unintelligible) --

DR. ZIEMER: Or just recording the interview? How about recording it?

MS. MUNN: That -- that would certainly be helpful. I know -- I suspect the working group would be more than a little bit interested in the results of that.

DR. ZIEMER: Well, we'll leave that somewhat open. The intent is to -- to carry it out with whatever is most suitable for Mr. Breslin. Further comments on the motion?

(No responses)

Are you ready to vote? After this motion we'll entertain a second motion, Mark, along the

lines of what you just said. Are you ready to think about that?

Okay. All in favor of this motion, aye?

(Affirmative responses)

Those opposed, no?

(No responses)

And any abstentions?

(No responses)

Okay. Now with respect to the other issues at Bethlehem, your suggestion is --

MR. GRIFFON: I mean I guess I -- I'm not prepared to give a Board action for each item, but I was --

DR. ZIEMER: No, no --

MR. GRIFFON: -- rather going to say that -- that --

DR. ZIEMER: -- how to proceed.

MR. GRIFFON: Right, I make a motion that a workgroup be assigned to -- to develop Board action on the remaining findings -- I guess that's three through six -- in the SC&A report.

DR. ZIEMER: And this would only require the working group's action to put together recommended formal --

MR. GRIFFON: Or any working group. I don't

know how we're doing this.

DR. ZIEMER: A working group, yes, right. And we'll assign such a working group if the motion carries.

MR. PRESLEY: Second the motion.

DR. ZIEMER: The motion is seconded. Any discussion? This would serve to bring closure to the other issues at Bethlehem Steel in terms of what the Board's position is on each of the findings. Wanda.

MS. MUNN: And I assume would occur following the conversation with Mr. Breslin that we just discussed.

DR. ZIEMER: I'm reading into this an intent would be to be able to, say at our next meeting, have closure on all the issues on Bethlehem Steel, one way or the other.

MR. PRESLEY: (Unintelligible) at our telephone conference that we have set up.

DR. ZIEMER: Or at our telephone conference call which is scheduled for December if it's completed by then.

MR. GRIFFON: Yes, yes.

DR. WADE: I do think we're going to put some things in the bin for a working group over this

next day and a half, so I think there will be a need for a working group and this will be one of the items.

DR. ZIEMER: We will wait till later tomorrow to appoint the group.

Okay, all in favor of that motion, say aye?

(Affirmative responses)

Any opposed?

(No responses)

Any abstentions?

(No responses)

Thank you. The motion carries, and we will proceed.

Thank you very much.

REPORT FROM SUBCOMMITTEE:

SRS SITE PROFILE

Next we have on our agenda the Savannah River site profile. Again, for the benefit of those who were not with us yesterday, you should have two documents in your folder. One is the presentation by our contractor. The other is a presentation by NIOSH. In the case of Savannah River, this is -- basically we're at the first -- at the front end of what we've come to call the six-step process. NIOSH has made some initial responses to the SC&A findings. SC&A

had seven findings and seven observations, and we're basically at the early end -- early stage of this so-called six-step process. I think there is an underlying assumption by the Board that we should proceed with the resolution process that has been developed in previous cases, and perhaps we need to confirm that expectation with some sort of formal action. But before we do that, let me ask again -- SC&A and also NIOSH -- if they have any additional comments pertaining to the Savannah River site profile.

None by SC&A, any by NIOSH? None by NIOSH. Okay. Mark?

MR. GRIFFON: I guess I -- my comment is -- I think it pertains to the next three items we're going to discuss, really, but my -- my concern I guess in our six-step process is that where, you know, we've got SC&A's report reviewing Savannah River, but it was a fairly old draft. I can't remember the dates on it. And I -- I guess my fear -- I think I said this yesterday -- is that in -- at the end of the day, are we going to be spinning our wheels to some extent reviewing some issues that are in the site

profile but not necessarily related to how they're finally doing dose reconstructions. I think -- I think there certainly is some basis in the site profile for how dose reconstructions are done, but -- I mean let's -- let's turn the clock back a little bit to our review of Mallinckrodt and I -- I reflect on this that it seems to me by the last meetings for Mallinckrodt I wasn't doing much referencing to the site profile anymore. In fact, it seemed that the entire method laid out was not in -- or I shouldn't say the entire method, but a lot of it was no longer in the site profile. So I think -- and I was looking at some of this last night. There's several new Technical Information Bulletins associated -- at least with Y-12; I'm not sure about Savannah River. I don't think some of them were -- some of them may have been reviewed by SC&A, some may not have. There's certainly some workbooks and -- that -- that my understanding is SCA has not looked at those. So I'm not sure if -- if we want to sort of insert those in our six-step process. Before we go too far and try to come to some

conclusions on a site profile, should we not look at these key elements that are part of that -- of the dose reconstruction process.

DR. ZIEMER: Well, maybe we should raise the question in a more formal way as far as we -- we don't want to be reviewing and trying to resolve things that are either out of date or no longer used. I believe the review was of Rev. 2 of Savannah River. Is that correct? And how up-to-date or out of date is Rev. 2? Or another way of saying this is are the findings -- are the issues raised in the findings still pertinent in the sense that they -- for example, you had the -- well, the characterization of the radiological conditions at the F and H area tank farms. Is that still an important issue, regardless of what Rev. we're in?

DR. NETON: Yes, Jim -- Jim Neton from NIOSH. Some of the issues are still relevant, some of them have been addressed in Technical Information Bulletins or reports. For example, I mentioned yesterday Savannah River, there is a Technical Information Bulletin being written -- drafted to address -- handle thorium

reconstructions at Savannah River, so that -- that would tend to address that finding. So it's a -- it's a little bit of a mixture. I mean I think -- I think the key issue that I'd like to focus on is that -- is there anything that is just technically wrong in the site profile. I mean are -- you know, there have been some issues raised in a site profile about using different solubility classes and that sort of thing, and those are key technical issues that if -- if SC&A believes that we're technically wrong, we need to address those. Where there are identified data gaps and things of that nature, then is that really relevant to us -- preventing us from doing dose reconstructions, because are they indeed captured in these workbooks and other Technical Information Bulletins. So you know, I think we need to maybe sit down and strategize where there are technical issues that are wrong versus where there are perceived data gaps in the profile and -- and work from that perspective.

MS. MUNN: Yeah.

DR. ZIEMER: Process-wise, does this involve a

face-to-face session? Is that what you're suggesting?

DR. NETON: I guess that's what I'm suggesting is we need to sit down and come to some agreement as to -- really much like the procedure reviews going, as Stu Hinnefeld spoke yesterday, which issues are really key and which issues are yeah, that's a very nice comment; we agree that we should address these incidents at some point, but in reality we believe the workbook is sufficiently bounding in the way we do these things so that it's not at this point worth our while to go and research 500 volumes, or something of that nature, of incidents to continue on with the dose reconstruction process.

DR. ZIEMER: So this could lead to a kind of matrix of the type that we've had on some of the others where we identify those kinds of issues and -- and their impact and whether they need to be pursued or not. Comment?

MR. GRIFFON: I -- I guess partially what -- what I was raising was what I talked about yesterday, was the notion of not looking at this in a vacuum, maybe to have a couple of

these examples that -- I think that really helped shed some light on things when we looked at Mallinckrodt is okay, you've got all this information in the site profile; how exactly are you going to apply that for an individual dose reconstruction? Give us an example when -- where it's used for best-estimate or worst-ca-- you know, or overestimate techniques.

DR. ZIEMER: And I don't recall -- I wonder, SC&A -- either Hans or Kathy, do you recall what you already looked at in terms of Savannah River --

MR. GRIFFON: (Off microphone) (Unintelligible) cases --

DR. ZIEMER: -- cases?

MR. GRIFFON: -- they've been all...

DR. ZIEMER: Were they all worst case -- yeah, there's Hans. Do we -- do we need some other representative cases of some sort to -- for -- for you or would that be helpful?

DR. BEHLING: I think to date we have had nothing but maximized cases or those that are minimal cases, so right now we have not had best estimates in the -- in the classical sense of best estimates, and that includes -- we've

had plenty of Savannah River Site audits at this point, but none have been anything other than either min or max.

DR. ZIEMER: Right.

MR. GRIFFON: Right.

DR. ZIEMER: Mark, you're suggesting that there -- that (unintelligible) --

MR. GRIFFON: Well, that -- that's the only reason I -- I mean the rea-- and part of the reason I raise it is, as Jim presented this yesterday, it gives -- it does have some deja vu aspects. I mean there's a lot of thorium air sampling, but how exactly do you apply that, what areas -- how do you know where people worked, how do you know by job title -- until -- and I think when you see how that's carried through, maybe in a best-estimate example, that's -- that helps to clarify it instead of just raising a bunch of issues on a -- on a document without seeing how it's carried through in practice.

MS. MUNN: Yeah, yeah, and --

DR. ZIEMER: Wanda.

MS. MUNN: Especially if they are now being addressed by workbook issues. I mean that --

my major concern, as a member of the working group, is if these -- if NIOSH is already addressing these through TIBs and workbooks that have not yet been reviewed by SC&A, then having this long list of issues with respect to the site profiles is counter-productive if the workbooks have already addressed it.

DR. ZIEMER: Let me ask this question, and either Jim or John, you can help my recall. Didn't -- didn't we, at one of the previous workgroup meetings, actually as part of the exercise, work through some sample cases with SC&A to show how some things were being done?

MS. MUNN: Yeah, we did four.

DR. ZIEMER: In Cincinnati. These were cases outside the audit, just -- it may be de-identified cases to show how you were carrying things out. Is this something that could be done in connection with the Savannah River issues, or -- or does it need to be done in connection with identifying those issues? That's sort of what I'm asking.

DR. NETON: Right. My recollection was that early on we did a briefing of SC&A on sort of the efficiency process, how we went about

bracketing claims that were well below 50 percent and well above 50 percent, and that sort of gave them a flavor for how we're doing these. And in fact, most of the Savannah River cases I think have been done that way. But it would be I think instructive for us to go through and -- and do another briefing maybe on these Savannah River cases that, if we can identify them, that have been done using a more detailed, you know, dose reconstruction process. That -- that might be useful.

DR. ZIEMER: I'm really asking whether we can do this outside the audit process where -- where they're not trying to identify, for example, whether the process was done correctly, but simply learning how you're doing it with some real samples, maybe de-identified sample cases, that may not even be closed cases yet -- as long as they're de-identified. Didn't -- didn't we do something like that before?

MS. MUNN: We did.

DR. NETON: I think we did. What I was thinking, though, was that they could -- you know, they -- they have raised a number of

findings that are related to completeness of the profile, and I think it was very useful to that degree, that SC&A has gone out and identified all of these issues that could affect the outcome of a dose reconstruction.

DR. ZIEMER: And for those you don't need this -- what we're talking about.

DR. NETON: Well, no, I think -- what I'm suggesting then is that they would look at a dose reconstruction that's been done now and say okay, yeah, we -- you know, NIOSH acknowledges that these things are missing and they're very useful pieces of information to be knowledgeable about, but have they been addressed in a -- in a claimant-favorable manner in the dose reconstruction --

DR. ZIEMER: Already.

DR. NETON: -- so that it really, at the end of the day, makes very little difference in how the case was dispositioned. I think we need -- we need to start getting there because, again, the profile will never cover every single nuance that happened at the site.

DR. ZIEMER: Yeah.

DR. NETON: It's just not possible.

DR. ZIEMER: And John, you have a comment?
DR. MAURO: When you were making reference to where we actually let the rubber hit the road, let's do some cases, that really was toward Mallinckrodt and that was essential. We went through some real cases.
DR. ZIEMER: Some Mallinckrodt cases.
DR. MAURO: Right. Now I think we're in a situation -- I mean it's very clear to me that the workbooks are where the rubber meets the road. That is, in a funny sort of way, we're only maybe three-quarters of the way home. We reviewed the site profiles. We reviewed as many of the TIBs that go with the site profiles. We reviewed -- these are the ones you've looked at already, the nine we've looked at and the six that we're about to look at. And a recurring theme is that, you know, very often we're not really sure what you're saying here or it appears to contradict here, and you didn't address this issue -- like the thorium issue -- so that -- yes, all of the -- you could almost start to sort out the big picture and -- of categories of things that we really can't get our arms around. And I think a large

portion of that is going to be cleared up when we engage the workbooks. And the first workbook that's before us right now, that we've put on the first burner -- on the front burner has been -- is Rocky Flats, and there's a similar workbook -- now there may be more. The one that we identified was on the O drive. If there's more than that that are forthcoming, it's important -- but I guess what I'm getting at is that there's no escaping it, we're not going to achieve closure until we get these workbooks behind us. Working simply with the paper TIBs and site profiles won't -- I think it gets us maybe three-quarters of the way there, but it's not going to get closure. How many of the issues that we've already identified in Savannah River have effectively been resolved in the workbook? Jim is probably in a great position to right now say he thinks that well, the thorium is about to be resolved and -- but this one won't be -- hasn't been resolved. And I think -- so until we do that, I hate to say this, but the workbook is part and parcel to the site profile and they have to be done.

DR. WADE: If I could add to the complexity, but maybe also to the solution, there are a couple of things that -- that I'd remind you of. As we look at next year for Task IV, the individual dose reconstruction reviews, John made a very strong plea to the group to focus that on best-estimate dose reconstructions. And he's going to present a proposal to you this afternoon where there'll be an attempt to focus on best-estimate dose reconstructions. Also in SC&A's extension of Task III, which is the procedures review, we've identified the fact that we need to now start to focus on workbooks. So I think there are a number of things that will unfold next year that will start to get to the issue that John brought to us, and that is there is very little benefit in simply reviewing minimizing and maximizing situations. So I think holistically we need to start to look at these things, but I think the -- the mechanisms are in place to start to make this a much more relevant, although a slightly redesigned, concept of review.

DR. MAURO: And I agree with that. And it puts us all in a difficult spot. We'd like to

achieve closure on many of the reviews that we've performed on the pa-- the one -- the nine that we've already completed or -- and the two we're about to complete this month, but I have a funny -- for many of those, getting closure is going to be a little bit off-balance until we get through the workbooks.

DR. ZIEMER: Okay.

DR. WADE: But Jim did sort of lay out a solution, which is there are certain issues you raised in the review of the first nine that are now still germane to NIOSH's consideration. We need to define what they are and reach closure on those. There are other mechanisms in place for dealing with some of these other things.

DR. ZIEMER: Okay, any other comments? Does anyone wish to make a formal motion relating to Savannah River?

MS. MUNN: Go ahead, Mark.

DR. ZIEMER: We're all looking at Mark.

MR. GRIFFON: I think you made it already, that we start --

DR. ZIEMER: You had the idea --

MR. GRIFFON: -- the six-step process --

DR. ZIEMER: -- in mind.

MR. GRIFFON: -- right.
DR. ZIEMER: Well, the general approach would be to ask NIOSH and our contractor to take the next step, along the lines that Jim described, and I think that's -- that's fairly -- we know how to do that. I think my question is how do we work into that process the issue relating to workbooks and so on, or do you want to have any formal instruction at this point or will that arise naturally as you discuss issues and identify that as a next step? That --
MR. GRIFFON: I think that's --
DR. ZIEMER: I think Jim is saying that will arise naturally.
MR. GRIFFON: I think once we have our first face-to-face with the workgroup and --
DR. ZIEMER: Then they can define those --
MR. GRIFFON: -- start looking at papers and handing them around -- I mean I -- just in reviewing this, I noticed the list of TIBs, and I don't know how many of them have been looked at by SC&A and stuff, so we can bring that up at the workgroup level, sort of go through that, see which TIBs, which workbooks are appropriate to -- to look further into. And if

we need sample cases, I think all that can be sort of fleshed out at the workgroup level.

DR. ZIEMER: Henry?

DR. ANDERSON: Yeah, it seems to me that NIOSH hasn't had a lot of time -- or hasn't been able to devote the time to -- to look over the SC&A in detail and I think what we need to sort out from that -- if they can look through some of those comments and say we believe this was addressed in this workbook or this TIB, that would help point us in the direction of where we may want to look there. And other issues, I think it's just helpful to say interesting -- you know, useful piece of information, but you know, we move on from there. So I think the face-to-face and NIOSH looking through and sorting these of -- these they have -- just as we've heard, this is important, it's still important. Then we need to focus on those and we can leave some of these others -- it's in the report, it's been mentioned, but really this is just done to inform the Board, as well as NIOSH, as to an outside audit of these. We don't necessarily have to resolve each and every issue, I don't think.

DR. WADE: I think the matrix approach has served this group --

DR. ANDERSON: Yeah.

DR. WADE: -- very well.

DR. ANDERSON: I think so, yeah.

DR. ZIEMER: Okay. Was -- was that a motion, Henry?

DR. ANDERSON: No, I -- I think we just proceed. I mean --

DR. ZIEMER: Well, I want to get it on the record that -- that this is the consensus of the Board that -- and therefore to do it by vote. I will interpret it as a motion that -- that we instruct -- or we request that NIOSH and our contractor proceed along the lines described in your preamble --

DR. ANDERSON: Soliloquy, right?

DR. ZIEMER: -- soliloquy, which in fact is to have a face-to-face meeting and take the initial steps toward identifying issues, resolving issues where possible, and bringing back to us a recommendation on proceeding with issues that need further clarification. Now that -- my wording of your motion --

DR. ANDERSON: I accept your --

DR. ZIEMER: -- is probably about as vague as the original motion, but I think the intent is clear.

DR. ANDERSON: I accept your...

DR. ZIEMER: Is there a second?

DR. DEHART: Second.

DR. ZIEMER: Comment, Lew?

DR. WADE: No.

DR. ZIEMER: Okay. So the motion, if it passes, will ask -- will basically ask the two groups to proceed. We may very well have a workgroup involved with them to -- we want to have a Board presence there when those face-to-face things occur.

All in favor, aye?

(Affirmative responses)

Those opposed, no?

(No responses)

And any abstentions?

(No responses)

It is so ordered. John, did you have an additional comment? You're still wondering what the motion was or are you --

DR. MAURO: No, I understand the motion well, I -- I have a request --

DR. ZIEMER: Maybe you can explain it to us then.

DR. MAURO: -- a request. We've been looking of course at the list of -- of workbooks, and there's one for Rocky Flats, there are three for Savannah River, there are several for Y-12. So you know, there's -- that we know of. We are -- so they're all before us. You know, they're -- that we -- and it sounds -- my understanding is -- we're probably going to have to start thinking in terms of priorities. My understanding right now is Y-12 and Rocky Flats are probably on the front burner, so if we're going to -- as opposed to Savannah River.

DR. ZIEMER: Right, and we will be driven in part by the SECs that Lew mentioned before, and we have not put a timetable on this last motion. I think the priorities, as far as site profile work, are going to certainly be dictated in part by completion of some things before we have SEC petition reviews. So --

DR. WADE: I think you have the priorities right from my point of view.

DR. ZIEMER: Yeah.

DR. MAURO: Okay. So a little -- a little

guidance along those lines --

DR. ZIEMER: Right.

DR. MAURO: -- as we (unintelligible) through the process --

DR. ZIEMER: Right.

DR. MAURO: -- would be helpful.

DR. ZIEMER: Thank you.

DR. WADE: Something else, very procedurally. I'm going to ask LaShawn to get out some calendars for you to mark availabilities between now and the spring of next year. I think there's going to be lots of work to do and we need to start to really put our shoulder to it. So you'll see calendars and I'd ask you to mark -- you know, follow the instructions LaShawn gives you as to how to fill them out.

DR. ZIEMER: Thank you. We're going to take a 15-minute break now. Actually it shows up as a 30-minute break, but most of our 15-minute breaks take 30 minutes, so however it works out, we will recess.

(Whereupon, a recess was taken from 10:15 a.m. to 10:45 a.m.)

DR. ZIEMER: We're ready to reassemble. Board members, if you'd take your seats, I guess the

most are back already, Lew Wade has a couple of comments here at the beginning of this session.

DR. WADE: As you mark out your calendars, it would be a great relief for me if we could consider -- we had talked about a conference call in the first of December, and I asked you to hold that. If we could change that, at least in our preliminary discussions, to the 29th of November, that would be very useful for me. So if I could ask you to consider that. Probably about a four-hour --

DR. ZIEMER: This would be Tuesday, November 29th rather than Thursday, December 1st as a possible conference call date, but you need -- just -- do you want to know now, Lew, or --

DR. WADE: Is there anybody who's --

DR. ZIEMER: Has a conflict.

DR. WADE: -- with that?

MR. ESPINOSA: What about the times?

DR. WADE: Well, it's -- well, we have two. What about the --

DR. ANDERSON: How long a call, is the question?

DR. WADE: I would assume four hours.

DR. ZIEMER: Maximum four hours.

DR. WADE: How about the Monday of that week?
DR. ANDERSON: The 28th?
DR. WADE: The 28th. That's --
DR. ZIEMER: You're following Thanksgiving weekend, I believe.
DR. WADE: The 28th?
DR. ANDERSON: The 28th's all right.
DR. WADE: Okay, if I could ask you in your mind, when we talk about that early meeting, let's talk about a meeting on the 28th -- we haven't committed to that yet, but I have a sense we're probably going to want to get together for some hours as a Board. I would ask you to talk about the 28th. Larry?
MR. ELLIOTT: November?
DR. WADE: November. Okay, thank you. That's a personal favor I asked.
DR. ZIEMER: Okay, and then --
MR. PRESLEY: That's about 8:00 o'clock in the morning --
DR. WADE: I would est--
MR. PRESLEY: -- Eastern Standard Time?
MS. MUNN: Don't you dare.
DR. WADE: Well, no, no.
MS. MUNN: Don't you dare.

DR. WADE: It would be about -- a fashionably -- maybe 11:00 in the morning, Eastern.

DR. ZIEMER: Board members, if you would mark your calendars, we'll have -- we'll collect them later today. Mark your -- the times when you're not available over the months ahead.

REPORT FROM SUBCOMMITTEE:

Y-12 SITE PROFILE

The next item for discussion is the Y-12 Plant. We had a presentation yesterday by Joe Fitzgerald on the review of the site profile for Y-12, and then comments by NIOSH and Jim Neton relating to the findings of SC&A. Those materials are in your notebook. There's a fair amount of detail in the SC&A report -- or in the -- in Joe Fitzgerald's slides detailing the five main findings, and then identifying the five additional findings. And then responses -- initial responses by NIOSH to those various findings. Again, I want to ask John Mauro or Joe -- is Joe still here? Do you have any additional comments this morning on your report to us yesterday, or on -- on Y-12, any additional overall comments or statements you want to enter in the record right now?

MR. FITZGERALD: No, except to affirm the value

of now go-- moving forward and actually looking at the data and exchanging information in a more formal sense. I think we've certainly heard from NIOSH, and particularly Jim, in terms of what his thoughts are. I think that's the process we're in now.

DR. ZIEMER: Thank you. And Jim, any additional comments? Okay.

Board members, comments or discussion on the Y-12 materials or recommendations for proceeding? And I want to give Le -- Leon and Rich opportunities, if you have any questions relating to those materials that you have or things that were discussed yesterday. Do you want anything elaborated on relative to Y-12 that you see in your packet? I'll give you that opportunity. No?

Leon?

MR. OWENS: Dr. Ziemer, would it be possible for just a overview? I mean I don't want to --

DR. ZIEMER: Yes.

MR. OWENS: -- take time away, but that would be beneficial to me.

DR. ZIEMER: Okay, we can certainly do that. And if -- if you would first take the SC&A

materials, review of NIOSH site profile for the Y-12 complex, it may -- in your booklet under Y-12, it may be the second set of materials. And Joe, if you wouldn't mind returning to the mike and -- kind of puts you on the spot, but let me -- there were five main issues that were raised, and maybe we could, one at a time, identify those and if you'd just make a couple of brief comments, Joe, on each one. The first one, the site profile does not clearly address support workers who were not routinely badged, and maybe identify for Leon and Rich who those workers were and any related issues that might be salient points here.

MR. FITZGERALD: Okay. On finding one we did spend a great deal of time talking to workers at Y-12, interviewed 40 to 50 of them, and about half that number were maintenance staff, support workers for the site, and this finding really stemmed from that, as well as some other documentation. We didn't think the site profile really got into the issue of support workers as opposed to process workers. In this case we felt there were a group -- a subset -- of these maintenance workers, ones not assigned

to specific facilities, which -- for which there were not monitoring records, they weren't bioassayed before '94 in any great sense, and of course the external badging didn't -- wasn't complete until '61, so we're raising a question of -- of unmonitored workers, which we determined from the interviews and other information were probably exposed not quite to the level of process workers but certainly substantial enough that you'd want to address that as a group and ascertain whether or not they -- what -- what kind of approach you would take to assign doses to them. So this is certainly identifying a population at the site that we think should be addressed by the site profile in a more significant way.

DR. ZIEMER: And while we're on that particular one, and perhaps this could be clarified, we -- I think we heard yesterday that it appears, I think NIOSH asserted that there was a kind of process or procedure at Y-12 whereby a determination was made as to the probability of different groups receiving ten percent or greater of the -- of the existing limits, and if it was determined that it was unlikely that

the exposures would be -- and I believe it was ten percent, you can correct me if I'm wrong -- would exceed that, they were likely not monitored. It wasn't clear to me if that applied to these -- this category of individuals or just to the regular workers. Do we know --

MR. FITZGERALD: Yeah, certainly --

DR. ZIEMER: -- either Jim or --

MR. FITZGERALD: Oh, certainly --

DR. ZIEMER: -- or Joe?

MR. FITZGERALD: -- it applied to the regular workers, and I think --

DR. ZIEMER: Do we know if it -- was it us-- was that process used on these people? Do we know that?

MR. FITZGERALD: Well, that was the question that we kind of raised with the workforce themselves directly, as well as the health physics staff. And it appeared that in the earlier years the support workers who weren't assigned to process operations, weren't in the operational staff, were not monitored before those time frames. And --

DR. ZIEMER: Was that based on just an

assumption that they didn't need to be, or was there -- do we know if there was a formal determination made that there was --

MR. FITZGERALD: Best we could gather was they weren't felt to be involved in the radiological operations --

DR. ZIEMER: And therefore --

MR. FITZGERALD: -- nonetheless, in talking with the -- interviewing the workers themselves and looking at accounts, they did do a lot of the cleanup, they did do a lot of the maintenance, and they did get in fact certainly exposed to activity levels that, again, would not probably approach the day-to-day routine workers, but nonetheless appear to be significant.

DR. ZIEMER: Yeah.

MR. FITZGERALD: There wasn't very much information, I guess that was our conclusion, just by virtue of trying to locate records as well as look at the documentation that was available. I think that's certainly a concern from our standpoint.

DR. NETON: I don't have much more to add to that other than, you know, we -- we have looked

at these special classes of workers such as welders, pipe fitters, plumbers and that sort, and we do have monitoring data for them. I mean they were -- I think they were monitored with about the same frequency as the other workers that we had data for in the early years, but SC&A has raised this issue of this sort of auxiliary set of workers that we need -- we need to run to ground. We're not quite certain about them, but we'll look into that a little closer.

DR. ZIEMER: Okay. So it's really not clear at this point what the policy was on those other than they weren't monitored.

MR. FITZGERALD: Yeah, and this just came out of the give-and-take, that there was a subset --

DR. ZIEMER: Right.

MR. FITZGERALD: -- that looked like it might have been unmonitored and may not have been treated the same way in the early years.

DR. ZIEMER: Let me ask if there's questions -- Mark, you have a comment?

MR. GRIFFON: (Unintelligible)

DR. ZIEMER: Okay, Mr. Presley and then Mr.

Griffon.

MR. PRESLEY: As stated in the past -- this is Bob Presley -- we did have a group of construction workers that worked construction for M. K. Ferguson, Rust Engineering, another contractor, some of the others, that that might have -- that that might have -- have been the case of. Their records should be somewhere. Not disputing what you said, but there was a subset of -- of welders and pipe fitters and carpenters and -- but they were construction workers that worked for a construction contractor and you might go back and see if you can find the records for those construction contract groups that -- that did work at all three plant sites.

DR. ZIEMER: Would -- would they have been monitored separately from the standard monitoring process --

MR. PRESLEY: That's what --

DR. ZIEMER: -- at a lab by their own?

MR. PRESLEY: That's correct. They were given a number of dosimeters and things like this and they ran their own programs and -- and passed out their own dosimeters.

DR. ZIEMER: So they would not have had the ORNL or the Y-12 badges themselves. It might have been a separate contract for --

MR. PRESLEY: No, it was the same badges. Our --

DR. ZIEMER: Oh, same badges.

MR. PRESLEY: -- our -- our -- if I remember correctly, somebody out there from Oak Ridge help me, we -- they were given the same monitoring badges that we all wore. They're just -- if they were working in an area where it may have been outside the site and they deemed that either it wasn't necessary for them to wear a film badge or maybe they only monitored a certain percentage back in the early days.

DR. NETON: I was looking for some paperwork when Mr. Presley was talking, but I think -- were you referring to these separate building trades type contractors that were there?

DR. ZIEMER: Ferguson and Rust and --

DR. NETON: Okay. Yeah, that -- that's a separate issue that we are -- we talked a little bit about this yesterday -- trying to deal with through a contract with the Senate to

protect workers' rights where we currently have on hold dose reconstructions for building trades workers who were not part of the prime contractor's work force. In other words, they were covered by a separate monitoring program, or at least not to the same degree that the prime contract workers were. And we -- we acknowledge that that's an issue and we're trying to work through that. Right now we're close to resolving that issue at Savannah River and hope to move that on to other sites soon.

MR. FITZGERALD: Just -- just to close -- close this issue out, I certainly acknowledge what Bob is saying, and we looked into the issue. The report basically suggests that the personnel records would be the way to delineate this clearer. Now from the interviews, it certainly wasn't the case that these workers identified themselves as working for Y-12 but not being in the group that was dedicated and assigned to particular facilities, but more or less freelancing for the site -- which actually makes some sense. But again, given the amount of time and resources, we couldn't search down the personnel records and actually do that kind

of verification. So what we're suggesting is that -- that would be the next step to really nail that down a little better in terms of figuring out, you know, was it -- you know, who was this group and how -- how was this group monitored and the rest of it. Now in general they were monitored, in terms of bioassay, maybe once every four or five years. Again, in '61 they were all badged, but before that it was intermittent. So you know, certainly the history is rather spotty for that group of workers.

DR. ZIEMER: Mark, did you have a comment on that?

MR. GRIFFON: No, I'll hold my question till after -- if Joe wants to go through all the issues --

DR. ZIEMER: Okay, ready to go on to finding two?

MR. FITZGERALD: Yeah, let me go to finding three, that was -- well, I'm sorry, finding two. There was a related issue, as Dr. Ziemer mentioned, that -- you know, this -- this question of using the coworker analysis for the pre-'61 workers, we -- it's not so much

questioning that process 'cause I certainly think that is a process that can be used, but trying to assure ourselves -- and this is not a new issue -- that in fact these are the maximum exposed individuals in terms of the ten percent. And what gave us some pause certainly was some documentation and interview feedback that, you know, the supervisors were very strongly in line in terms of deciding who would get badged. I think the new information that Jim is talking about yesterday would be very helpful, which sort of suggests maybe it was more of a collaborative affair, which would shed more light on -- we're all trying to reconstruct the -- the management of that process and trying to figure out can you really have confidence that these were the maximum exposed individuals if in fact that's going to be the cornerstone of how you assign your missing dose on the pre-'61 era. That's a pretty big issue, so we certainly want to be sure about that.

And a sort of related issue on that is -- when we get to the internal section is if -- in terms of applying probabilities, I think it's

very helpful to nail down these sub-groups. You know, we're going to assume that, you know, we have a number of people that were unmonitored, but they were not part of this ten percent or were more administrative in nature, we just I think need to make sure they weren't subgroups such as these maintenance workers who, you know, really weren't administrative, were in fact sort of in between, were exposed more but not quite as much as process workers, so just trying to be a little careful about that.

Finding three I think was a collection of issues in the internal area. Leon, we had Joyce Lipsztein on the phone, who had written a section -- a number of questions, issues, clarifications. I think our point was it wasn't clear from -- for us on the TBD, you know, why certain things were the way they were in the internal section. These have, in our view, some implications -- the use of Type F uranium compounds we felt wasn't considered adequately in the -- in the assessment; particle sizes in terms of measured versus assumed on the five micron we felt were some

measurements that should have been considered in some cases may be more claimant-favorable. For a plant like Y-12 we felt certainly ingestion needed to factor in. I understood that there might be some bounding equations where ingestion's accommodated, but because of the history certainly we felt that needed to be treated more specifically -- more prominently in the site profile.

And I think we're going to have some lively exchanges in the issue resolution process on issues such as the 40-hour delay, the solubility questions and the 50th -- 50th percentile. Again, I think these are areas where it wasn't as clear in the site profile. We didn't really disposition those in some of our conference calls. I think those are issues I'd like to tell the Board I think we really can converge and understand where the technical chips fall on those and come back and give you a clear idea of what those mean. But they will have, in our view, a fairly strong implication of the results in dose reconstruction. We felt these are important points.

Finding four -- I think this is actually an

issue where we and NIOSH are in agreement that the -- this revision of the site profile is a fairly old one, one of the original -- going back two, two and a half years ago, and there were a number of radionuclides that were in fact obviously handled at the site, not addressed in the site profile, thorium being perhaps the most prominent. They had a very major thorium operation, but there was other nuclides that came into it from recycled uranium and other sources, and I don't think there's really a disagreement that -- that, beyond uranium, there needed to be a broader treatment of these additional source terms. And I think NIOSH is in the process of doing that.

The last -- well, I won't say the last finding, but the -- the fifth one of the five that we wanted to highlight, deals with, again, a rather familiar issue that seems to crop up -- a lot of -- a lot of reviews, but NTA film response. We -- the question here is not so much the response capability. I think we've debated that and I und-- you know, certainly NIOSH has the -- has the guidance document.

It's more that there were -- confident that the spectral measurements at Y-12 are such that -- that the -- the neutrons you're measuring are in fact over 500 keV or not. We have some concerns that there's some source terms that we've identified in the plant that -- and we've listed them here -- that would perhaps give you some pause as to whether those -- a neutron source term that might not be as easily detectable by the NTA film and, you know, how can we accommodate that. I think that would be a call for, you know, do we have any additional information on neutron spectra that would give you more confidence that your NTA film in fact is adequate to the task. So that's another question that we'd like to pose.

The other issues, not to diminish them, but really are scope issues, ones that I think we've mentioned before that -- certainly these are areas of potential exposure. Just want to go ahead and raise them, but I think the other five are the more prominent ones.

DR. ZIEMER: Thank you. Board members, any additional comments on Y-12? Yes, Mark.

MR. GRIFFON: Just this -- this is going along

toward the process rather than specific comments, but I just wondered if for all three of these sites -- Y-12, Savannah River and Rocky -- if we can -- before the next workgroup meeting, which I'm assuming is going to happen in the near future, could we get a listing of the relevant TIBs and workbooks that would be associated with dose reconstruction for these sites, for best estimates, I guess, or -- primarily. And -- and also along those lines, I think -- as I'm looking through items on the O drive, I find these interesting and I'm not sure what to call them. They're not TIBs, they're not procedures or anything, but other supporting documents developed by ORAU or -- or OCAS. For example, for -- for Y-12 I think there's some very relevant documents. There were documents that -- that basically describe the validation process for the dosimetry data that you used from the CEDR data, I guess. I think the were generated sometime in 2004. But anyway, there's some of these other documents that are out there that sort of support the models, and I think those'd be helpful to expedite the process in the workgroup. And I

see John's going to say how many workbooks.

DR. MAURO: No, no.

MR. GRIFFON: Yeah.

DR. ZIEMER: John Mauro.

DR. MAURO: Yes, just to help out a little bit, in our proposal for -- which hasn't been approved -- for Task I and Task III, you should all have copies, there was an attachment to it which listed all of the new procedures, all of the new TIBs, all of the generic workbooks and all of the site-specific workbooks that we're aware of and are within the scope of our responsibilities in this fiscal year. It would be very helpful if there are others -- these are the ones that were on the O drive, listed for us at the time we wrote the proposal. Now I sense this is a living process. The extent to which some of them have been deleted or replaced, new ones are coming up, I think there should be an ongoing interaction with the working group, with NIOSH, as to the relevance and the current -- the currency of any one of those documents. 'Cause that's where we're starting from --

MR. GRIFFON: Right.

DR. MAURO: -- and if -- when -- so that would be very helpful.

MR. GRIFFON: Yeah, and I think that there's a spreadsheet that's updated pretty regularly, I think, by ORAU on the approved procedures or the -- I think there's even one that says pending and approved procedures, so -- I've also looked through there, and I think a lot of them are on there. There's some of these other supporting documents that don't -- they're not really procedures or TIBs that might also be included, so I just thought it might be helpful to narrow that for us so we don't have to go searching if -- if -- if that -- if that's easy enough to do. I mean the people that are doing the work probably can pull this together fairly quickly.

DR. ZIEMER: Yeah, and Jim.

DR. NETON: We could certainly do that. I might suggest that we could put a separate folder out there that's accessible by the working group and put those things out there so they're easily identifiable as these meetings occur and work products are developed.

MR. GRIFFON: That'd be -- just -- just to make

things more efficient.
The other thing along those lines is for several of the workbooks on the O drive, at least from my access standpoint, the macros are disabled so I can't really look at -- at the workbook, and I'm not sure if that can be resolved. There might be specific reasons for certain ones being disabled or --
DR. NETON: We can -- we can accommodate that. I don't think that's a problem.
DR. ZIEMER: Okay. Other comments?
MR. GRIFFON: Yeah, if -- I've just got a couple more.
DR. ZIEMER: Go ahead, yeah.
MR. GRIFFON: Some are along the same lines. There -- there's -- there's also, too, on the O drive -- at least for the Board's access standpoint, you know, I'm seeing this come up, especially for Y-12 and Savannah River, maybe for Rocky -- I'm not as familiar with that -- but there's a -- there's a coworker folder that we have -- "access denied" comes up when I try to go into that coworker folder, and I don't know if that's -- does that have the coworker model data? Is that something that the Board

can get access to, or is that just not relevant at this point? I -- I don't -- I don't know -- the same goes for -- there's another folder which I think is labeled "uncertainty analysis" which is also -- can't be accessed by the Board. But I think of -- of immediate relevance I thought was this coworker folder, especially if -- if it has any of the -- maybe that's in the separate site folders and it's irrelevant --

DR. NETON: Yeah, I'm not honestly familiar with what would be in that coworker folder. We -- we could look at it. You know, I would be reluctant to release to the Board preliminary work products where we're developing models and such like that.

MR. GRIFFON: Maybe that's what it is, maybe --

DR. NETON: It may be something like that --

MR. GRIFFON: -- it's preliminary --

DR. NETON: -- but I'll look into it and see, and if it's -- if it's something that makes sense to -- to put in this workgroup folder, we have no problem doing that.

DR. ZIEMER: It appears that there's already tacit agreement between the contractor and

NIOSH to take the next steps on Y-12. I would like to ask, though, if the Board wishes to formalize this in any way, again, either specific directions or general directions?

MR. GRIFFON: Do we need a motion for each one of these? I think we're going to take all of these through the same six--

DR. ZIEMER: Well --

MR. GRIFFON: --step process.

DR. ZIEMER: -- that may be. I --

MR. GRIFFON: Oh --

DR. ZIEMER: -- think it's, again, probably good to have it on the record as the sense of the Board so that there's no question that it's not just the Chair's opinion or Mark's opinion this is what we should do -- or Leon's or anybody else's.

DR. WADE: My only opinion is the timing. I would like to see the Board address itself to the issues of the timing, as I would hope we could be in a position to deal definitively with an SEC petition for Y-12 at the end of January.

DR. ZIEMER: And the implication of that is we would like to have some level of closure on the

site profile so that we're not in the midst of reviewing a site profile while trying to deal with an SEC petition --

DR. WADE: Correct.

DR. ZIEMER: -- is your -- is the implication of what you (unintelligible) --

DR. WADE: Yeah, that's what I bring. I mean we all -- we all -- we're through Mallinckrodt. I think we reminded ourself after Mallinckrodt that there was a lesson learned there that we wanted to heed, and I think that was the lesson.

DR. ZIEMER: Roy?

DR. DEHART: Would that then imply that we would provide a -- an instruction or priority as to which to be performed? I -- I would feel that that would be the case. Y-12 would become the number one priority.

DR. ZIEMER: There actually are two SEC petitions that we need to deal with. There is also a Rocky Flats --

DR. WADE: Let me spend a moment talking about dates, and I apologize for this being confusing, but I think it's important for the Board to have the sense. For Y-12, the later

years, that particularly is Y-12 from -- is it '44 to '57 is the dates we're talking about? That petition qualified on April 29th of '05. NIOSH has 180 days to get an evaluation report before the Board. That would take it to sometime next week that NIOSH would be submitting to you an evaluation report on Y-12. Again, remember we've dealt with issues of Y-12 before, so the exact form of that evaluation report is something under discussion with NIOSH and counsel. So let's say there's an evaluation report in front of you the end of this month.

Then the next full Board meeting is in Jan-- the end of January that we have scheduled. Common sense would say you would take up that -- that petition then. There is no legal requirement that you take it up then. I think there is the common sense requirement to want to do it as quickly as possible, so keep those dates in mind.

With regard to Rocky Flats, the dates are more kind. Rocky Flats qualified on June 16th, '05. That means you could expect something from NIOSH in the middle of December of '05, where

again we could hope to work the SEC petition the end of January, or we could leave it for a subsequent meeting. So I think in terms of your setting your priorities, I would put the highest priority on Y-12, second on Rocky Flats, and third in this discussion on the Savannah River Site.

But again, if the Board was to come before the January meeting and say we need more time to finish our business on Y-12, you could have that time. There is no clock that runs on the Board's action. There is a clock on NIOSH's action to get an evaluation report before the Board 180 days after the petition qualifies.

DR. ZIEMER: That answers your question I think that, by implication, the Y-12 SEC petition would have priority and therefore the need to complete the site profile in a timely fashion also then takes priority.

DR. WADE: If I could even speak just another minute --

DR. ZIEMER: Sure.

DR. WADE: I mean I'd like the Board to put itself in mind of what it would like to have before the Board -- let's say we're going to

vote on the Y-12 SEC petition at the end of January. Would you like to have statements from NIOSH and SEC (sic) that they've reached closure on all major issues? Would you like them to go beyond that? Would you like to see the implications, as Mark has raised this morning, of some sample dose reconstructions? I guess now is the time for us to think about what we would like. We have three months, but those three months will go by very quickly and, you know, the end of January will be upon us. I think it's prudent to think about what you would like to have in front of you as you approach the making of an SEC petition evaluation judgment.

DR. ZIEMER: Of course it's rather easy to say that we would like to have closure on all major issues before we meet. That -- that may or may -- we can't mandate that, of course. That's always an endpoint that you would like to reach, but -- Henry?

DR. ANDERSON: I mean certainly if we're going to -- hey, what do we need closure on -- it would be those major issues that maybe are related to the SEC petition and dose

reconstruction. I mean there may be other issues and -- I mean this is a complex site, so I'm not sure we can expect to have everything resolved. But if there are key issues related to the petition, we certainly don't want to be arguing those in the -- or not have resolved them in the site profile and be dealing with them in the SEC petition. So I -- you know, without -- if we're going to know pretty soon to see what the decision is, that also, you know, becomes important.

DR. ZIEMER: Now we took an earlier action on Savannah River, which was to request the next step in the process, without putting a timetable on it. In the case of Y-12, you -- you may wish to have a similar action but in fact to indicate priority-wise that that should proceed with highest priority. Something somewhat analogous could be done with Rocky Flats, which is another discussion.

MR. PRESLEY: Can I --

DR. ZIEMER: Robert Presley.

MR. PRESLEY: Can I ask a question, please? Number one, counsel, can I speak to a SEC submission evaluation?

MS. HOMOKI-TITUS: (Off microphone) For (unintelligible)?

MR. PRESLEY: Y-12.

MS. HOMOKI-TITUS: (Off microphone) No, you have (unintelligible).

MR. PRESLEY: I have a conflict with Y-12.

MS. HOMOKI-TITUS: No, for SECs and dose reconstructions you would have to recuse yourself from them completely. If you wanted to offer comments during a public comment session as a member of the public, you could do that.

MR. PRESLEY: (Off microphone) (Unintelligible)

MR. GRIFFON: This is a sidebar.

DR. ZIEMER: I think we're trying to determine whether Mr. Presley can legally make the comment he wants to make.

(Pause)

MS. HOMOKI-TITUS: Okay. The rule is, for a Special Exposure Cohort and a dose reconstruction, you have to recuse yourself completely. For a site profile, you may make comments, but you cannot vote on recommendations from the Board to the Secretary.

DR. ZIEMER: So if your comment pertains to site profile issues, then you may make such a comment. Okay, Richard Espinosa.

MR. ESPINOSA: I'm a little bit under confusion. I -- I already thought there was an SEC in front of us for Oak Ridge, I mean in this document right here that -- SEC tracking number 28, I already thought that was before us.

DR. ZIEMER: There is an SEC petition. The evaluation by NIOSH for that petition is due on --

DR. WADE: Well, we have to turn back the clock. The Board has acted on a Y-12 petition for the early years.

DR. ZIEMER: (Unintelligible) the early years.

MR. GRIFFON: Right.

DR. WADE: And that the Board has recommended action and the Secretary has taken that action. Now we're looking at a subsequent year petition that is not yet formally before the Board. It has been received by NIOSH on the date that I mentioned.

DR. ZIEMER: I think we got the evaluation -- what is it called, Larry -- the evaluation

process that NIOSH will use. We're normally given a copy of that when the petition comes in.

MR. ELLIOTT: The evaluation report that you handled meeting before last on Y-12 early years is part of one petition. We part -- we handled and in evaluation report to you the early years at Y-12. We presented that evaluation report and concluded it, that a class should be added for the Calutron operators. We -- and we concluded at the end of that that we were still examining the remainder of the petition, the remainder of the years at Y-12 and trying to determine whether or not there was a -- an additional class that either should be added or should be denied, based upon this one petition -- one -- this same petition that we're dealing with. So you've already handled part of that petition. We're still working up the remainder of it, and that's what we want to bring forward to you in the future.

MR. ESPINOSA: And the years of that were the '44 through '57?

DR. ZIEMER: '44 through '47, I believe, right -- right?

MR. ESPINOSA: '47?
DR. WADE: My notes are '44 to '57.
DR. ZIEMER: '57.
MR. ESPINOSA: '57, okay, that's what I wrote down, too.
MR. ELLIOTT: I don't have them right in my head right now so I'm --
DR. WADE: We can verify that.
DR. ZIEMER: And then that recommendation from NIOSH is the one that is due actually later this month, which then comes to us for our action. Okay. Jim?
DR. NETON: Just some clarification. The years under evaluation currently are '48 to '57. If you recall, the Y-12 early years, '43 to '47, were already granted by the Advisory Board.
DR. ZIEMER: Okay. We stand corrected, it's apparently '48 to '57.
DR. NETON: Right.
MR. GRIFFON: I think they were split, yeah.
UNIDENTIFIED: (Off microphone) (Unintelligible)
DR. ZIEMER: Right, those -- the early years were already handled as a separate group.
MR. ESPINOSA: Thank you, Larry.

DR. ZIEMER: Roy?

DR. DEHART: Yes, I'd like to move that the Board instruct NIOSH, to the degree we can, and the contractor, SC&A, to give priority to the Y-12 site profile, with the intent to have as much information and resolution as possible for January.

DR. ZIEMER: Okay.

MR. GRIFFON: Second.

DR. ZIEMER: Seconded. Now discussion. Rich, you have another comment?

MR. ESPINOSA: Oh, no, I'm sorry.

DR. ZIEMER: Okay. Any comments relative to the motion that's before us, pro or con? Are you ready to vote on the motion then?

MR. ESPINOSA: Was it seconded?

DR. ZIEMER: Yes, I believe --

MR. GRIFFON: Yeah, I --

DR. ZIEMER: I think Mark seconded the motion.

MS. HOMOKI-TITUS: Sorry -- if you have a conflict for Y-12, then you can't --

DR. ZIEMER: You cannot vote on --

MS. HOMOKI-TITUS: -- make motions, either.

DR. ZIEMER: -- any motion.

MS. HOMOKI-TITUS: And you can't vote on

motions.

DR. ZIEMER: Roy, I -- is Y-12 or only X-10?

DR. DEHART: No, Y-12, as well.

DR. ZIEMER: Okay, so you can't make the motion.

DR. DEHART: Okay.

MR. GRIFFON: The motion that --

DR. ZIEMER: Did anybody overhear the motion and --

DR. ANDERSON: I'll adopt the motion.

DR. ZIEMER: The suggested motion. The suggested illegal motion, the motion -- Henry, are you making the motion?

MR. GRIFFON: I'll still second. I'll second Henry's one, too.

DR. ZIEMER: Okay.

MS. HOMOKI-TITUS: (Off microphone) You can't second a motion (unintelligible).

DR. ZIEMER: Do you have a --

DR. WADE: Mark seconded.

MS. HOMOKI-TITUS: (Off microphone) (Unintelligible)

MR. ESPINOSA: I'll second the motion then.

DR. ANDERSON: And then we don't have a quorum.

DR. ZIEMER: No, before we vote, I want to -- I

want -- is -- is there a conflict for Mr. Griffon at Oak Ridge?

MR. GRIFFON: No, there's not.

MS. HOMOKI-TITUS: According to his waiver that's current right now, there is. What we asked was anyone who --

MR. GRIFFON: There is not. There -- there is not. We went through this with several conference calls. I'll talk to you outside, but there's none. We put very specific language in there about this.

MS. HOMOKI-TITUS: Right, for the SEC there's very specific language --

MR. GRIFFON: Right.

MS. HOMOKI-TITUS: -- but what we -- when Wanda and us discussed this and we discussed it with Ethics, for the SECs you can be involved in the discussion, but if you have any type of conflict there, then you don't vote.

MR. GRIFFON: But this is not an SEC we're talking --

MS. HOMOKI-TITUS: I'm sorry, site profiles.

DR. ANDERSON: So who can vote?

MS. MUNN: I can vote.

DR. WADE: Okay, let's put a (unintelligible).

Who is conflicted for Y-12?

MS. HOMOKI-TITUS: Roy DeHart --

DR. WADE: Mr. Presley --

MS. HOMOKI-TITUS: -- is conflicted.

DR. WADE: -- Dr. DeHart, and under --

DR. ZIEMER: Well, the Chair needs to know whether he's conflicted --

MS. HOMOKI-TITUS: Yeah.

DR. ZIEMER: -- for Y-12 since I've spent time there myself.

MS. HOMOKI-TITUS: (Off microphone) (Unintelligible) the list, don't you, (unintelligible)?

DeHart, Griffon, Presley and Ziemer --

DR. ZIEMER: Are conflicted.

MS. HOMOKI-TITUS: -- that according to the waivers that you currently have, are conflicted for voting on an SE-- a site profile.

MR. GRIFFON: Let me just say for the record, I disagree with that interpretation, but I'll -- I will work with them more on that.

DR. ZIEMER: Okay. Also -- I'm not sure the Chair can even hear the motion then. I think we need -- well --

MS. MUNN: You have five people here.

DR. ZIEMER: I guess I can recluse (sic) without voting, right?

MS. HOMOKI-TITUS: Right.

DR. ZIEMER: Can I still Chair the motion?

DR. WADE: Can he be in the Chair when the motion is made?

MS. HOMOKI-TITUS: (Off microphone) Probably should appoint someone else (unintelligible) --

DR. WADE: Okay.

MS. HOMOKI-TITUS: -- (unintelligible).

DR. ZIEMER: Can I appoint the Federal Official to Chair the -- Lew, would you see if there's any motions dealing with Oak Ridge?

DR. WADE: I would be pleased. Just for the record, on Y-12 at Oak Ridge, apparently the waivers would conflict DeHart, Griffon, Ziemer and Presley, so let's do the arithmetic now. With those four excluded, we have one, two, three, four, five, six members that are here. That constitutes a quorum and we can conduct business. Okay?

Is there a motion to be made by those who can make motions on Y-12?

DR. ROESSLER: Henry made the motion.

DR. ZIEMER: Henry's -- Henry --

MS. MUNN: Right, Henry made the motion.
DR. ROESSLER: I seconded it.
MS. MUNN: She seconded.
DR. ROESSLER: I don't know --
DR. WADE: Okay, so the record will show that Henry has made the motion and it was seconded by Gen. Discussion?
(No responses)
Let's take a vote. All in favor indicate by saying aye.
(Affirmative responses)
Opposed?
(No responses)
The motion carries. I've done quite well.
DR. ZIEMER: Thank you very much. I think we have concluded our morning business --
DR. WADE: I'd like to talk a little bit in the realm of fantasy, so (unintelligible) --
DR. ZIEMER: That's what we've been doing for the last two days, some people think.
DR. WADE: No, not at all. Not -- I'm not one of them. So you can imagine a working group meeting that would take place quite quickly; a Board call that could consider, among other things, the result of that working group on the

28th of November. You could imagine another working group that would take place before the Board meeting. You could also imagine another ball -- another Board call that could take place early January. So I would ask you to consider all of those things as we sort of lay out the realistic plan. We're all very good at sort of fantasy planning and imagining that things are going to go well, but given the importance of this -- I mean we have a number of bites at the apple, and I think we want to lay out our plan to try and get this thing done, so -- I mean consider that as you do your -- your consideration and deliberation.

DR. ZIEMER: Thank you.

DR. DEHART: Lew, a question. On the working group, any of us from Y-12, if that -- if we're going to be discussing Y-12, shouldn't be on the working group.

DR. WADE: I think there's a judgment to be made there. A working group doesn't really vote anything out.

DR. ZIEMER: The working -- I think since we can discuss -- working group can discuss site profiles, you should be able to also be in a

working group.

DR. WADE: Right. I think so, so I would make the judgment that it's really value you bring to the discussion. I would include yourself. Again, the working group will not normally be voting anything out that might be --

DR. ZIEMER: Now before we actually appoint a working group, which will probably occur tomorrow, we can get a definite ruling from counsel on that later as to whether that would preclude it. I --

DR. WADE: Right.

DR. ZIEMER: Since we're allowed to actually enter into the discussion, I see no problem with it. Wanda?

MS. MUNN: And I would actually point out that, for the sake of the working group's constitution, individuals with actual site experience might be extremely valuable in the interaction between NIOSH and SC&A.

DR. WADE: I would agree.

DR. ZIEMER: Thank you. Okay. And I think we have concluded our morning session. We're scheduled to recess for lunch until 1:00 p.m. It's now 11:30, a few minutes past, so we're

pretty much on schedule, so I'll declare that we're in recess until 1:00 o'clock.

(Whereupon, a recess was taken from 11:30 a.m. to 1:05 p.m.)

DR. ZIEMER: Okay, we're ready to begin the afternoon session. If you will take your seats, we'll get underway.

REPORT FROM SUBCOMMITTEE:

ROCKY FLATS

The first item on our afternoon agenda is a report from the subcommittee on Rocky Flats, and let me report that in the case of Rocky Flats the -- the site profile review for Rocky Flats has not yet been issued by our contractor. Of course you have the -- the site profile itself that NIOSH prepared.

Also you're aware, as previously indicated, that there is in process a SEC petition for Rocky, and the action on that petition -- NIOSH has to make a recommendation by mid-December on that, so that, priority-wise, is coming up.

But we at this moment do not have a review from our contractor.

They did, however, make a kind of a preliminary presentation of some issues which were emerging. Initially there was the issue of

high five plutonium, but I understand from a later exchange that Joe Fitzgerald had with -- with others that the high five plutonium may not be quite the issue that they thought it was initially, but there are some other initials -- or some other issues emerging at Rocky. And Joe, if you -- you or John, probably you would be best prepared to do that -- just very briefly summarize the issues that SC&A sees with respect to Rocky.

MR. FITZGERALD: Yeah, I am looking back 'cause I think Hans Behling is right behind me and I want him to spend just two minutes on this subject because he had summarized it. In general we did want to look at the high five issue in some detail. We started out looking at that, and I think we came around to appreciating that a bigger issue in -- respecting this site profile is the question of how the MDA was being handled in terms of the assignment of doses.

(Off microphone) Hans, I -- we're just going to take a couple of minutes to talk about the MDA issue at Rocky. I was going to (unintelligible) --

DR. ZIEMER: Okay, Hans. Thank you.
DR. BEHLING: Yeah, the issue that we're addressing is what MDA is applicable here, and I looked through the TBD and I assessed the method by which the median value of the MDA were derived and that MDA is really based on an (unintelligible) standard and incorporates about four different variables. And I believe the median value assumes a couple of parameter values that I consider relatively unconservative, such as the yield and the counting efficiency and a couple of others. And at the same time, the TBD also has a table on page 47, I believe, that says what if one of the four variables is either at the 5th or 95th percentile value, what would that do to the MDA. And also what if two out of the four and three out of four of those variables were at the extreme end and what would that do to the value of the MDA, and you realize that the MDA value is going to be a critical component in dose reconstruction because I suspect that many of the people who were working in an environment where there was plutonium are likely to be assayed for urine that will result

in a what's called either a background -- noted as background or zero. And so now the question is what do we do as a surrogate value when you have either BK for background or zero, and the options are several. That is, you can use the central value or median value. You can use one outlier or two outliers, one of the parameters, or even three. In addition to that, there are reportable levels. Apparently there was a period of time when the urinalysis data were -- were looked at and said well, if it's ten percent of the guidelines, then we're not even -- if it's less than ten percent, we're not even going to -- to record it, and so those numbers could also very well reflect either a background or zero value. And it turns out that that value of reportability is somewhere around 0.088 or 0.9, I think, rounded off. So those are the options. And when I looked at the users workbook or the guidance given to dose reconstructors, the median values were identified as the recommended to use for -- for using when a individual's bioassay turns out to be either background or zero. And we discussed it with NIOSH and they recognize that this is

an issue that needs to be looked at very carefully, and so I think we're in the process right now in establishing a dialogue and finding what it is that we think might be the recommended surrogate value in instances where the urine data will either be defined as background or zero.

DR. ZIEMER: So although the report itself is not out, the dialogue has already started with -- with NIOSH --

DR. BEHLING: Yes, yes, we started that last week.

DR. ZIEMER: -- on some of these issues.

DR. WADE: John -- John Mauro, when will we receive the -- will the Board receive the Rocky Flats report?

DR. MAURO: Both Rocky Flats and a Nevada Test Site report, both of which we were hoping to deliver to you by the end of September, the end of first fiscal year, are going to be delivered by the end of this month. So you'll have Rocky -- I actually have a complete draft in my briefcase of Rocky and -- and Nevada Test Site is a little behind, so -- but both of them will be delivered by the end of this month. And

that would basically close out what I call our fiscal year 2005 scope of work, all nine reports will have been delivered. Of course many of them are still in the stage of expanded review, but that's a part of the budget for Task I for next fiscal year. So the -- the only thing that's really outstanding that we owe you right now for FY '05 -- 2005 are Nevada Test Site and Rocky, and you will see them by the end of the month.

DR. ZIEMER: Right. At which time NIOSH will also have the official report, so they've not really officially had a chance to respond to it, in any event, even though you've started some dialogue, raising some questions and trying to define some of those issues.

DR. MAURO: What's been very helpful is that as we see these is-- the important issues, as I mentioned, we bring them up, inform the Board, the working group, perhaps even have a telephone conference call regarding some of these -- this has happened on Rocky, but it has not yet happened on Nevada Test Site. Probably would be a good idea to maybe move that forward, too. We -- I would say Rocky is a

little bit more mature down the line than Nevada Test Site.

DR. ZIEMER: Okay. So actually there's no action we actually need to take on Rocky since we don't yet have the site profile, but it's understood that -- that initially there will be the opportunity for NIOSH to look at the findings and prepare their responses. And as our working group is -- has an opportunity and as we have an opportunity in telephone conversations to review the progress, then we can make more definite plans from there. But at least we are aware that this has also a priority, since it is related to the upcoming SEC petition from Rocky. And Lew, do you want to add to --

DR. WADE: Well, just -- you know, thinking about this realistically, again, you will probably receive a petition evaluation report from NIOSH the 16th of December. It's possible we won't take up the Rocky Flats petition until the meeting after the January meeting. I don't think we need to make that decision today, but given the fact that we don't have the report, we have lots to do. I mean I would hold open

that possibility.

DR. ZIEMER: Right. Okay. So are there any additional questions or comments on Rocky Flats? This is more in the line of a progress report today.

Okay. Thank you, then we'll continue on our agenda.

REPORT FROM SUBCOMMITTEE:

SC&A CONTRACT TASK III

Our next item is a report from our subcommittee on the SE-- SC&A contract -- Task III contract, which is the procedures evaluation. And for that part of our discussion we need to make sure everybody has a copy of the summary of Task III procedures finding matrix. And as we indicated yesterday in the subcommittee meeting, there are three versions of that. The initial version has the findings of SC&A. The next version has NIOSH responses to the findings. And the third version has our working group's recommended Board action on the responses, and it's that third one which we want to address since it contains everything that the other two contain, plus the output from our working group.

Now that recommended Board action comes from

the Chair of the working group, who is Mark. Yesterday in our subcommittee meeting we simply summarized what had been done, but we did not look at the individual findings. We have the opportunity to do that now. We have -- basically have an hour if we need it, Mark, to go through these. But in any event, why don't -- why don't you lead us through these findings and the recommended outcomes.

MR. GRIFFON: I --

DR. ZIEMER: Or recommended actions.

MR. GRIFFON: I was wondering if -- if Board members have had a chance to review this. We might -- it might be easier just to go down somewhere -- I was -- where there's an issue on the Board action that I proposed. There's some that I have highlighted or put a question mark next to because I was unclear in my notes and --

DR. ZIEMER: Right, and if necessary we -- we can simply work through these and delay action till later, if you wish. But --

MR. GRIFFON: Yeah.

DR. ZIEMER: But let's at least work through them and see what questions and issues --

MR. GRIFFON: Okay, if you want to go through item by item, that's --

DR. ANDERSON: (Off microphone) (Unintelligible) let's just take the ones you've highlighted or the question mark.

MR. GRIFFON: That was what I wanted to know. Do you want to go through item by item or go through the ones where there's questions?

DR. ZIEMER: Well, a lot of these have the same outcome recommended, but I think you at least -- we should take a couple of those to --

MR. GRIFFON: Okay.

DR. ZIEMER: -- and then we can say okay, this follows that previous pattern, but -- for example, recommended NIOSH modify procedure, low priority. Sort of what does that mean and --

MR. GRIFFON: Right.

DR. ZIEMER: -- and when it turns up again, then we'll know what that means.

MR. GRIFFON: Okay. All right. Yeah, for the first item it's -- it's for OCAS IG-001, and Board action there is recommend NIOSH modify procedure, low priority. There are several of those -- as Paul stated, several of those types

of recommendations -- low priority, medium priority and high priority for those kind of things, and in general, for this first procedure especially, they -- they -- several of them appear. This is the implementation guide for external radiation dose reconstruction, and -- you know, in a -- several of these cases, the low priority items are ones where -- to some extent, it was a -- it was a stylistic comment, too much background information, should be rearranged to highlight the other information and put the background information in appendices, things that -- that -- that I don't think are priorities to -- to make the changes. NIOSH said they -- they would change them, as their schedule permitted, that sort of thing, you know --

DR. ZIEMER: Right, Stu Hinnefeld --

MR. GRIFFON: -- and we agree with that, yeah.

DR. ZIEMER: Stu Hinnefeld indicated yesterday on these kind -- most of these are ones where a change doesn't affect what they actually do --

MR. GRIFFON: Right.

DR. ZIEMER: -- in terms of the use of it. It simply lays it out in a more convenient way,

but doesn't change the technical use of it and the -- most of the dose reconstructors are used to the old layout anyway, so --

MR. GRIFFON: Yeah.

DR. ZIEMER: -- it's more, as you say, a stylistic thing. This would read better or look better if it was reorganized, but it really doesn't affect the -- the final outcome of anything; therefore it's low priority in actually making the change. Why spend time and effort when it doesn't change how the work is done.

MR. GRIFFON: Right. So I can move down to --

DR. ZIEMER: Whenever we have one of those -- recommend NIOSH modify, low priority -- it tends to be one where actually --

MR. GRIFFON: Right, it would affect a dose reconstruction --

DR. ZIEMER: It wouldn't affect (unintelligible) --

MR. GRIFFON: -- much at all, right, right.

DR. ZIEMER: Okay. And the next one is in that same category. Right?

MR. GRIFFON: Right. Then I was going to move to the third one, just to make sure that I --

that I summarized the workgroup discussion correctly here. I think where we came down on this was that we -- there was no action necessary.

DR. ZIEMER: Yeah, and go -- maybe go through the example here, what it is -- the finding, inadequate guidance.

MR. GRIFFON: Right, and the finding in this case, you know, inadequate guidance for classifying a case that has potentially less than 50 percent or greater than 50 percent. NIOSH's response, basically they're saying, you know, yes, we agree this issue has to be addressed, but it's in Proc. 6. It's not in the broader implementation guide. So if -- if it is included and spelled out properly in Proc. 6, I think there's no action necessary for this finding.

The only thing I would ask, as I'm thinking -- thinking about this in real time is that -- that four pages from now we come to that Proc. 6 -- the thing I mentioned yesterday -- where they said all the findings are the same for Proc. 6, and this is one example where I was thinking to myself as I was putting this

together, well, is this -- and I'll ask SCA and NIOSH -- is this spelled out in Proc. 6 and does SCA find it acceptable in -- in Proc. 6?

DR. ZIEMER: Hans, you have a comment to that?

DR. BEHLING: Yeah. Proc. 6 really gives you a summary capsule of what's in the implementation guide, but it also gives you something that is not in the implementation guide, and that is the various attachments that follow the main body of Proc. 6 where they by and large define what methodology needs to be applied in dose reconstruction involving a case where the probability of causation, based on Task II review, is less than 50 percent/greater than 50 percent. They talk about methodology of the dose reconstruction involving a case where shallow dose is a key component of the dose reconstruction, so forth. So they're not exactly duplicates of each other, except that the core component up front in Proc. 6 is a summary component of the implementation guide. And our comments that pertain to Implementation Guide 1 does in fact apply to the up-front component of Proc. 6 and -- and we do not address the issue of the attachments, which are

step-by-step guidance, unlike the implementation guide, which is sort of a -- a foundation. The Proc. 6 actually does provide step-by-step guidance for dose reconstruction. That is not part of the implementation guide.

MR. GRIFFON: Am I understanding this right? I mean you -- you can't tell me right now if this issue is adequately addressed in the attachments in Proc. 6. Have you reviewed that?

DR. BEHLING: Yes.

MR. GRIFFON: What I'm asking is is this issue adequately addressed, in -- in your opinion, in the (unintelligible)?

DR. ZIEMER: (Unintelligible)

DR. BEHLING: Yes, in fact the Proc. 6 --

MR. GRIFFON: That's what we want to get at.

DR. BEHLING: -- the first time actually identifies the task group review group, which apparently is -- is a group of individuals at NIOSH who actually do a screening of the claims and say this is likely to be a --

MR. GRIFFON: Okay.

DR. BEHLING: -- a -- a maximized claim, and when the dose reconstructor gets it, he already

has been told whether this is a -- a -- likely to be less than 50 percent POC claim, and so he comes already geared to doing a dose reconstruction that is a maximized. Or, in other words, also a -- a best estimate. But that is part of Proc. 6, that initial screening, and that's not identified in the implementation guide.

MR. GRIFFON: Okay. So -- so I think he's answered my question, no action necessary.

MS. MUNN: He's happy with the answer.

MR. GRIFFON: Right. Right.

DR. ZIEMER: Thank you. Okay, proceed.

MR. GRIFFON: Fourth one, you'll notice a similar language, except medium priority, and -- you know, this is sort of a subjective call, but uncertainty and -- and the clarification on how the uncertainty analysis is done, I -- I sort of thought that was -- it's not just simply wording changes, maybe. I think there's -- at least we have to make sure that there's consistency in the way it's described in the implementation guide and the way it's being carried through in the workbooks, and I think that's -- at least -- maybe it's not a high

priority, but it's somewhere in the middle. It's medium priority.

DR. ZIEMER: Let me ask Stu Hinnefeld here at the moment, NIOSH has also used different language here than you did in the first one. Does that imply that you agree that this one not only needs some revision, but probably would be done at least sooner than the -- the top one on the page?

MR. HINNEFELD: Yes, that's correct. I've been following my notes against Mark's notes and we're pretty much lined up. There are a --

DR. ZIEMER: Right.

MR. HINNEFELD: -- few that --

MR. GRIFFON: Okay.

MR. HINNEFELD: -- we're not exactly lined up, but --

DR. ZIEMER: And medium priority, what -- what we're saying here I think -- I want to make sure that what we think it means and what you think it means are the same thing. It means probably that it doesn't have to be done on an urgent basis, but you can't put it off indefinitely, either.

MR. HINNEFELD: Correct. Correct.

DR. ZIEMER: That's still a lot of latitude, but -- okay, I think --

MR. HINNEFELD: (Unintelligible)

DR. ZIEMER: Yeah, I think we're on the same page here.

MR. GRIFFON: Hans has a comment.

DR. ZIEMER: Hans.

DR. BEHLING: Yeah, I also want to make comment because the fourth item also goes -- ties into the second item, and I have to say the response NIOSH gave is, at this point, something that I'm not convinced of is the case, which says that the implementation guide is really not to be used for dose reconstruction purposes. But it turns out that it is the only document that I've seen to date that actually provides you with some kind of a methodology by which uncertainty for recorded photon and neutron doses are even provided. I have not yet seen any other document, whether it's a procedure or a TIB, that actually identifies the methodology that's to be used. In fact, in looking at all of the dose reconstructions that we've audited to date, you will see usually a reference to the implementation guide as to the methodology

for doing uncertainty -- with the exception of TIB 8 and 10 where there is a maximized uncertainty that says multiply all recorded dose by a factor of two, and that exempts you from doing the uncertainty. But if you are looking to do best-estimate, which mandates the need for defining the recorded dose plus some measure of the sigma value, there is no other document to my knowledge that defines the method or the mathematical formula that one might be used -- that may be used in defining uncertainty. So the -- the -- comment number two has to be somehow or other introduced into another document that looks at the methodology for uncertainty -- unless it's incorporated now into some method that Crystal Ball makes use of and is part of a workbook, and I think that may very well be the case, but I haven't seen it and I haven't really looked at it. And I think probably Stu might want to comment --

DR. ZIEMER: This is -- this is where perhaps the language was not clear, even though the usage may be. Stu, can you --

MR. HINNEFELD: One of the -- one of the things that I did note that my notes were different

than Mark's is that two of the three -- there's a three-part comment on IG 1-2, there are three parenthetical parts to that.

MR. GRIFFON: Right.

MR. HINNEFELD: I had -- for parenthetical one and two, I had that as an intermediate or medium priority as part of the uncertainty preparation -- description of what uncertainty is doing, and I only had number three as a -- as a low priority, so that was -- so I -- I think I'm agreeing with what Hans said there.

MR. GRIFFON: And -- and to Hans's second part of -- of his comment, are -- are these fleshed out in the workbooks more or is this the only guidance for...

MR. HINNEFELD: Well, certainly the workbook does the calculation. I think --

MR. GRIFFON: Right.

MR. HINNEFELD: -- it would be relatively difficult to discern from looking at a workbook --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- what's behind that, so my intent here is to describe the -- the uncertainty approach that is being utilized --

MR. GRIFFON: But there --
MR. HINNEFELD: -- not the uncertainly approach that's currently --
MR. GRIFFON: So there --
MR. HINNEFELD: -- (unintelligible) --
MR. GRIFFON: There are no procedures prescribing how to do uncertainty -- IG 1 is it. Right? Is that correct, or --
MR. HINNEFELD: As -- well, I don't know them all by heart. I -- I won't dispute that. That could very well be the case.
MR. GRIFFON: Okay.
DR. ZIEMER: Clarify for us then, this second item that you're saying there's really two parts to it or three?
UNIDENTIFIED: (Off microphone) Two.
DR. ZIEMER: Looks --
UNIDENTIFIED: (Off microphone) Three.
UNIDENTIFIED: (Off microphone) Three parts.
DR. ZIEMER: Looks like (unintelligible).
MR. HINNEFELD: There are three parts. I put two -- the first -- parenthetical one, two and three in the actual finding itself. There are three -- I consider that three parts. Okay? Parenthetical one and two both deal with

uncertainty, I believe -- hang on (unintelligible) --

MR. GRIFFON: Right, that's correct. Yeah.

MR. HINNEFELD: Right, both deal with uncertainty and therefore should be addressed in the write-up about uncertainty. Parenthetical --

DR. ZIEMER: Wait a minute, are we all -- when you say parenthetical one and two, what are you referring to?

MR. GRIFFON: On the second finding.

MR. HINNEFELD: Finding IG 1-2 in the finding -- finding description column.

DR. ZIEMER: 1 dash --

MR. HINNEFELD: IG 1-2, that would be in the second column, finding number --

DR. ZIEMER: Yeah, right.

MR. HINNEFELD: Okay, in the finding description column --

MR. GRIFFON: There's three parts.

DR. ZIEMER: Those three parts, okay.

MR. HINNEFELD: One and two I believe should be addressed with intermediate priority in the write-up of uncertainty that we have promised to prepare. Item three we believe is the one

that's the low priority (unintelligible).
DR. ZIEMER: So --
MR. GRIFFON: And I would agree the uncertainty part is probably, you know -- just like four, it should be a medium. That was my oversight on that. I don't know -- I guess we can separate the finding into two, medium and low.
DR. ZIEMER: So items one and two would be medium and item three would be low in that sec- - the second item. Is that correct?
MR. GRIFFON: I think so, yeah. I agree with what Stu said, so...
DR. ZIEMER: Okay, rather than the whole thing being low.
MR. GRIFFON: Yeah.
DR. ZIEMER: Okay. Thank you.
MR. GRIFFON: Okay. So we can move on to the second page, I think. That's pretty fast, compared to last meetings.
Okay, first two items, five and six, deal with limit of detection. And I think what -- reading quickly, but I think it was that these were illustrative in the IG 1 document, whereas the specific LODs are going to be in the site profile documents or site-specific TIBs or

whatever, so -- but this is a -- no action required here, unless there's an action to indicate more clearly that these are illustrations or examples, not -- I think Stu mentioned that yesterday, possibly that there might be a clarification -- if there's a table, that it's only for illustrative purposes or --

MR. HINNEFELD: I had recorded these as a low priority edit that's probably fairly easy to do.

MR. GRIFFON: Right.

MR. HINNEFELD: You know, insertion of some text, so that's how I'd recorded (unintelligible) --

MR. GRIFFON: I guess I might change -- change those to low priority, but they're -- they're basically simple -- make sure you list them as examples rather than -- yeah.

DR. ZIEMER: Okay. Thank you.

MR. GRIFFON: Finding number 1-7, I listed this as a medium priority, and it -- it is the issue that we've heard about a little yesterday as well on the NTA film that -- detection limits at various energies, and I -- I think this one's in a -- you know, it's coming up again

and again at many sites. I think we -- we -- I think it deserves to be addressed more quickly and it's -- it's -- it is a technical issue, not just a simple editorial issue, so I judged it as a medium.

I'm also not sure what medium means in terms of time frame, you know.

DR. WADE: You need to do that.

MR. GRIFFON: Yeah. And I don't know if we want to put any -- associate any kind of times with these.

MS. MUNN: It might be a wise idea for some of these, like this one that we see as a fairly important technical issue, for us to identify a recommended early addressment from NIOSH.

DR. ZIEMER: One way to do this would be to specify a date at which we would simply ask NIOSH to report on the status of these, what changes have been made.

MS. MUNN: Yeah. Yeah, that would be good.

DR. ZIEMER: And then you could determine your level of comfort with that. If they say well, actually we haven't made any changes and six months has -- and I don't know when you would want that report.

MR. GRIFFON: Right.

DR. ZIEMER: I suspect it may be a little early to ask for that for the next meeting since on even the medium and low priority things we're not really wanting them to spend a lot of time on those till we get our high priority stuff out of the way, but would you want to -- and we can -- we can do this at the end, if you wish. But would you want them, for example, to report back in a certain number of months on the status of what they've done on these? It could be that we've made the following changes, or we didn't do anything, or whatever it is, and then --

MR. GRIFFON: Right, I think that's a good idea. Let's get a status report and maybe think about the time when we get -- let's get through the matrix, then --

DR. ZIEMER: After we're through this, then we'll -- we'll do that, so have that in the back of your mind.

MR. GRIFFON: Right.

DR. WADE: Right now I'll (unintelligible) in the meeting after the January meeting and we can talk about it.

MS. MUNN: Yeah.

DR. ZIEMER: Right.

MR. GRIFFON: Yeah. That seems...

DR. ZIEMER: I do want to ask, though, what are we asking be done when we say modify the procedure here? What are we asking that they be done? There's some literature values. Are we asking NIOSH to select a different threshold value, or what? What is being asked for? It's not clear to me.

MR. HINNEFELD: The note I recorded, which may or may not be the definitive word, but the note I recorded was that the question of a threshold for NTA film is sort of a -- it's not a clear-cut -- there's a threshold -- there's a particular threshold at which you can start to see the recoil and so the film be-- starts to become sensitive, but it is particularly sensitive to the energy of the neutron -- you know, your tracks per fluence -- until you get up to around one MeV. And so from this original cutoff, whether it's 400 keV, which is the lowest number in the table, or whatever number it is in there from that very lowest part where you can register a track up to about

one MeV, there is an energy dependence in terms of tracks per fluence. And so what we had -- what I thought we would do is we would insert language into the site profile to reflect that, that there is no -- you know, that there is no hard and fast lower cutoff. You start to see tracks at this energy. It's energy-dependent up through this energy and that --

MR. GRIFFON: Into the --

MR. HINNEFELD: -- and that you need to have some knowledge about particular spectra at the site and calibration procedures in order to interpret it if -- if we say, you know, something like that.

MR. GRIFFON: You said -- you said insert language into the site profile. You meant into the IG?

MR. HINNEFELD: I meant the IG. I meant into the IG, I'm sorry.

MR. GRIFFON: I agree with that, yeah.

DR. ZIEMER: So you're simply telling the dose reconstructor that here -- here are the values and -- and use them in connection with the spectral information to make a judgment on that.

MR. HINNEFELD: Right.
DR. ZIEMER: Okay. As long as we understand what it is they're changing.
MR. GRIFFON: Okay, number eight -- again, a medium priority, and it was because -- I think this is really dealing with neutron to photon ratio issues, and again, it's because it's come up at several sites and I think it's a issue that's ongoing at several sites, so...
DR. BEHLING: Actually this goes beyond the neutron to photon ratio. This actually involves reconstructing neutron dose from a source term. And --
MR. GRIFFON: Right.
DR. BEHLING: -- I think we discussed it and I think the answer was the following: If you're trying to reconstruct a neutron dose on -- on an individual who was around let's say a reactor, this methodology is virtually impossible. On the other hand, if you're dealing with a californium 252 source and you have some understanding of the moderation that may take place, a -- the approach that has been outlined by taking the neutron source -- the strength of the neutron source and so forth can

be used as a surrogate for dosimetry data, but it would be highly selective for the individual in terms of how you define his neutron dose based on the source term.

MR. GRIFFON: Right, right, so I guess the key language in NIOSH's response is better describe -- describe more achievable methods, right, and that's -- that's how they're going to modify their procedure.

DR. ZIEMER: And this would be an example -- now at the point at which NIOSH reported back and said we now have made a modification in this process or procedure, at that point the Board could say well, we'd like SC&A to review that, or we could say no, that's fine or something -- we could react in some way to it. 'Cause there could -- you could agree to make a change, but it might not be useful. Well, I -- I don't want to prejudge, I'm just -- this is theoretically, you understand. Okay. Wanda.

MS. MUNN: It would seem to me that as these changes are made, SC&A would automatically be advised of those changes. Right? So what --

DR. ZIEMER: Well, it's the Board that needs to be advised, and one of our options would be, as

part of the regular status report, is to report changes that have been made -- if you want to do it that way as opposed to at a specific time. I don't think we have to decide that at this moment, but that would be an option. You know, here -- here are changes made in our procedures since the last time we met. I -- did that not address what you --

MS. MUNN: No, I understand what you're saying. I'm just thinking that in simple terms of expediting all the processes that we can possibly think of, if NIOSH is going to issue a change in their procedure, minor or major, it seems to me that -- that it will become a public document -- right? -- and as such, would not our contractor see it at the same time we did?

DR. ZIEMER: Only -- well, they -- it would be available to them, but I don't think -- unless we task them to automatically review all changed procedures, I don't think they would --

MR. GRIFFON: That's what we're trying to avoid, not to have to review the next rev of something, you know, just to specifically have the action done on these items, yeah.

DR. ZIEMER: At some point we may elect to go back and -- and task --

MR. GRIFFON: Right.

DR. ZIEMER: -- the contractor, but we shouldn't automatically expect the contractor to have to review everything that NIOSH does, so --

MS. MUNN: No, I wasn't thinking of reviewing. I was thinking if they had it --

DR. ZIEMER: They certainly -- it would certainly be available to them, as it is to everybody, and they would be aware of it. And in fact, and would end up using it as they reviewed dose reconstructions, perhaps, so -- okay.

MR. GRIFFON: Number nine -- number nine is a -- addresses the neutron to photon ratio, and also -- the reason I put a recommended action as described in NIOSH response because it's kind of two parts to this. One was the neutron to photon ratio question, and the other was just deleting this general reference to the neutron doses being 20 percent. And -- and NIOSH has agreed to remove that language in -- 'cause -- in the generic document. And the

other part of that I think is also a medium priority, so I might want to clear that up.

DR. ZIEMER: Okay. Questions on that?

(No responses)

Okay, go ahead.

MR. GRIFFON: Number ten is the -- the question of the dose conversion factors that we've discussed at several meetings, and the reason I highlighted this -- it doesn't show up that well on the copy, but I -- I wasn't cl-- it seems to me that NIOSH agreed to investigate this further, but I don't know -- again, this is one where I don't know if there's a time line on this or -- it -- it's clearly not going to be a simple -- it doesn't seem like a simple switch, but I think it's a higher priority, so I -- I don't know what research further means and if NIOSH has any sense of how long this might take or Hans -- Hans wants to...

DR. BEHLING: I think you're -- you're slightly ahead of yourself because the issues I think you're about to address are in -- in issues 12 and 13.

MR. GRIFFON: Oh, 12 and 13, you're right.

DR. BEHLING: Number ten is really confined to

a single set of DCFs that involve the bone surface, and I think we talked about it and I agree with NIOSH. They looked at ICRP-74 and ICRP-4 (sic) acknowledges that the electron equilibrium where you go from surf-- from soft tissue into bone and you encounter high Z, a high atomic number value of 20 at bone, we're going from atomic number of 6 to 7 for soft tissue to 20, accelerates the electron equilibrium to a much higher dose. And if you look at, for instance, in -- in EPA guidance document 11 and look for bone dose, you will see that it's represented there. But ICRP-74 does not, so they're correct in saying that if we adhere to ICRP-74, the bone surface dose for low energy photons, which is driven by the photoelectric interaction, is not necessarily one that they acknowledge or is somehow or other diluted. And I concur because I'm familiar with ICRP-74. At the same time, other documents -- like the Federal Guidance Report 11 -- will in fact, if you look at those values, acknowledge the bone surface dose to two -- factors of two or three higher. And so for -- for special cases such as bone cancer,

that may make a significant difference. But again, it's an arbitrary decision here. (Unintelligible) go with ICRP or with other potential documents.

MR. GRIFFON: You're right, I -- I was -- I was thinking about 12 and 13, but I guess what threw me here on -- as to what to put for a Board action was the last statement, that says -- in NIOSH's response it says (reading) but might consider alternative values, with sufficient reason.

So I guess the question I had was do you -- do you currently have, based on what S-- based on our discussions with SC&A, do you have sufficient reason now or -- or, you know, what -- what -- where does this stand? Are you sticking with the ICRP values or...

MR. HINNEFELD: Well, we have a -- we have a prejudice toward ICRP values.

MR. GRIFFON: Right.

MR. HINNEFELD: You know, we tend to accept -- you know, accept those. I believe the ICRP description specific to bone surface where they talk -- there's an excerpt that I included in our initial responses. As I understand that

excerpt, it says that the -- they don't bother dealing with the transition from soft tissue to mineral bone at bone surface because they assign the dose to the bone, the mineral bone, as the dose to the bone surface, and that this is an overestimating approach.

Now that's the way I interpreted this excerpt out of ICRP-74 so that bone surface doesn't seem to be a -- you know, that since they consider the dose to bone surface the dose to mineral bone, which is the higher dose, and our dose correction factor for bone surface is quite a lot higher than soft tissue dose conversion factor in our own table from -- for that, so it seems to have been accounted for, is -- is what I think. But certainly this may require some additional discussion. We -- and you know, we can -- we can either do it e-mail and copy the Board, we can do it however. This may involve a little more understanding of each other's positions, I think, to resolve it -- to know if we're going to change something or not.

MR. GRIFFON: Okay, I guess --

DR. ZIEMER: I'm just thinking, it seems to me at a bone surface you're virtually always going

from a lower Z to a higher Z.

MR. HINNEFELD: Correct.

DR. ZIEMER: Are there any cases where that wouldn't be true?

MS. MUNN: I can't imagine.

DR. ZIEMER: Maybe -- maybe if you had an artificial knee or something it might be true, but -- but in fact if that's the case, electronic buildup is always going to give you a bigger value a little deeper into the bone than the surface. So if that's the value you use, you're overestimating bone surface values.

DR. BEHLING: No, I think it's the other way around. If you're going from a -- a -- at the interface --

UNIDENTIFIED: That would not (unintelligible) --

DR. BEHLING: -- obviously at that very --

DR. ZIEMER: Dose at the interface is going to be lower.

DR. BEHLING: At the very point of the interface, but within the range of osteoclasts which are the source for bone cancers, you would probably end up with a mean free path of a beta or electron that is relatively short,

but you would go to a very steep rise --

DR. ZIEMER: Well --

DR. BEHLING: -- at the interface.

DR. ZIEMER: -- let me ask then, what is ICRP-74 using? Are they using the peak of the equilibrium point?

DR. BEHLING: I think they use a volumetric dose. In other words, they say what is the average (unintelligible) --

DR. ZIEMER: (Unintelligible)

DR. BEHLING: -- (unintelligible) mean dose --

DR. ZIEMER: Okay.

DR. BEHLING: -- and you -- and you realize that -- I think in my write-up I actually took a figure that comes out of Hine and Brownell that identifies the -- the conversion of dose to -- to absorbed -- of -- of -- the absorbed dose as a function of tissue depths, and there's a steep spike at the point of the interface.

DR. ZIEMER: Right, right.

DR. BEHLING: And so if, for instance, you were to take a film badge or a TLD that measures an HP-10 dose, that's really a dose that you'd expect to see at a depth of one centimeter in

soft tissue. And of course as the equilibrium -- electron equilibrium is established in mineralized bone based on the high Z value of mineralized bone, you end up with a significantly higher dose than actually the -- the air dose at the entry. In other words, if you have even a shallow dose, an air dose entry level -- kerma dose -- and look at the bone -- mineralized bone dose, you -- you will actually see the dose, even though there's some attenuation that has taken place. But based on the Z value of bone for low energy photons, you would actually see a higher absorbed dose. Again --

DR. ZIEMER: I think we -- we may have to get some debate on this. I don't think an HP-10 dose is necessarily at ten. Usually it's not. I believe it's the highest value between the skin -- what's -- what do we use for skin now, is it --

DR. BEHLING: A shallow dose, a zero -- it's a seven milligrams --

DR. ZIEMER: Okay, from seven milligrams to ten, the HP-10 dose is the highest value in between there, is it not? And it's assigned.

No?

DR. BEHLING: I was under the impression it's 1,000 milligrams per centimeter squared, which in soft tissue is (unintelligible) --

UNIDENTIFIED: (Off microphone) (Unintelligible)

DR. ZIEMER: The actual value at -- at ten?

DR. BEHLING: Yes.

MR. GRIFFON: That's what I (unintelligible).

UNIDENTIFIED: (Off microphone) (Unintelligible)

MR. GRIFFON: Yeah.

DR. ZIEMER: Okay. I guess I want to look at those definitions again.

MR. GRIFFON: Yeah.

DR. BEHLING: It may be a moot issue, but it's one that I brought up and it is brought up also, as I said, in Federal Guidance Report 11. If you look at the dose conversion factors as a function of photon energy, you will see a big spike that occurs at the surface, and then of course it goes exponentially down based on attenuation. But the transition between soft and mineral bone is a very steep rise and the actual dose at the interface can be a factor of

two or three times higher than actually as the entry dose.

DR. ZIEMER: Oh, I -- sure, we're --

DR. BEHLING: And it would affect bone cancers, that's -- that's my point.

MR. GRIFFON: So I -- I think maybe my Board action was correct in the first place. We -- we should leave it as more research is needed on this and -- you know.

DR. ZIEMER: Okay.

MR. GRIFFON: That refreshes my memory of the workgroup discussion, too.

DR. ROESSLER: Yes.

MR. GRIFFON: Okay.

DR. ZIEMER: Yeah, I may be thinking of the absorbed dose or the dose equivalent index, which is the highest value between -- rather than the -- in ICRP-74 they're -- they're using the -- the depth -- or the H sub ten as the actual value at ten.

MR. GRIFFON: Yeah, I think they are, yeah. I'm not sure.

DR. ZIEMER: But I think the absorbed dose and dose equivalent indices where you take the dose equivalent sphere with a ten centimeter radius,

the value given for HP-10 index is the highest value in the sphere. It's not the value at the center. It makes a big difference. If not, I'm going to have to go back and give a lot of students credit for wrong answers. Okay.

MR. GRIFFON: Number 11, I think, again, this is an uncertainty question, and medium priority assigned.

DR. ZIEMER: Okay.

MR. GRIFFON: Then number 12 and 13 were the dose conversion factors -- the issue I was thinking of before, which I -- I put them as high priority because again and again there -- this question has come up on dose reconstruction reviews we've done and -- and it could have an effect on past DRs that have been done, although I'm not sure what assumptions were made in terms of geometry and things in -- in the past DRs that were done, but I thought it was a high -- high enough priority we -- we should resolve this issue 'cause it's going to come up in --

DR. ZIEMER: And (unintelligible) --

MR. GRIFFON: -- in most (unintelligible) --

DR. ZIEMER: -- what does high priority mean.

Is NIOSH -- is it NIOSH's position that indeed it's important to change these sort of right away?

MR. HINNEFELD: Yes, we -- we are engaged in the evaluation of the effect and our contractor's also doing their evaluation of the effect. We have some intermediate products, but nothing really ready to put our imprimatur on yet, so it's (unintelligible) --

DR. ZIEMER: So it's already underway?

MR. HINNEFELD: It is underway.

MR. GRIFFON: Right. Okay.

DR. BEHLING: And let me just make comment. I think interim fix is to use AP geometry, which is -- may not solve the entire problem, but surely is a step -- a far step in the right direction. And to date most of the audits that we've done and assuming that the represent the ones that have already been adjudicated, do in fact involve maximized doses where AP geometry is the rule of thumb for applying a DCF. So as far as I'm concerned, no harm has been done up to this point in time, even if it turns out the DCF need to be corrected.

DR. ZIEMER: Thank you.

MR. GRIFFON: Yeah, I just qualify that 'cause I wasn't sure that that's true -- true for all the cases that have been done, so -- the one's we've looked at, though, you're right. Okay. And number 14 falls into that same category, I think, with the high priority.

DR. ZIEMER: Okay.

MR. GRIFFON: This is one where I wasn't clear where we came down on this as far as whether we had consensus between SC&A and NIOSH, whether SC&A accepted NIOSH's response on this, and I just wanted to hear more before we decided on an action. That's why I have a question mark there, so maybe you can...

DR. BEHLING: I think this may require a dialogue between us and NIOSH because I'm not quite sure what has happened here. If you look at, for instance, the Savannah River Site TBD, they will tell you that in 1985 or thereabouts they converted a -- their -- their calibration methodology to include (unintelligible) phantom calibration. Now I'm not sure I know what necessary (sic) that means, especially when we talk about the older methodology of -- of film badge dosimetry. It's clear if I have let's

say a point source here and I put my TLD over here or my film badge here, that I'm going to get a certain response based on the source strength of my -- my calibration source. If -- under the same condition, let's assume I expose it for one solid minute, with or without a phantom, it's clear that my dosimeter's going to get a higher reading if I put a phantom behind it because you're now introducing back-scatter. And on the other hand, that's going to be recorded, so what you're dealing with here when you take a person's film badge is, in essence, a person who is -- who himself has served that purpose of a phantom and -- and whatever the -- the film blackening or the response of a TLD takes that already into consideration. And so I'm not sure I understand exactly what the 11 percent correction factor for pre-1985 is for -- for Savannah River or the three percent for the year 1986. And I guess it does require us to sit down and get some clarification.

In my write-up I had cited some information about the difference between a phantom and a not a phantom, and based on photon energy and

the dimensions of the phantom, you can get a back-scatter factor that at some instances can contribute 40 percent of the total dose. So with or without phantom can make a difference of 40 percent in your -- in your film dosimeter.

On the other hand, like I said, you do in fact have a dosimeter that is worn which takes that into consideration. And I'm very uncertain at this point what the 11 percent as cited in the Savannah River Site TBD actually accounts for, and it does I think require a dialogue between us and NIOSH.

MR. GRIFFON: Yeah, agreed.

MR. HINNEFELD: I don't have anything to offer. I just agree that we'll share -- there's a number of things that went into that 12 percent reduction. It wasn't strictly the -- the back-scatter wasn't the only change that occurred, so we'll reconstruct that, so to speak.

MR. GRIFFON: So I think I should change that from no action to further discussion necessary.

UNIDENTIFIED: (Off microphone) Yeah.

MR. HINNEFELD: Now this -- this is for Savannah River specific question that's been

araised -- has been raised. The -- we believe that the discussion in IG 1 --

MR. GRIFFON: Okay.

MR. HINNEFELD: -- doesn't necessarily need action or -- or change.

MR. GRIFFON: Maybe that -- that -- maybe that was my confusion.

MR. HINNEFELD: That's probably what happened.

MR. GRIFFON: That's why I was -- I thought -- yeah. Okay. So as far as IG 1, no -- no change necessary there.

DR. ZIEMER: So the application for Savannah River is what's the question, but the procedure itself...

MR. GRIFFON: How -- how do we -- how do we capture this as a action to follow through with? I mean that's --

UNIDENTIFIED: (Off microphone) Medium.

MR. GRIFFON: No, no, no, but I mean it's a Savannah River-specific comment. If we're going to --

DR. NETON: This comment is addressed or covered in the Savannah River site profile review --

MR. GRIFFON: That's what I was going to say.

DR. NETON: -- as one of the issues. Matter of fact, there's a fairly detailed analysis of all Hans's diagrams --

MR. GRIFFON: Right.

DR. NETON: -- with and without phantoms and -- and that sort of thing, so --

MR. GRIFFON: I think -- I think --

DR. NETON: -- it would be resolved under that -- that pathway, I think.

MR. GRIFFON: I think that's agreeable to everybody, that we resolve that under Savannah River profile discussions. Right.

DR. ZIEMER: But in general, is there a back-scatter issue that has to show up in this procedure as far as the dose reconstructors are -- is there -- in -- in procedure 15, if a dose reconstructor's using this procedure, is there something they need to do specifically to make sure that back-scatter is accounted for?

MR. GRIFFON: Procedure? You mean IG 1?

DR. ZIEMER: In IG 1-15.

DR. BEHLING: Yeah, we're still talking about implementation guide 1. This is just item number 15, and --

UNIDENTIFIED: (Unintelligible)

UNIDENTIFIED: (Unintelligible)
DR. BEHLING: -- the implementation --
DR. ZIEMER: The implementation guide (unintelligible) --
DR. BEHLING: Yes, it doesn't really address back-scatter, and maybe it shouldn't.
DR. ZIEMER: Okay. That's what --
MR. GRIFFON: Okay. Yeah.
DR. ZIEMER: So no action is --
MR. GRIFFON: No action.
MS. MUNN: No action.
MR. GRIFFON: The next one, I think -- it's an uncertainty issue and I think it should probably be consistent with the other uncertainty issues, unless I'm mistaken, as a medium priority instead of a high. I listed it as a high priority. I don't know if Stu and Hans agree with that.
DR. BEHLING: I think what happened in the implementation guide is that there's reference to environmental uncertainty, and there is -- somehow or other was a mix-up in terms of what that means. If you look at the NRC-89 document, they talk about uncertainty as being defined by -- laboratory uncertainty, that is

how you process the film, how do you manufacture the film. The radiologic uncertainty that includes among other things such as the angle of sensitivity. And lastly, environmental uncertainty, meaning high humidity, temperature and other factors -- physical factors that may somehow or other affect the performance and dose response of a dosimeter. In the implementation guide they somehow got things mixed up by identifying environmental uncertainty as meaning environmental dose, when you walk from Building A to B, and that was my concern here is that the concept of environmental dose was misrepresented in the implementation guide and I think it just needs to be deleted there.

MR. GRIFFON: Well, I think the -- I think the key here is that it -- it -- NIOSH's response, the second -- I mean the -- basically indicating that -- that it'll be revised, or reflect what's going on in the program, so no -- you know, there's no statement in here that therefore things are being miscalculated in the dose reconstructions. In fact, it was just a --

MR. HINNEFELD: Right, I'd captured this as a medium --

MR. GRIFFON: A medium (unintelligible) --

MR. HINNEFELD: -- (unintelligible).

MR. GRIFFON: That's why it's a medium, because it's not affecting any dose reconstructions. Right.

Again, the next item's also uncertainty and medium. Then we're on to Proc. 6, which we've heard the description of that, that it's -- very much extracts the information from IG 1, except for the attachments.

DR. ZIEMER: Okay.

Okay, we're ready for PR 3 then?

MR. GRIFFON: PR 3, and I guess there's -- one, two, three of these, and the -- the Board action -- I mean this -- the indication here was that it seems like NIOSH is going to cancel this procedure, but it was unclear to me, at least, listening in, where -- where the components of this or the key elements of this procedure were going to end up. That's why I said we should probably review the changes in replacement procedures or -- procedure or procedures.

MR. HINNEFELD: Well, I suspect they've already been reviewed. I suspect they're part of this body of procedures that have all been reviewed. This procedure's more than three years old.

MR. GRIFFON: Right.

MR. HINNEFELD: It was written very early on, and there's more specific guidance been delivered. But we can, as a matter of course -- during our cancellation one thing we want to make sure is there's nothing in there that's not proceduralized anywhere else --

MR. GRIFFON: Right.

MR. HINNEFELD: -- and then cancel it so it's not anywhere. So as part of that we'll make sure we find it where it's currently developed -- the better, more recent procedure --

MR. GRIFFON: Okay.

MR. HINNEFELD: -- and make sure everything's covered. We can point those out just as a matter of the (unintelligible) --

MR. GRIFFON: Yeah, I guess just to -- just to --

MR. HINNEFELD: -- (unintelligible).

MR. GRIFFON: -- be able to cross-walk these would be useful for us, I think. For each of

those findings I'd like to know where --
MR. HINNEFELD: Yeah.
MR. GRIFFON: -- those components were addressed, what procedures, you know.
MR. HINNEFELD: Okay.
MR. GRIFFON: That was the only thing.
DR. ZIEMER: Stu, while you're at the mike, are these replacement procedures likely to be in one-to-one correspondence, or are they captured in different ways in different procedures?
MR. HINNEFELD: They'll be different ways in different procedures, I suspect.
DR. ZIEMER: So the issue of having SCA review the replacement procedure sounds like a one-to-one -- here's that old one you're getting rid of, here's the new one. I think what you're going to hopefully tell us is that it's been replaced by this other one, which perhaps has already been reviewed or (unintelligible) --
MR. GRIFFON: That's why I -- that's why I put the slash-S, because procedure or procedures, if it's in a couple of different areas, he -- Stu could just tell me -- tell us where they are.
MR. HINNEFELD: I really believe they've

probably already been reviewed as part of this population of procedures (unintelligible) --

DR. ZIEMER: I'm really asking if we're developing a new task here as part of this.

MS. MUNN: Yeah.

DR. ZIEMER: I don't know if this --

MS. MUNN: It sounds like it.

MR. GRIFFON: Yeah, maybe we -- maybe we --

DR. ZIEMER: Well, maybe once we identify where they are, we can decide whether review (unintelligible) --

MR. GRIFFON: Maybe we can just say NIOSH identify where changes are, you know. That would be an action.

DR. ZIEMER: How about the action recommend canceling procedure and identifying where its replacement appears, or something like that.

MR. HINNEFELD: Okay.

DR. ZIEMER: Would that --

MR. GRIFFON: I guess so. My -- my concern was that if it -- I mean if all those have already been reviewed, that's one thing. But if it's in newly-developed procedures, then you know, do we still have the sa-- I mean we don't know if we have the same issue that was in the

finding, you know, if --

DR. ZIEMER: Right, but --

MR. GRIFFON: -- so (unintelligible) --

DR. ZIEMER: -- (unintelligible) identify where they are, then we can decide, I think, whether --

MR. GRIFFON: And then review as necessary, I guess, is -- is -- you know, have SC&A review as necessary. Because if they've already reviewed it, we're not going to do it again. Right?

DR. ZIEMER: Right.

DR. BEHLING: I guess to answer your question, my recollection of procedure number three is that it was an old procedure and I think just about everything that it contains has been replaced in other procedures, including the implementation guide, Procedure 6 and TIBs, so if -- if -- if I'm -- unless I'm mistaken, I don't believe there's a need for rewriting this procedure. It has just been assimilated into other existing procedures which are procedures which we already have looked at and -- and --

MR. GRIFFON: That was the --

DR. BEHLING: -- and audited. So my feeling is

that nothing needs to be done other than to cancel the procedure.

MR. GRIFFON: Well, that -- that's the question, Hans. If we're sure -- I think we can just say, you know, canceling the procedure and then recommend NIOSH indicate where the changes are located, period. And if Hans is confident that all those have already been reviewed, then we don't -- we're not going to review something we've already looked at. Okay.

DR. ZIEMER: So it would read recommend canceling procedure; NIOSH indicated -- indicate where --

MR. GRIFFON: Changes are located.

DR. ZIEMER: Where changes or replacements appear.

MS. MUNN: Or replacement appears.

MR. GRIFFON: Right.

DR. ZIEMER: Thank you.

MR. GRIFFON: Okay.

DR. ZIEMER: And that's true of the next several here --

MR. GRIFFON: Right.

DR. ZIEMER: -- coming down.

MS. MUNN: All the way -- all the way to page six.

DR. ZIEMER: All the way through that whole section.

MS. MUNN: Uh-huh.

DR. ZIEMER: So that takes us up to --

MR. GRIFFON: That was a quick one, huh?

MS. MUNN: Yeah.

DR. ZIEMER: -- up to --

MR. GRIFFON: Page 6 --

DR. ZIEMER: -- (unintelligible) ten.

MR. GRIFFON: TIB 10, right.

DR. ZIEMER: Okay.

MR. GRIFFON: Now here -- here's where I might have -- I was trying to read my notes on these, and I -- I think there was a consistency issue here between a few procedures, TIB 10 and 8, and I'm not sure if that's true on this particular finding, but I think -- what I put on the recommendation was to check for consistency and modify as necessary, but I might have -- that might not be true for this first finding. I'll just ask Hans or Stu to clarify.

DR. BEHLING: Yeah, I -- I think if you look at

TIB 8 and 10, one's for film dosimeters, others for -- the other one is for TLD --

MR. GRIFFON: Right.

DR. BEHLING: -- and there are a couple of tables in each of those TIBs that provide default values. And I think in both instances the default value, for instance, for missed photon dose, is to assume a monthly changeout or 12 cycles per year, which may not necessary be the desirable approach. There were obviously instances where perhaps the frequency is greater than 12, maybe up to 52 a year, or perhaps only on a quarterly basis, which means four. And I think perhaps the approach would be to say if the information's available that defines the number of cycles, be generous with your LOD -- in this case the default value of four -- defining missed dose is to use N times LOD instead of LOD divided by two, but leave the value of N open so that it can be anything that is reasonable. And it may be defined by a site profile that says during that year we changed out 52 times a year, or just quarterly, et cetera. The table on TIB 8 -- and it's a complex-wide document to be used for

overestimating. In some instances, if it turns out that the person was only monitored on a quarterly basis, you would certainly overestimate by using an N value of 12 when it should be four, or in some -- in the -- alternatively, you could underestimate it if it turns out the person was monitored on a weekly basis or in the very early years, so that -- that comment is strictly a reference to the -- this deterministic value of 12 as opposed to leave it as N and make a decision what that may be based on the time and the site-specific practice.

MR. GRIFFON: So I'm not sure that if that -- it's simply a consistency question on this one. I mean there is a consistency question between 8 and 10, but also, Hans, there -- there is a more substantive point there that -- that -- you know, instead of saying 12, should you just replace that with N cycles or whatever, and I don't know if NIOSH agreed with that suggested change or not.

MR. HINNEFELD: Well, I think the -- the intent of these was to be applied only in cases where the frequency was monthly or less frequent.

And so as an overestimating approach, to assign 12 missed dose -- 12 zeroes, regardless of whether it was all missed or not, assign 12 zeroes in the missed dose calculation, you're providing an overestimate of the missed dose since he's got -- he doesn't have any more than that, certainly. So -- now having said that, there's quite a lot to be clarified in both 8 and 10 that -- so there's some revision that has to be done to this. This specific issue I don't know -- from our standpoint, it's not particularly -- you know, I -- we don't really understand why it's necessary to do that. You know, we think that if you have an overestimating approach and you do an overestimate and you rec-- you get to a -- a dose reconstruction that you can use, that it's okay to have more than one overestimating approach, you know, for either --

MR. GRIFFON: Where does the question of -- of the weekly come up, the 52 --

MR. HINNEFELD: This shouldn't be used for a weekly exchange, so the idea was -- you know, there's a time frame on utilization of these.

MR. GRIFFON: Okay.

MR. HINNEFELD: They only go back to a certain date. And certainly these should not be used for a site where there's potential for a weekly exchange or even -- or any more frequently than a monthly.

DR. ZIEMER: Well, that actually appears to be the issue, that maybe -- maybe we're only talking about clarifying that this procedure is only applicable to 12-month or -- or --

UNIDENTIFIED: (Off microphone) Less.

DR. ZIEMER: -- less frequency exchange.

MR. HINNEFELD: Right.

DR. ZIEMER: Then -- then it always is an overestimate.

MR. HINNEFELD: As I said, there's a lot of clarification that's required to 8 and 10 because of the -- the other things that are listed yet to come, and so we can -- we can take a shot at -- see if we can come up with something more clear there.

MR. GRIFFON: Okay.

DR. BEHLING: And I do want to make a comment here. For those people who are looking to use that, there are some conditional aspects to the use of these TIBs, and -- and they do def--

they do define a time frame, which is not oftentimes abided by. I think the -- the film dosimeter says only after 1970, I believe, and yet people use it throughout. And -- and I do have one case where in fact this complex-wide overestimating approach was used way back in time when in fact the person was monitored -- and I have records of that -- 52 times in a year. And so obviously I'm not saying this is the fault of the -- the procedure, but it was not followed by the dose reconstructor in saying you should not use it during a certain time frame when this procedure's not applicable. But we have already found a couple of cases where in fact it was used during time periods that are not prescribed for this procedure.

MR. GRIFFON: What I -- what I would offer as -- as modifying this -- this Board action is recommend procedure be checked for consistency with TIB 8 and language clarified regarding when this is -- when this procedure is applicable -- when this TIB is applicable.

DR. ZIEMER: Uh-huh. Okay. Okay, proceed.

MR. GRIFFON: The next one really -- I think

that TIB needs to be modified as described in the NIOSH response.

DR. ZIEMER: Is this -- what priority is this?

MR. GRIFFON: I don't know. Let's see --

MS. MUNN: Uncertainty.

MR. GRIFFON: Yeah, I think it's probably a medium, in my opinion, 'cause --

MR. HINNEFELD: I recorded --

MR. GRIFFON: -- it's probably being done in the ord-- yeah.

MR. HINNEFELD: I recorded it as a medium.

MR. GRIFFON: Yeah.

MR. HINNEFELD: I had recorded it as a medium.

MR. GRIFFON: Okay.

DR. ZIEMER: Okay. Thank you.

MR. GRIFFON: Glad we agreed on that. All right.

This is a -- has too much background information, should be modified, low priority certainly on this kind of thing.

Yeah, the next one is the same, low priority.

DR. ZIEMER: Uh-huh.

MR. GRIFFON: Where are we here?

DR. ZIEMER: Okay, we're at TIB 10-05.

MR. GRIFFON: Yes. I initially put recommend

change as described in NIOSH response, and then my parenthetical is just my own question, which was that I thought the IG 1 -- they're saying current plan is to include it in early revision of -- of OCAS IG 1, but I thought that primarily included examples, not necessarily specific guidance. And this seemed to me to be specific guidance, so --

MR. HINNEFELD: Well, it's -- it's sort of general instruction. IG 1 is -- you know, these are the general rules you follow, and it would seem like there would be a general rule for treating a recorded dose that's less than what we believe to be the detectable amount. So it could go there or there's probably other places it could go, too. I mean that was just, you know, what came to mind, that if you have a guidance document that guides -- supposed to guide all dose reconstruction, the policy for how to deal with a recorded number that's less than what you believe the limit of detection to be is a universal policy, and so that was the thought for -- but --

MR. GRIFFON: I -- no, I accept that. I -- I misread that. I was looking at the

parenthetical with the 40 millirems, but that -- that was just your -- i.e., you said there, and I was thinking you were going to give specific -- yeah -- LO -- LODs, but you -- you're saying that --

MR. HINNEFELD: No, generally the policy for what to do with a recorded dose that's less than what you believe the limit of detection (unintelligible).

MR. GRIFFON: Yeah, so strike my parenthetical there and just recommend using the NIOSH response.

DR. ZIEMER: Priority?

MR. GRIFFON: Probably a low priority, I believe, 'cause it's not affecting any dose reconstructions.

DR. ZIEMER: Okay.

MR. GRIFFON: This is the same, recommend the change described in NIOSH response, and it's applicable to both TIB 10 and TIB 8, as they noted in their response.

DR. ZIEMER: Priority?

MR. GRIFFON: Medium.

DR. ZIEMER: Okay.

MR. GRIFFON: Here's -- this is just a

consistency question between Proc. 6 and TIB 10. I'm asking to recommend -- or review for consistency and make changes where applicable. Priority -- I know you're going to ask me -- I would say medium again.

I'm assuming if -- if Stu or Hans disagree, you'll step in.

DR. ZIEMER: Okay. Stu?

MR. HINNEFELD: Well, I just want to comment just briefly here that --

MR. GRIFFON: Yeah.

MR. HINNEFELD: -- I don't necessarily disagree with making this -- you know, but there may be -- may be the case that it would be okay to have more than one overestimating approach, you know, that may-- and I don't know when that would occur. I'm saying if you have an overestimating approach and it's -- you apply it, and you just go ahead and apply it. Why have more than one? But we don't know that it's particularly a conflict to have two different approaches that provide an overestimate, as long as you're confident that it's an overestimating approach. So while I'm -- I don't know that -- I can't think of any

situation where it would be a particular advantage to do -- to have two available to you, I do want to see what kind of perturbation -- since they're out there now --

MR. GRIFFON: Right.

MR. HINNEFELD: -- and they're available now, I would like to see what perturbation that causes to say choose one that is going to the overestimating technique and we will use that. See, I just don't know what perturbation that causes in what we're doing now. So with that caveat, I'd say yeah, I agree with how you categorized it, with the idea that we may find that doing that causes significant work that we had not planned on doing or makes some things harder. I just don't foresee what that is, but it's possible.

MR. GRIFFON: Okay. I don't -- I don't think that changes our --

DR. ZIEMER: No, the changes as needed gives you a bit of flexibility.

MR. GRIFFON: Right. That was intended, though.

DR. ZIEMER: Okay.

MR. GRIFFON: I think we're on number TIB 10-8.

DR. ZIEMER: 08.
MR. GRIFFON: Yeah. And it's the same -- same Board action recommended.
DR. ZIEMER: And medium priority?
MR. GRIFFON: Yeah. Actually, I'm not -- I'm not -- that might be a low priority, but if they're changing -- if they're looking at those, they'll probably do it all at the same time, but --
DR. ZIEMER: Uh-huh.
MR. GRIFFON: -- they could do that either way. Maybe that's a medium, I guess.
DR. ZIEMER: Okay, 09?
MR. GRIFFON: TIB 10-9, this is where we didn't quite -- I think we needed more discussion on this one between SC&A and NIOSH.
DR. BEHLING: Well, I -- I kind of -- after having a discussion with Stu and Jim, I withdraw that comment, and I believe that their assessment's correct. I formulated my idea, as stated in the finding description, on the basis of a single event. In other words, for instance, if you look at the NRC study, they will show you that doubling the recorded dose is about the 95th percentile value, which is

not an -- unusual -- highly unusual. But it would be unusual if you have 12 dosimeter readings in a given year and each time you assume it's a 95th percentile value, and so I concur with their assessment and I think that comment should be withdrawn.

MR. GRIFFON: Okay, so no action on that one.

MS. MUNN: Good, I like those.

MR. GRIFFON: If everybody accepts that, yeah.

DR. ZIEMER: Thank you.

MR. GRIFFON: TIB 10-10, I need a little help here. I'm not sure where -- if we resolved this or not.

DR. BEHLING: In TIB 10 it says this is a default value, LOD of 40 millirem. On the other hand, and I think I'm correct, in many of the TBDs if you look at the early years, 40 millirem is in fact the recommended LOD. So I don't know if that requires any -- any change or -- or the comments here are correct that 40 millirem for at least the early years is not an unusual or a highly conservative LOD value. It is in fact an LOD value that in many of the TBDs is cited as such.

MR. GRIFFON: And this says -- their response

is for post-'70. Is that... You were talking about the early years.

MR. HINNEFELD: Well, this goes back to the applicability of 10-10 and whether it's being used within its range of applicability. It's --

MR. GRIFFON: Right.

MR. HINNEFELD: -- only supposed to go back to about that time.

MR. GRIFFON: Right.

MR. HINNEFELD: So that's what the response is based on. My notes from the 6th -- meeting on the 6th was that we were to evaluate the information that's presented in that NRC NAS report that's referred to a couple -- on a couple of other responses. There's an Appendix 3, according to my notes, that describes what might be a more favorable -- favorable LOD or -- you know, not necessarily a realistic one, but one that's somewhat favorable. And so that was my note.

Now we've not done that since the 6th, but that's what I recorded. So this would be like an additional research and decide what to do or something like that.

MR. GRIFFON: Hans, is that...
DR. BEHLING: (Off microphone) (Unintelligible)
MR. GRIFFON: Okay. Additional research. I didn't have that NRC report cited for that finding, but you had that?
DR. BEHLING: (Off microphone) (Unintelligible)
MR. GRIFFON: Okay. I won't dispute it.
MR. HINNEFELD: I wrote -- it's in my handwritten notes from the 6th, so that's my word -- only place (unintelligible) --
MR. GRIFFON: So additional discussion necessary, yeah.
MS. MUNN: Research and discussion.
MR. GRIFFON: We're on to TIB 8.
DR. ZIEMER: I'm sorry, what did we -- did we have a priority on that?
MR. GRIFFON: I don't know that we prioritized these discussion items. We might just cover that in our status reports, I think. It might -- I guess we can...
DR. ZIEMER: The action here then is additional research and discussion? Again, though, I mean --
MR. GRIFFON: I know.
DR. ZIEMER: -- is that in five years or is

that next week or -- how pressing is this issue as far as actual dose reconstructions are concern?

MR. HINNEFELD: Well, in our view, like in our response, this is a -- a value for LOD that is used in a maximizing -- maximizing number of zeroes approach, so we believe there is sufficient overestimating in the selection of more zeroes than were really there in order to be able to continue to use it. I mean that's -- that's our view of the situation where we are, that, you know, if you -- if it's -- for -- it -- maybe it -- a better number would be 50 or 60, but in every case --

DR. ZIEMER: It's not going to have much effect (unintelligible) --

MR. HINNEFELD: -- in every case we assign 12 zeroes, regardless of how many zeroes the person actually had in a year, we believe that we are still overestimating. I mean -- and so we don't believe there's a critical need to fix it before it's used.

DR. BEHLING: I agree with that, and perhaps this issue should be withdrawn, for the simple reason that it's really not -- the overestimate

is not governed by the LOD value but the fact that we're not dividing it by half. In TIB 10 and TIB 8, both procedures define a maximized approach that takes LOD times N. We do not divide it by two, so even if it's a -- maybe not a upper-bound value, the fact that we're not dividing it by two makes it a maximizing attempt to estimate exposure that's missed. So I think perhaps these -- that this issue should be dropped.

MR. GRIFFON: And the LOD values proposed in the NRC report are not that much higher than the 40, so it wouldn't -- right. So that's why I had the question marks in the beginning 'cause I thought (unintelligible) --

DR. ZIEMER: (Unintelligible) action then.

MS. MUNN: No action.

MR. GRIFFON: No action, right.

DR. ZIEMER: Okay. Okay, so we're up to -- now we're into TIB 8, right?

MR. GRIFFON: Yes.

MS. MUNN: Uh-huh.

DR. ZIEMER: TIB 8, Procedure 1.

MR. GRIFFON: Yeah, this one --

DR. ZIEMER: Or item one.

MR. GRIFFON: This one where -- I'm anticipating that Stu might disagree with me a little bit, but I put it as a medium priority only because it's come up in our dose reconstruction reviews very, very often that it's been misapplied.

DR. BEHLING: Yes, and --

MR. GRIFFON: And I thought that -- for that reason alone, it should be a medium priority.

DR. BEHLING: Eight and 10 are -- basically parallel each other. One's for film and one's for TLD, and they read almost identically except you read the word "TLD" instead of "film". And so the comments that we made in 10 apply to 8.

DR. ZIEMER: Right.

DR. BEHLING: And so I think we don't really have to spend a lot of time -- the difficulty we've had in our dose reconstruction audit is that people have essentially misinterpreted the intent of this document, and in specific a table that comes at the end of each. And I think Stu fully understands what the difficulties are for dose reconstructors in their interpretation. I think it's something

we can readily fix.

MR. GRIFFON: The only rea-- I don't disagree with you, Hans, that they're -- you know, TLD versus film, they're the same thing. But the findings, as I go down them, aren't the same. So we'll try to step through them quick, but I think we should go through them.

MR. HINNEFELD: Well, I did record a medium for this revision, and I think this is a -- you know, the revisions in 8 and 10 are parallel. I mean the same kinds of things need to be done in both, so if you'd like, you know, we -- we agree that this is a medium revision to clarify those two TIBs and just go through to the bottom of this -- this one without going through them one by one.

MR. GRIFFON: Okay, that's fine with me. I guess if everybody's happy with that, we can assume that the others on TIB 8 are medium priorities and we'll --

DR. ZIEMER: Well, your very next one shows up as low.

MR. GRIFFON: Low, I know, I just --

DR. ZIEMER: You're saying go ahead --

MR. GRIFFON: We're going to do the whole

thing, is what Stu's saying, I think, so...

DR. ZIEMER: The next one you don't have a priority, but you are suggesting we list that as medium?

MR. GRIFFON: Medium, right. Then we're down to the bottom of the page there, TIB 7.

DR. ZIEMER: The action here is to withdraw?

MR. GRIFFON: I believe so, in this -- Stu, you're saying withdraw this and all of it's going to be included in site-specific profile documents (unintelligible) --

MR. HINNEFELD: Well, that's our intent. This -- this is a procedure that's been out there for a while. It's complex-wide. It addresses an issue that's better addressed site by site. It was put out there as a way to deal with environmental dose -- you know, early on -- and so I suspect, you know, that's what we'll be able to do is -- so we just don't really need this anymore 'cause it's being dealt with site by site. So that's what I believe we'll be able to do.

MR. GRIFFON: Were -- were -- was this procedure used in the early dose reconstructions?

MR. HINNEFELD: Uh-huh.
MR. GRIFFON: Would it have affected past cases at all or -- or...
MR. HINNEFELD: Well, I mean it -- it could. There's -- theoretically we'll -- well, we will look at that and see if, you know, any of these sites, you know, that -- where we have site-specific information now are -- where the site information is actually more favorable that was used in TIB 7, we would have to look and see if that's the case. I -- I -- I'd have to just go look. I don't really know what the status is, but that would be part of it. It was used in some when -- you know, if you don't -- when you don't have a site profile yet you want to do the dose reconstruction, how are you going to deal with the environmental dose; this says well, here's a nice big number to use, use this. So this is kind of what it was.
MR. GRIFFON: Okay.
DR. ZIEMER: Okay.
MR. GRIFFON: I guess the -- the same recommendations carry through all the way for this TIB 7.
MS. MUNN: Yeah.

MR. GRIFFON: You know, the -- the only question I would have is how to -- I guess we'd deal with these on the site profile reviews. I don't know that we can track these findings through in any fashion to make sure (unintelligible) --

DR. ZIEMER: But as far as -- as far as it being an approved procedure, it's going to disappear, so --

MR. GRIFFON: It's disappearing, right, right.

DR. ZIEMER: So from a procedural point of view, that takes care of the item.

MR. GRIFFON: Right. I -- I guess I -- when I was writing this up I was thinking well, I hope the same errors aren't being repeated in the site profile guidance.

DR. ZIEMER: Right.

MR. GRIFFON: But I don't think that'd be the case.

DR. BEHLING: Well, I think -- and I may be speaking out of turn here and making a statement that perhaps is best made by -- by NIOSH, but this issue of (unintelligible) is a very difficult one. What you're talking about is potentially subtracting background dosimeter

data when in fact you don't even have that data. But one way to compensate that would be a very easy one. If you suspect that there were periods of time when dosimeters were used to measure background and then were subtracted from individually-assigned dosimeters, one could simply go back and say what does the ambient environmental dose look like and, as a default value, simply add that on as a claimant-favorable way of accommodating that, to just simply look at the years during which perhaps that practice prevailed. Look at the data that's already contained in the environmental on-site section of the TBD and simply add that back in there. That would be one quick way of fixing it and be very claimant-favorable on top of it.

MR. GRIFFON: That doesn't sound like what NIOSH is proposing. They're proposing to do it on a site profile basis rather than -- rather than establish a new procedure with general guidance, I think they're going to just wipe this one out and do it site by site. Is that correct, Stu?

MR. HINNEFELD: Well, that's our intent. Now

if -- if we change from that -- for instance, if there's a site without the site profile done yet, is there a way to deal -- you know, and this is our only way to deal with the ambient exposure -- the subtraction of ambient exposure from a measured dose on a badge, if they did that or not -- we may want to retain it. So that's why I'm saying I think that we would like to deal with it site by site, but I'd like to make sure what -- see what I -- what that does to us bef-- you know, before I just say well, we're going to cancel it and then find out that now we don't have a way to do environmental dose for, you know, a half-dozen sites where we would --

MR. GRIFFON: But that's --

MR. HINNEFELD: -- otherwise we can do dose reconstructions. So I guess my preference is to deal with it site by site, but if we need to retain it, we can get back with specific responses to the -- some of the issues here. I think --

MR. GRIFFON: I guess that's why I -- I didn't want to --

MR. HINNEFELD: Yeah.

MR. GRIFFON: -- you know, I just wanted to make sure we weren't going to lose these findings if in fact --

MR. HINNEFELD: Right.

MR. GRIFFON: -- you ended up using this for some sites where you don't have site profiles --

MR. HINNEFELD: Right.

MR. GRIFFON: -- or whatever, yeah.

MR. HINNEFELD: Right, we'll --

MR. GRIFFON: That was my concern.

MR. HINNEFELD: Okay, we'll come back specifically with these then if -- if in fact we have to retain this, we'll come back with some specific responses and a status report in the future. Is that acceptable?

MR. GRIFFON: Okay, we can -- yeah.

MS. MUNN: Yeah.

MR. GRIFFON: We can follow through on a status report with it.

TIB 6 -- I'm almost out of time, huh?

DR. ZIEMER: We're doing good.

MR. GRIFFON: Okay. This was more of a -- a -- the first one is kind of a stylistic thing, I think, and low priority.

DR. ZIEMER: Low priority, right.

MR. GRIFFON: And here I think -- I think qualifications were unnecessary. I think Stu agreed that some change in language for clarifying what the procedure was saying were -- were necessary, and then NIOSH will do this. I'm not sure of the priority on this. You have any sense...

DR. BEHLING: I -- I think maybe --

DR. ZIEMER: (Unintelligible) a wording issue again?

DR. BEHLING: Yeah, it's basically something that Stu and Jim had comment on. At this point most of the people have read it. They have waded through the up-front data. They know that the real stuff is in the back of the document. Whatever, you know, time has been spent in going through unnecessary data has already been invested and at this point people know that they have to go to Table 4- -- 4.1 and -- and look up the numbers and --

MR. GRIFFON: So it's probably a low priority --

DR. BEHLING: It's a low priority.

MR. GRIFFON: -- low priority, yeah.

DR. ZIEMER: Then you've got three cancellations coming.

MR. GRIFFON: Yeah, this is what confused me last time, too. This next one is OCAS TIB 6 as opposed to ORAU TIB 6, so it's OCAS TIB 6-001 is the finding.

DR. ROESSLER: Did you skip one?

MR. GRIFFON: Did I?

MS. MUNN: No, the two --

DR. ROESSLER: What happened with --

MS. MUNN: The two were the same, number one and number two.

DR. ROESSLER: Number one and number two were both the same?

MS. MUNN: Well, I mean the action is --

MR. GRIFFON: The action is both low priority --

MS. MUNN: Recommend --

MR. GRIFFON: -- make the changes, low priority.

So OCAS TIB 6, finding TIB 6-1. This is a Savannah River-specific TIB. Is that correct? Yeah. And I think they're deferred to the site profile -- making the changes in the TBD.

MS. MUNN: Uh-huh.

MR. GRIFFON: I don't -- I don't -- anyone has any problems with that?

DR. ZIEMER: Stu --

MS. MUNN: No.

DR. ZIEMER: -- comment?

MR. HINNEFELD: Well, I think the findings are that there's -- the instructions aren't particularly clear in -- in the TIB. I mean exactly what am I supposed to do as a dose reconstructor? There's a lot of -- sort of up in the air, it's not clear. So we need to decide clearly what people should do, and then whether we cancel TIB 6 or put it in the site profile, which may be a better -- is better suited to be in the site profile. But certainly there's a clarification of this. It's information that needs to be provided, either in a revised TIB 6 or in the site profile.

MR. GRIFFON: And I guess the -- the same would apply for the last one you discussed, which was --

MR. HINNEFELD: Yeah.

MR. GRIFFON: -- give us a status report, you know, if -- if TIB 6 is going to remain, then

we need specific ways that it's going to be modified.

MR. HINNEFELD: Okay.

DR. ZIEMER: Is now our recommendation then clarify or cancel?

MR. HINNEFELD: Sure.

MR. GRIFFON: Clarify or cancel?

MR. HINNEFELD: Is that okay?

MR. GRIFFON: Okay.

MR. HINNEFELD: Yep.

MR. GRIFFON: And that carries through for all three items, I believe.

DR. ZIEMER: Uh-huh. Okay.

MR. GRIFFON: And the last but not least --

MS. MUNN: What priority?

MR. GRIFFON: Oh, what priority?

MS. MUNN: Well, if we're being concerned with SRS now, it seems to me it's fairly high.

MR. GRIFFON: Yeah, medium to high, I would say -- I think leaning toward high since we don't want things up in the air with the site profile and a TIB at the same time, so I would lean toward having this a high priority.

DR. ZIEMER: Okay.

MR. GRIFFON: And I think in the next -- TIB 7,

NIOSH has agreed to -- that they'll revise and clarify it. Again, this is Savannah River, so I think it probably should be a high priority.

MS. MUNN: Uh-huh.

MR. GRIFFON: Now Stu, on this one you're saying revise and clarify, but not roll into the site profile. Did I get that correct?

MR. HINNEFELD: Well, that's -- that's how we prepared it. I think, again, we would want to have the flexibility to decide that should -- should it be in the site profile and it could be -- maybe it should be there so we can get all this instruction in one place rather than having it in others, but --

DR. ZIEMER: So (unintelligible) would revise it --

MR. HINNEFELD: There is some clarification that's required --

DR. ZIEMER: Yeah.

MR. HINNEFELD: -- in the instruction that's given.

DR. ZIEMER: Right.

MR. GRIFFON: So I'll make the find-- the Board action the same as the above ones there, recommend NIOSH clarify or cancel, and make

changes in site TBD as necessary, you know.

MR. HINNEFELD: Fine, that's -- that's good by me.

MR. GRIFFON: Okay. And that's -- that's it, 'cause the remaining findings are the internal and I think the CATI interview procedures. The only thing I would ask is at some point we have to decide when we're going to address these, probably at a workgroup level, but --

DR. WADE: I think tomorrow on the agenda we have an hour to set scheduling issues. We'll have to set some schedules for the internal and CATI reviews.

DR. ZIEMER: Now if you would like at this point, we could entertain a motion to accept these actions, as we've gone through them individually. We can --

MR. ESPINOSA: So moved.

DR. ZIEMER: -- act on them as a group. Motion to do so. Second?

MR. OWENS: Second.

DR. ZIEMER: Second. Any discussion or further clarification needed?

THE COURT REPORTER: Who made the motion?

DR. ZIEMER: Yes -- yes, Roy?

DR. DEHART: I would --
DR. ZIEMER: I'm sorry --
DR. WADE: Richard.
DR. ZIEMER: -- Rich made the motion. I believe Leon seconded. Roy DeHart, comment?
DR. DEHART: Yes, I would like to suggest perhaps adding to the motion that this topic be an open item on the agenda, ongoing -- in the quarterly meetings specifically. That would mean that --
DR. ZIEMER: And to ask --
DR. DEHART: -- every three months we -- any changes, modifications, et cetera be addressed in that --
MR. GRIFFON: In a status report, yeah.
MS. MUNN: That's one way to do it.
DR. ZIEMER: So we would simply ask that NIOSH include in their regular reporting the status of any changes on the matrix --
DR. WADE: And I'll put it on --
DR. ZIEMER: -- as an update.
DR. DEHART: Yes.
DR. ZIEMER: Is that considered a friendly amendment?
MS. MUNN: Yes.

DR. ZIEMER: Leon -- okay. So the motion is to accept these Board changes as we've gone through them individually, and to request that NIOSH give us a regular update on the progress of the procedural changes as they occur.

All in favor, say aye?

(Affirmative responses)

Any opposed, say no?

(No responses)

And any abstentions?

(No responses)

The motion carries. Thank you very much.

SC&A CONTRACT TASK IV UPDATED PROPOSAL

DR. LEW WADE, EXECUTIVE SECRETARY

We -- we are to have a phone call from David. Right? Is --

DR. WADE: David, are you on?

MR. STAUDT: (By telephone) Yes, I am.

DR. ZIEMER: Oh, David, okay, you're on the line, good.

DR. WADE: Welcome.

DR. ZIEMER: We're ready for the item on SC&A contract Task IV, the updated proposal. Let me make sure that everybody has the -- the right paperwork.

DR. WADE: Yeah, I didn't -- I don't think it's

in the book.

DR. ZIEMER: No, it's not -- it's not in the book.

DR. WADE: It was e-mailed to you a week or so ago and it was on your place earlier today.

DR. ZIEMER: There's a -- there's a letter from SC&A dated September 16th. Is that the correct date? Yes.

MS. MUNN: Uh-huh.

DR. WADE: Yes.

DR. ZIEMER: Which has the proposed work, which includes basic reviews for 40 cases, advanced reviews for 20 cases, blind dose reconstructions for two cases; delivery -- preparation and delivery of a report for each set of Board-assigned cases; participation in expanded review cycle; and final audit report reflects the findings of the resolution process, et cetera. Does everybody have that document?

DR. WADE: No, if I can talk about that --

MR. GRIFFON: Okay.

DR. WADE: -- by way of introduction?

DR. ZIEMER: Yeah, there is -- there is -- there was sent to the Board a separate cost

sheet.

MS. MUNN: Yes.

DR. WADE: Let me explain --

MR. GIBSON: (Off microphone) It's in the back of this (unintelligible), too.

DR. WADE: But it's public information. That cost sheet is public information. It doesn't include the labor, and so let me sort of explain.

If you recall, at the last meeting SC&A brought proposals for the continuation into this current year of all tasks. You voted to approve and give the contracting officer the go-ahead on all of those tasks except for Task IV. There was some confusion as to SC&A not rigidly adhering to the basic and advanced reviews, and you asked SC&A to come back with a proposal that was more consistent with the way they carried out the task in previous years, and they have done that.

What I have done is I've talked to the contracting officer and, in order to keep these meetings opened, I asked if there was a way we could prepare these packages that would allow for open discussion. And he agreed to pursue

that and the package you have now can be involved in open discussion.

The business confidential information, which is really the labor rate information, you have in your possession. It was what SC&A used in their last proposals. It's just been expunged from this. So you see hours here. You'd have to --

DR. ZIEMER: But not the rate.

DR. WADE: -- do the multiplication with rates to get to the total cost, which is also shown here. I would ask your indulgence in this. I think it's best for us to conduct our business in the open, and I think if this is suitable we would pursue this, you know, in the future.

You will have all of the information privately available to you, but what we give out and discuss in public I think would best be this kind of information.

I did this because in no discussion with the contractor did we ever discuss the business confidential information, and yet we made the nice public go outside. And I don't think that serves the transparency of what we're trying to do.

So you've got a full proposal. John Mauro is prepared to walk you through how he has followed your instructions to the T. What I would like is a vote at the end of this giving the contracting officer the go-ahead to make this real in terms of starting on their Task IV work this fiscal year.

DR. ZIEMER: And before John addresses us, David, do you have any preliminary comments or instructions for us, as well?

MR. STAUDT: No, I think Dr. Wade covered those.

DR. ZIEMER: Then we can proceed, and we'll ask John Mauro to come then and summarize the proposal and make any appropriate comments. John?

DR. MAURO: Well, this proposal of work is virtually identical to our original proposal of work for the first set of 62, except now it includes a little bit more descriptive material related to the case tracking and closeout process. That is, as you know, over the past year working closely with Mark we have come up with checklists, scorecard, closeout process, which has brought us to the point where now not

only do we deliver reports -- audit reports for each of these cases as you have been seeing them, these very thick reports that you've all been seeing, but they also contain in the front for each case a scorecard. And then it also includes a roll-up of those scorecards, so it becomes like a -- a continually-tracking system, all of which is very highly -- very rigorous. That is, every -- the numbering system used in each audit report tracks back to the checklist, which tracks back to the -- the tracking system, so it becomes something that's very, very traceable as to where the -- you know, where does each issue lie, what category it lies in, and also we're being -- we're in a position now to sort on -- in a very -- in any way you would like. That is, effectively, whether we run -- we could run all this in -- through our access database, so the day will come when we will anticipate that the Board may -- may like us to prepare various reports that sort of summarize where we are and our findings, cutting across by cancer type, cutting across facility or any one of the other fields that are currently in the checklist. So

where -- all of that now is sort of behind us as a result of year number -- the first year of work.

So that's -- so now, in effect, we have a very mature process. And we basically have proposed to continue that process exactly the way we did it before, of course be-- but being a little bit -- in a better position to provide you with summary level information.

We have made the modification in here that, as the previous one, we're assuming that there will be advanced reviews, that the Board will identify those cases to us that you would have us do an advanced review -- so that's the difference between the previous version of this proposal that you had earlier and this version.

We also have included -- another change beside including that, along with this budget, we also made certain assumptions regarding how much other direct costs we may encounter in doing an advanced review. We assumed some fraction of those 20 cases that would be advanced reviews would actually require a bit of travel, interviewing people, and we made certain assumptions, all of which are delineated in the

cost proposal.
So I guess it's -- it's -- it's just continuing to do what we've done before. We will continue to hold those special conference calls, as you know, between -- we've been (unintelligible) Kathy and Hans and individual members to go over your cases. It's all part of the process. So this whole write-up really memorializes the -- the process we have been using and -- and have grown into over the past year. And I think that -- I was hoping to capture it to everyone's satisfaction. I believe it does. Certainly if there's anything I may have missed or anything that requires clarification, I'd be happy to make the necessary changes.
By the way of cost, in effect what we've done is we have now the -- a lot of things have hap- - transpired. The -- the original -- the costs themselves of -- per case, so to speak, has -- there are things that have happened where we've gained a lot of experience. We've done a lot of -- for example, all of these checklists. All that's -- we don't have to do that again, so we're going to save some money there. Also we're a lot better at doing it, so we're

probably a lot more efficient. But we -- so those are things that are going to help reduce the number of work hours per case.
By the way, we act-- our actuals from last year turned out to be about 100 work hours per case. Okay? Now -- to do the full -- full-blown audit, right to the end audit, you know, after the whole cycle's over. We -- now -- but we -- first reaction is well, that's going to come down. Okay? So there -- because of the efficiencies of having all this experience behind us, having these checklists in place. However, conversely, as you know, we are -- we are, in theory, going to move into realistic cases. Which means doing a lot more -- in other words, the min/max -- the amount of min/max that we're going to be doing, which can be done relatively quickly, we're going to be shifting into ex-- seeing cases that are going to be what we call more realistic cases where we actually have to go into the de-- do detailed IMBA runs to check the numbers, for example, as opposed to simply running calculations. So that part is going to result in some increase in cost. So what hap-- and --

and then of course there is this additional cost that we've included in here for doing advanced reviews, which would include perhaps some travel and some -- so the bottom line is that instead of 100 work hours per case, effectively we're coming down to about 88 work hours per case. And that's how this -- this story ends, so to speak. The cost -- the other direct costs associated with every-- everything that goes with putting these reports out.

DR. ZIEMER: Thank you very much, John, and you do indeed have -- you've memorialized in a way the six-step process, so it's -- it's here in black and white so everybody can see it, and it's a process that really developed over time as we got -- gained experience.

Now let's open the floor for questions or comments the Board members have on -- again, this is Task IV for the year ahead. Wanda Munn.

MS. MUNN: I just have a comment, no question. I want to thank John and his team for those enormous volumes that he sends me, even though I -- I cringe when I open them. They are -- they are indeed presented in a very helpful

manner. And it's been much, much simpler to be able to identify, in my mind, what we've done and what the findings have been because they were so well presented. Thank you.

DR. ZIEMER: Thank you. Other comments?

DR. WADE: I might have two, if I might. I mean John mentioned that in his costing he built in the -- a likelihood that he'll be looking at more best-estimate dose reconstructions. That -- that's partially controlled by the Board as we go through and do our assignments, so I would ask that you keep that in mind. I think that's important.

I also think at some point -- not at this meeting -- but I'd like to get it on the record that it would be worth also collectively looking and making an evaluation as to what good has come of the first year of individual dose reconstruction reviews. We've spent a lot of the taxpayers' money. I think it's incumbent upon us to say in retrospect, at some point, has it been worth the trip. And I would ask you to consider that as you -- as you do follow-up on -- on this task.

DR. ZIEMER: Indeed it might be a value to have

a summary report even to the Secretary to kind of summarize the experience after we finish a certain number of those.

DR. WADE: Right, we're not quite there yet, but we're getting --

DR. ZIEMER: John.

DR. MAURO: Yes, within the scope of this work is to prepare such reports, as requested by the Board, in any form that you would like. We're in a posi-- because we put the system into a database management form, that's relatively easy to do, and sort on any of the fields that you folks have created.

DR. ZIEMER: Right. Thank you. Other comments or questions?

DR. ROESSLER: I have a question.

DR. ZIEMER: Yes, Gen.

DR. ROESSLER: Perhaps I'm not up to date, but very early on we talked about whether our contractor would be able to interact directly with claimants, and apparently that is a part of this advanced dose reconstruction review. And I notice it said in here if the claimant or representative is -- is willing -- so apparently we've gotten past that point and

this is now a part of what they are going to be able to do?

DR. ZIEMER: Well, the mechanics of doing that and the -- whatever legal issues are involved, I -- I think probably have to be addressed on an individual basis. But maybe -- I don't know if staff can help us on that or not -- or general counsel. This -- I think in -- in the -- the proposal they are allowing for time to do that. I don't think this guarantees that they actually can do that, unless so instructed and if certain -- whatever legal hurdles may be there, but I -- as I understand it, you're at least allowing for that possibility in terms of estimating time and cost to your staff. Is that not correct?

DR. MAURO: That's correct. The way we've worded it is we've -- we've included some budget, delineated how much budget, both out of pockets and work hours, in our cost -- report. How-- also we also point out that any travel, any meetings with --whether it's folks from DOE, whether it's claimants, whether it -- whatever -- whatever -- wherever the thread takes us on an advanced review, all of that

would be coordinated through the Board and through NIOSH. So we will not be taking any unilateral action or any -- any type of reaching out, so to speak, without coordinating very closely with all of you.

DR. ZIEMER: And that probably -- and Liz, do you have some comments? Clearly there will be some issues on -- with claimants, as far as our contacting them.

MS. HOMOKI-TITUS: Right.

DR. ZIEMER: 'Cause these are --

MS. HOMOKI-TITUS: We'll --

DR. ZIEMER: -- these are closed cases, remember.

MS. HOMOKI-TITUS: Right, these are closed cases, so the rules haven't changed. They would not be able to contact claimants, although they're still able to contact site experts, I believe, that you all have been talking to, and go up and see workers, that kind of stuff.

DR. ZIEMER: Right. So these are not -- these are not the claimants themselves. These are -- let's see how the wording is here.

DR. ROESSLER: It says claimant or claimant

representative.

DR. ZIEMER: I think we had a ruling early on on that that probably would not be able to contact claimants directly, but perhaps would be able to contact individuals -- and -- and this would not necessarily be individuals who would even necessarily know that claimant. You couldn't identify to the individual who the claimant was, I don't believe. Is that correct?

UNIDENTIFIED: (Off microphone) Yes.

DR. ZIEMER: But if you knew a claimant worked at Y-12, and there was some issue about the workplace and you knew someone who worked in that workplace that could shed light on some condition --

DR. WADE: Like with Bethlehem Steel and Ed --

DR. ZIEMER: Or wherever it may be.

DR. WADE: -- Ed Walker.

DR. ZIEMER: I do have a recollection that we had information from counsel early on that contacting of claimants whose cases are closed probably would not be permitted in any event.

MR. GRIFFON: I think we did reword our task to say site experts rather than --

MS. MUNN: Yeah.
DR. ZIEMER: Yeah, so if -- if claimant appear-- I'm looking for the words here. What page are we on?
DR. ROESSLER: Page five.
DR. MAURO: I don't want to say anything right now till I see the exact language I used.
MR. GRIFFON: Page five?
DR. WADE: Page five.
DR. ZIEMER: Page five, paragraph --
DR. ROESSLER: The first paragraph --
DR. ZIEMER: -- one.
DR. ROESSLER: -- sixth -- fifth line down.
MR. GRIFFON: Supplemental claimant interviews.
DR. ROESSLER: Well, that whole paragraph kind of talks about it.
MS. HOMOKI-TITUS: Right, they wouldn't be able to go back and interview -- do these supplemental claimant interviews, so I don't know if you want to say perhaps supplemental interviews or site expert interviews, however you made that correction in your last one.
DR. ZIEMER: Yeah, perhaps the terminology dealing with supplemental claimant interviews may have to be actually deleted as part of this

task. And I think if -- in taking action here, we would understand that within the legal boundaries of what would be permitted, but it's more likely that it would be meetings with site personnel or requests for additional information.

MR. GRIFFON: Right.

DR. ZIEMER: That would not require a claimant's approval itself, since it would simply be a site expert.

DR. WADE: So where it says --

DR. ZIEMER: And claimant's representatives probably would be off-bounds, too. This would --

DR. WADE: Right.

DR. ZIEMER: -- be --

MR. GRIFFON: Yeah.

DR. ZIEMER: -- survivors and others.

DR. WADE: So I would propose we change that sentence -- if authorized by the Advisory Board, advanced and blind dose reconstructions may require meetings with site personnel and requests for additional information, period. And then strike the rest of that sentence, including the parenthetical, and that's what

we'll have in front of us.

MS. MUNN: I would agree.

DR. ZIEMER: Well, I think site personnel implies perhaps site experts. That would be the intent, John, would it not?

MR. GRIFFON: (Unintelligible), I would guess. Right?

DR. MAURO: Yeah, we have been loosely using site repres-- you know, interviewing individuals that worked at a site would be -- you could refer to them as a site expert or site personnel.

DR. ZIEMER: It's sort of a generic term.

MR. GRIFFON: It's generic.

DR. ZIEMER: Thank you. So it's understood that we're not -- when -- this Board is not approving contacting claimants by -- in this tasking. Yes.

MS. HOMOKI-TITUS: Just to further clarify that the next sentence, you may want to change it, too -- this level of estimate, et cetera, et cetera, associated with travel and meetings with claimants, claimant representatives -- to whatever you're calling them, site personnel or site experts.

MR. GRIFFON: Yeah, meetings with site personnel I think --
DR. WADE: Right, we would change it --
DR. ZIEMER: Instead of meetings with claimants and claimant representatives, it would be travel and meetings with site personnel. John, does that sound appropriate to you, as well?
DR. MAURO: Absolutely, I -- sure.
DR. ZIEMER: The -- the previous sentence dealing with coworkers, I think we need to understand that is coworkers in a fairly generic sense -- might be people who worked on the site in a similar job, but they wouldn't necessarily be people who even knew this person. And in any event, you could not reveal to them, you know, we're looking into John Doe's dose reconstruction. It would be someone you identify on the site. I just want to make sure we understand when we say coworkers that we're not trying to find people who knew this person and can -- or maybe that was your intent, but I think that --
DR. MAURO: No, I understand what you're saying. The language, though, right now is -- is -- doesn't explicitly make that clear. In

other words, what we're really saying is job cat-- had -- perhaps had similar job categories or where we could get more information about people who worked on those types of jobs. You're right, the way it is right now, a coworker -- in (unintelligible) definition -- could include someone that may have worked right next to him.

DR. ZIEMER: Well, it might indeed do that, but you could not reveal to that person who you are looking at. I mean if -- if you somehow learned that there was a person that did work by this --

MR. GRIFFON: I guess --

DR. ZIEMER: -- I'm not sure that would be excluded.

MR. GRIFFON: I guess part of the -- part of --

DR. ZIEMER: If you learned that John Doe worked next to Sam Doe or --

MR. GRIFFON: Part of -- part of where this comes up, I think, is that in the CATI interviews sometimes they -- they indicate people they've worked with, coworkers --

DR. ZIEMER: Yeah --

MR. GRIFFON: -- and --

DR. ZIEMER: -- yeah, we're talking generically coworkers which would be people of similar job types and --

MR. GRIFFON: No, no, no, but that -- that's talking specifically. That's what I'm saying. In the CATI interview, they --

DR. ZIEMER: Right, I understand.

DR. BEHLING: I think the genesis of this whole thing, and I think this is where we made the mistake that is now being corrected, we responded to -- in fact, in the third set of audits that you're about to review for us and we'll talk about next week when we contact you, we made certain points in our audits, and I think the issue of contacting the claimant were -- was -- was an issue that came out of our audits where we realized there were discrepancies between what was reported in the CATI interview and what the dose reconstructor chose to do. And of course the extension of that are issues that involve coworker data where we again identify coworkers in the CATI report and we were under the naive assumption that perhaps we would be in a position to contact them to verify certain statements made

by the claimant himself, or his heirs, et cetera. And now of course now Liz tells us that's obviously off the table and we have to amend our approach to doing --

DR. ZIEMER: Well, let me --

DR. BEHLING: -- those claimant interviews.

DR. ZIEMER: -- suggest something, though. Suppose this individual says during a certain time period I worked in a certain building and this event occurred. It seems to me that if one could identify another person who worked in that building at that time period that could act to verify that, I'm -- I'm -- let me throw this on the floor and you can react to it -- not necessarily a friend or even a person named by this individual, but that generically is a coworker that might be contacted to verify something. Is that legal? As long as there's not a linkage made to the claimant, a person who --

MS. HOMOKI-TITUS: That's the legal part of it is there can't be a linkage to the claimant and they have to protect the claimant's privacy. They have to --

DR. ZIEMER: Right.

MS. HOMOKI-TITUS: -- protect the coworker's privacy. I guess the other part of your question really goes to the program, as to what is the extent of SC&A's job.

DR. ZIEMER: Yeah. And -- and that -- that issue is -- is what -- on doing the blind dose reconstruction, do you actually go to the site to gather information.

MR. GRIFFON: Not only blind, advanced. I think we've been through this scope (unintelligible) --

DR. ZIEMER: (Unintelligible) advanced.

MR. GRIFFON: That's an old issue, I think.

DR. MAURO: One of the I guess defenses against moving in a direction that might be inappropriate is that we are not going to take any unilateral action by any means of -- of reaching out, whether it's a DOE representative, a -- a site expert or some -- or a person that may have worked at a site at a certain period of time at a certain facility, without -- you know, that's made very clear in here -- speaking to you. I -- I believe that there is this -- there is this boundary, and we recognize this now as a result of this

conversation -- very clear to me that there's a very clear boundary that we cannot cross over. The degree to which we will need to work these lan-- this language into this is really -- I'm -- I'm not sure. I mean I understand the point that's being made here. I think we've certainly crossed out the offending language for sure. Right now we still --

DR. ZIEMER: We may have to have some definition on what -- what it means by coworker in this case, that there can't be a direct linkage to an individual claimant. You're talking about gathering information -- which might even be done by a phone call --

DR. MAURO: Uh-huh.

DR. ZIEMER: -- or something like that. I mean the question of do you have to go to the site to pursue this...

DR. WADE: I think we understand the intent of the Board's discussion. I'll work with program and counsel to see that the words here, that we ask you to include in your proposal, are the correct words.

DR. ZIEMER: Okay. Thank you, Gen, for raising that issue. It's very important in the --

DR. WADE: Thank you very much.
DR. ZIEMER: Are there other items in here anyone wishes to address? Other questions or concerns in the scope?
Basically -- do we need to approve both the scope and the cost value? Are -- are they --
DR. WADE: Yes.
DR. ZIEMER: And we -- we might in fact do this in two separate actions, or it could be in the same action.
DR. WADE: I think it could be in the same action.
DR. ZIEMER: But I mean the Board could say we like the scope and we'd like you to do it for half this price, too, see. Okay, Wanda Munn.
MS. MUNN: I'd like to move that we accept the scope and cost as presented in the letter of September 16th to us.
DR. ZIEMER: With the modifications as identified on --
MS. MUNN: With the modifications that we have discussed to be provided by Dr. Wade.
DR. ZIEMER: Thank you. Second?
MR. GIBSON: Second.
DR. ZIEMER: That includes the cost, Wanda?

DR. WADE: Yes.
MS. MUNN: Yes.
DR. ZIEMER: It includes both the scope and the cost.
MR. GIBSON: (Off microphone) (Unintelligible)
DR. ZIEMER: And it's been seconded by Mike. Before we vote on this, David, if you're still with the discussion, do you have anything to add for us or comments to make?
MR. STAUDT: No, I think we're okay.
DR. ZIEMER: Okay. Are you ready then to vote?
MS. MUNN: Yes.
DR. ZIEMER: Okay. All in favor of the motion to approve the scope as modified, and the cost of this Task IV proposal, please say aye.
(Affirmative responses)
And those opposed, no?
(No responses)
And any abstentions?
(No responses)
It is so ordered. It is now time for our next half-hour break. It will be 20 minutes long.
DR. WADE: Thank you, David.
DR. ZIEMER: Thank you very much, David.
(Whereupon, a recess was taken from 3:10 p.m.

to 3:35 p.m.)

DR. ZIEMER: All right, Board members, if you'll return to your seats we'll get underway again.

I want to make a comment before we begin the next presentation. This comment deals with the action that we just took on the SC&A task and contract. It was pointed out that the SC&A task mentions that Dr. Mauro and Mr. Fitzgerald would be involved in interacting with the case managers and so on, but it also pointed out that there is no time assigned in the task for Mr. Fitzgerald. In fact, in the attachment it shows Salient, which is Mr. Fitzgerald, as zero hours. I have talked with John Mauro about this and he assured me that Joe's time isn't free -- well, he really didn't say that. What he did say is that the -- the total cost will go unchanged, and Joe's time would be either assigned to the management task, which is separate, or it would be covered by John's part of the task, or some appropriate person. The actual time that Joe would be involved with this part of their activity is actually very small, in any event. But they may, as they

revise this and working with Lew, make a very minor adjustment in those hours, if needed; but the total cost would remain the same. I want to make sure everybody understands that. So unless -- without objection, if necessary, a minor modification might be made in showing a few hours, whatever it is, for Salient for the management part, if necessary.

PROGRAM UPDATES

NIOSH, MR. LARRY ELLIOTT

Okay, with -- with that, we're -- we'll move to the program updates, and we haven't had an official update for a bit, so we're glad to have one, Larry. And we had part of an update earlier when we heard about where we were on Bethlehem, and actually many of our Board members were surprised -- pleasantly surprised by where we were on Bethlehem Steel dose reconstructions in terms of both the numbers completed and the percent that were, in a sense, successful from the claimants' point of view. But now we're pleased to have a more complete report on the overall program, so welcome back to the podium.

MR. ELLIOTT: Okay. Well, thank you, Dr. Ziemer, and good afternoon, ladies and

gentlemen of the Board and members of the public.

Let me just start off with that Bethlehem Steel statistics that I commented on earlier. I want to correct what I said there. These numbers are a snapshot in time, and they change. And I think this morning I said 94 percent of the Bethlehem Steel cases have been completed. Actually I have learned this afternoon that as of today it's 88 percent. We had another influx of cases from DOL, so the number changed.

DR. ZIEMER: It's gone down --

MR. ELLIOTT: It's gone down.

DR. ZIEMER: -- but only because more cases have come in.

MR. ELLIOTT: People hear that we are -- that dose reconstruction is working and people are getting compensated, I guess, so they submit their claims. And I said this morning 45 percent of those completed dose reconstructed cases were found to be compensable by DOL. Actually that number has dropped by one percentage point, as well. It's now 44 percent today. We'll have the complete numbers, Dr.

DeHart -- and I believe you have asked for a complete set of statistics -- in case you want to develop a response letter to the -- to the New York delegation who submitted letters to the Board, and so we'll have that information ready for you.

Let me go ahead with this presentation on the program, and I'm so pleased to be able to do this. We've changed the face of this report for you a little bit. We're going to start off with something we usually ended with in the past, which was our accomplishments, and catch you up now to date on what we have accomplished.

As was mentioned earlier in the meeting, we have finished over 10,000 dose reconstructions to date. All of the numbers that I'm going to present to you in this presentation are as of October 5th. And so here again, we're -- these are a snapshot in time and they would have been different had I put these numbers together today. 10,679 draft dose reconstruction reports have been sent to claimants, and a total of 10,121 final dose reconstruction reports have been sent to DOL. The difference

between these two numbers are those draft reports that are in the hands of the claimants and we're waiting for them to sign their OCAS-1 form and send it back so that we can move it on to the Department of Labor.

There have been 1,352 claims that have been affected by Special Exposure Cohort class additions, and those claims have been sent to the Department of Labor. As you see depicted in this slide, 116 cases -- claims have been sent to DOL regarding Mallinckrodt early years, 506 cases for the Iowa Army Ammunition Plant, 728 cases have been returned to DOL regarding the early years of work under Calutron operation at Y-12, and two cases on the Iowa Army Ammunition Plant radiographers' class. Department of Labor is busy evaluating each one of these claims for their eligibility to fit into the class and determine compensation, and then each of these classes -- there is special designation on what happens if the claim is presented without one of the 22 cancers, or enough time in the class. And in some instances they may be returned to us for dose reconstruction; in some instances they may not,

and there may not be any remedy at that point. There have been 3,877 final dose reconstruction reports sent back to DOL out of the first 5,000. We're talking here about our attempt to finish off the oldest cases, the 5,000 one -- we assign a tracking number, as you know, to each case, so case one, that was the first one sent to us, up to 5,000 we're monitoring very closely what it takes to finish those cases.

As you see here, there are 60 -- and I would caution you that these numbers are not going to add up to the remainder of 5,000 minus 3,877, and that is because there have been some reworks, some going back and forth.

But 69 claims below the number 5,000 have draft dose reconstruction reports in the hands of the claimant -- we're waiting on those to be returned to us with the OCAS-1.

484 of the claims below 5,000 have been pulled by the Department of Labor -- this means that they have retrieved them from us for a specific reason. Again, that reason varies. It may be a claim that was inappropriately sent to us by DOL. It may be due to new information that they're developing on the claim that we need

before we pursue dose reconstruction. And unfortunately, in a small handful of cases it may mean that there -- the claimant is deceased and there are no other survivors, and I think that's the most unforgiving and embarrassing point, to me. I -- I want to make sure that we work these hard so that we don't have any more than, you know, the handful that we already have where we lose the opportunity to get a claimant a decision. But the majority of these pulled cases are due to other reasons than -- than the claimant becoming deceased.

Forty-three claims before 5,000 have been administratively closed. What that means is -- and I'll show a slide later on how many total claims have been administratively closed. We -- we close a claim when we don't get the OCAS-1 form back. Our rule says we have 60 days to await that decision by the claimant. We grant them some grace time. We take up to a total of 74 days waiting, and if we don't hear from them then, then we administratively close the case. We can reopen it at any point in time that the claimant wants us to reopen it if they'll send us the OCAS-1 or they provide us new

information that should be used, in their mind, in the dose reconstruction.

Ninety-three claims have been pended. Pended means we've -- we put a status hold on the -- on work on a case for some particular reason. There's either a technical reason that we can't proceed with the dose reconstruction, or there's information that Department of Labor is developing about the case that we need before we continue our dose reconstruction effort. So pended has a variety of meaning, as well, for -- for these 93 cases.

461 claims are active with no dose rec-- draft dose reconstruction to the claimant. So we are working on what it takes to finish up the remainder -- these 461, plus when we see the 93 come to us when whatever issue revolves around those -- when we get that satisfied, we'll move those forward.

We are going -- in the next three or four weeks here we'll be working up a critical path plan, a plan that will identify a work structure, the activities and what is the critical path through those activities that needs to be understood and resolved in order to finish

these cases. And so that will be forthcoming very shortly.

We've had 13 requests to -- from individuals to add a class to the Special Exposure Cohort that -- these 13 have been qualified. Eight petition evaluation reports have been completed and sent to the Board for your evaluation. They cover a total of 11 petitions. Three petition evaluation reports are in the process of being completed. Those include, as you've talked about today and yesterday, Y-12 and Rocky Flats, also the Ames University -- Ames, Iowa University class.

We have six current requests to add a class to the SEC that are going through the qualification process. If you read our rule on Special Exposure Cohort, a petition has to qualify. It has to meet the basis for qualification that's spelled out in that regulation, and that's what these six are undergoing right now.

We've had 20 requests for addition to the Special Exposure Cohort that have been administratively closed because they -- they were -- they did not meet the qualification

basis, the petition -- the basis for a petition as specified by the rule.

As I've reported before, we are -- in OCAS and in NIOSH we are busily looking to identify cases where we cannot do dose reconstruction. This is accounted for under our dose reconstruction rule at Section 82.12, and once we identify a case like that we move it into and we handle it under our SEC rule under Section 83.14.

I've got to modify this slide a little bit. There are actually two cases we've identified to date, and they're both on your agenda for tomorrow. The National Bureau of Standards is one case where we worked really hard with the only claimant that we had, and determined that we did not have any data or information upon which to do dose reconstruction, so you have that on your agenda tomorrow. As well we have Linde, which is another site where in the early years we have no data and we have determined that we cannot do dose reconstruction for that time frame for Linde.

I hope that in the near future, as we work through the critical path plan and understand

the remaining cases that are still active in our hands, we will come forward with additional cases that we can't do dose reconstruction on and put them in front of you as a petition for a class.

We've made a change in our technical support contract structure. Last week we awarded a contract to work on 1,400 atomic weapons employer claims. These are claims that represent more than 250 sites, so you can imagine how -- across 1,400 claims, there's a lot of sites that only have one or two or three claims. We're -- we're struggling with developing a site profile for each of these kinds of sites and situations. And the intent here is to allow ORAU to focus their energies on the major sites, the bigger sites, the site profiles that had been put on a schedule for development. And we're asking Battelle to work on those 1,400 AWE claims, and we have in our scope of work with Battelle an approach that categorizes these sites by similar process and operation, and we'll treat them with a site profile that -- for that similarity.

This is a one-year contract, and we'll see what

happens at the end of the year. This will be another situation where I'm also calling for a critical path plan to finish up these 1,400 AWE cases.

We've been participating in the Department of Labor outreach -- town hall meetings. This is quite an intensive process. It requires a lot of effort and resources on -- from -- from NIOSH to participate in these meetings. As you can see here, we've been at 67 meetings at 33 sites as of October 6th. Next week we'll have some more folks going out, so -- we think this has paid dividends, though. We get -- we've piggy-backed on DOL's town hall meetings where they're explaining their -- their new rule under Subtitle E, and we stand out in the hallway and answer any questions that come forward about dose reconstruction and Subtitle B cases. And I think the people that we've encountered have been appreciative of our presence there, and we'll continue to make sure that that happens.

We've also finished up, with our ORAU support contract, the completion of 23 Technical Basis Documents. They -- that's for this calendar

year. And we've also finished up and approved ten Technical Information Bulletins in the same time frame.

I'll quickly go through some of the typical graphs that you've seen in the past. This -- this graphic portrays, in the blue line, those cases that have been received from the Department of Labor. The timeline here is by quarter, and you can see that there has been a decrease in the submittal of cases to us for dose reconstruction. And I think what's important, from my perspective, is that I expected to see this line go up as the Department of Labor had their town hall meetings on Subtitle E, but we haven't really seen that yet. Maybe that's out here somewhere to come.

The green line gives you an understanding of the number of draft dose reconstruction reports that we have provided to claimants, and then the red line shows the reports that we've received back from claimants and moved on to the Department of Labor. So we're tracking all three of those streams of information.

As far as our requests to the Department of

Energy for exposure information relative to the claims that we have, we have only 335 outstanding requests. I think this is remarkable. Less than 21 percent of the outstanding requests are later than 60 days-plus over, and I can speak -- I'm sorry Dr. Melius is not here; I know he asks this question -- but they really reside at one or two sites, and we are working those case-specific issues with those sites.

As far as our telephone interview statistics, they're presented here. We've had at least one interview conducted for 17,910 cases. We have seen interview summary reports sent to over 24,000 claimants. Let me just explain that. There's more claimants listed there than we have cases in our hands. That's because many of these claims have multiple survivor claimants and each one has an opportunity to evaluate the interview report and edit it. The number of interviews left to be conducted are around 200.

We have 6,601 cases in the bin of pre-dose reconstruction assignment development. This is where all of the review and screening and

understanding about a particular case goes on -- can it move into dose reconstruction, do we need additional information, where are we pursing that additional information from -- that's what's happening in that bin.

There are 1,029 cases that have been assigned for DR. This means that a dose reconstructionist has been named for a particular case and the conflict of interest letter has been sent to the -- and the claimant has an opportunity to take exception to that individual or not. Dose reconstructionists then know that these cases are in their queue.

Draft dose reconstruction reports sent to claimants total 558. That's that number I spoke earlier about on the first slide. And again, 10,121 claims sent to DOL for adjudication with dose reconstruction reports.

This graphic gives you, I hope, a better understanding of where we stand with -- by 1,000 -- 1,000-case columns. We finished up 809 cases in the first 1,000. It also shows you what's been done, in red, prior to January 2005 and, in blue, since January 1, 2005. So you can see some of the progress that we have

made.
Yes, we do work our priority, and the directive that I've given is that the oldest cases need to be done first. That's where we want to pay particular attention, and our focus is given to those. But as we see cases in the later submissions here in the 19, 18, 20,000 tracking numbers, cases that can't be done and done easily, this is the cherry-picking that goes on. These are the efficiency processes that are used. We do move those cases through.
This slide gives you a total of the administrative closed cases by quarter, and as you can see, I don't know that I have any remarks to make about the blips here and here or what happened there. I haven't had a chance to analyze that yet, but I will look into it.
Total, 110 that we've administratively closed.
Here's a graphic on how many reworks. Reworks are a case that's returned to us by the Department of Labor for a variety of reasons. These reworks may be sent to us for deficiencies that they've identified where they think we missed something. They may be sent -- returned to us as a rework in an instance where

the claimant has provided new information that's been developed by DOL and we need to factor that into dose reconstruction.

The green line shows the ca-- the reworks that have been received by NIOSH for rework, and the blue columns indicate those that we have returned back to the Department of Labor. Returned, 666; and total received, 1,003.

Our phone calls -- we still take a lot of phone calls. We do a lot of work not only in the field at the town hall meetings, but when we come back we still get a lot of phone calls. As you can see, over -- almost 42,000 calls to date. ORAU takes a lot of phone calls, and they're quite busy over there. That number includes the interviews, as well as the closeout interviews, an interview done at the end of the draft dose reconstruction report cycle where it -- the draft report is explained to the claimant and the claimant's encouraged to file the OCAS-1 form.

We get a lot of e-mail traffic, as you can see, and our policy still is to attempt to provide a response, if at all possible, within 24 hours of receiving that e-mail -- if it's not on a

weekend, I guess.
I think that's it, and I'll be happy to respond to any questions you might have.
DR. ZIEMER: Thank you very much, Larry. Let's see who has questions here now. Yes, Leon.
MR. OWENS: Larry, thank you for that update. I had a question in regard to the 461 claims -- active claims with no draft dose reconstructions. Are those claims particular to a certain site, or have you had a chance to -- to evaluate that?
MR. ELLIOTT: That's in -- I believe you're talking about the slide that shows the first 5,000 cases. Right? That's where the --
MR. OWENS: Yes.
MR. ELLIOTT: -- 461 --
MR. OWENS: Yes.
MR. ELLIOTT: -- cases have not been assigned yet. No, they're not particular to one site, but they are -- we have acknowledged certain obstacles that we're working on, like glovebox issue where we're working on -- on -- you know, we have a TIB for glovebox. We're working on that. We have some -- there's some sites in there that deal with -- or some cases in there

that deal with trades workers in the early years, and so we're working with Center for Protection of Worker Rights to come up with a document and a way -- a Technical Basis Document and a way of treating dose reconstruction for th-- for the early trades workers. I think Jim alluded to that earlier; Savannah River's the first site we'll be seeing that used at.

And then there's other obstacles and -- but it's not one site and not two sites. There's probably, you know, 20 sites involved there.

MR. OWENS: Do you think it'll be possible by the next meeting just to have a general update on some of those issues --

MR. ELLIOTT: I hope by the --

MR. OWENS: -- (unintelligible) the Board?

MR. ELLIOTT: I would hope that at the next meeting, your meeting in January, I'll be able to show you the critical path. If this is -- the 461 aren't done, I'll show you what the critical path is to get them done.

DR. ZIEMER: Thank you. Rich.

MR. ESPINOSA: Just out of curiosity, with the other SEC from Mallinckrodt, about how many --

how many are going to be sent to the SEC -- how many claims that are going to be affected by the SEC on that?

MR. ELLIOTT: On the later years of Mallinckrodt?

MR. ESPINOSA: (Off microphone) (Unintelligible) years of Mallinckrodt.

MR. ELLIOTT: I don't have that number with me right now, but I could get it and -- get it for the Board. I just don't have it off the top of my head.

MR. ESPINOSA: And also on the 21 percent of the outstanding requests or ones that are 60-plus days or older, are you seeing a pattern of -- what -- what specific sites are kind of causing the -- and is there a pattern of these sites?

MR. ELLIOTT: There is no pattern. This -- these situations are individually specific.

(Whereupon, Dr. Melius arrives.)

MR. ELLIOTT: There are issues associated -- like where we can't find the data for this particular person. We can't verify that they were even here that time frame. In -- in one block of cases we're talking about ETEC in

California where we've actually -- they've held cases and we're working with DOL on trying to make sure that these folks are eligible. So we're working through those issues. There's not any -- I don't see any trend here. If I saw a trend like we saw in the early days with -- we had a trend going on at Idaho where we really had trouble retrieving information, then we put our folks out there to help them get that information in -- into a format where it was easily retrievable. If I saw a trend like that, we'd take some action. Right now we're working on individual situations for those -- those cases.

DR. ZIEMER: Gen Roessler.

DR. ROESSLER: In your statistics on the SEC petitions, you show 20 requests that have been closed because they were found not to meet the basis for petition. That sounds like a really high number to me in the realm of the SEC right now, and I'm wondering, is that -- it seems like that's a lot of work to put one through. Is there misinformation or misunderstanding or what were the reasons that they were turned down?

MR. ELLIOTT: Again a variety of reasons, some of those include a person who had a dose reconstruction and had their claim already adjudicated and they didn't like the outcome, and so they just filed a petition with no basis. We worked -- we worked with them, and there was no basis for a class. In -- in one or two instances we had a petition filed that covered multiple sites, and the rule says you have to focus on one site. We had one petition that covered workers across sites; can't have that. Working with the petitioners then, they withdrew their petitions in those three examples that I've given. So that's -- that's mainly it. There's no -- I would say that there's no -- there's -- there's no one single reason that they haven't met. There's a variety of reasons they haven't met the basis.

DR. ZIEMER: Okay. Rich?

MR. ESPINOSA: Larry, isn't the rule one site or (unintelligible) workers?

MR. ELLIOTT: Pardon me?

MR. ESPINOSA: Isn't the rule on the SEC one site or a class of workers?

MR. ELLIOTT: It is a class of workers at a

site. At a site. The class of workers cannot go across sites.

DR. ZIEMER: Okay, further questions? Did you have an additional, Gen -- no. Dr. Melius has joined us. Welcome.

DR. MELIUS: Wanda's given me a very nice brief briefing.

DR. ZIEMER: Okay. Mark Griffon.

MR. GRIFFON: Just -- just a question, Larry, on the worker outreach meetings. I didn't see any slide on your worker outreach meetings that -- that been going on, that -- I just wondered if you can give us an update on those or how many have been done and how many are scheduled? What -- what sort of is the outcome of these, I guess?

DR. ZIEMER: Well, there was one slide. Right?

MR. ELLIOTT: That was town hall. You're right --

DR. ZIEMER: Town hall.

MR. GRIFFON: -- Mark, you're right. I don't have that information at my -- right off the top of my head. I appreciate your comment, though, Mark. We'll add that to the program report. That's something we should -- should

get in front of you. We do have a program where we have -- where ORAU, and at times OCAS staff, go out into the field and interact with workers on a site profile, collect worker input about site profiles or Technical Basis Documents. We've done a number of those, but I don't have those off the top of my -- I'll make sure that we add that to our presentation for you.

DR. ZIEMER: Okay, other questions?

MR. GRIFFON: I guess -- I guess one -- just one follow-up, a comment on the worker outreach meeting. I mean I've read some of the minutes and there -- there are some very specific questions in some of the meetings, and -- and sometimes the response -- I think there was sort of a response that said we'll follow up on that, and I wonder to what -- what's the mechanism for following up with these groups or getting back to them on -- you know, or answering the questions that are laid out in these minutes? I hate to just have the people involved in these meetings think that it's a one-shot deal and (unintelligible) --

DR. ZIEMER: Or basically are they tracking --

MR. GRIFFON: Right.

MR. ELLIOTT: Sure. Sure. No, they are tracking the comments. They are in a document control process. I'm not at a -- at a position where I can speak about, you know, how many they have responded to and how many affected changes have been witnessed in a Technical Basis Document. I would say that Bethlehem Steel, though, we -- we know that what we heard, we addressed in -- inhalation and ingestion was addressed in Rev. 2. We still accept and hear input on that and we're considering what we hear. But yes, there is a formal mechanism. We need to make that more apparent and obvious to you as to how it works, and we'll do that.

DR. ZIEMER: Thank you.

MR. GRIFFON: Thank you.

DR. ZIEMER: Okay. Thank you very much, Larry.

PROGRAM UPDATES

DOL, MR. JEFFREY KOTSCH

We also have a status report from the Department of Labor, and Jeff Kotsch is here again today. Jeff, welcome back to the podium.

MR. KOTSCH: Department of -- the Department of Labor thanks -- thanks the Board for the

opportunity to give an update. I don't know -- I don't know when the last time we probably gave one was. At least for me it's been a while.

The number of -- well, let's start with the number and types of claims received under Part B. Total number of claims received is 69,016. This is -- most of this data is as of October 6th of this year, and you see on the display the primary categories of claims that we see, which are the categories under Part B -- cancers, beryllium sensitivity or chronic beryllium disease, silicosis for the workers engaged in activities at the Nevada Test Site or Amchitka, the RECA claims for the Radiation Employees Compensation Act, then -- and under Part B, the conditions that are covered, which I won't see later under Part E, they will now have coverage, or potential coverage.

The case status -- again, like Larry said, there's a difference between the numbers between cases and claimants because cases can have more than one claimant. Total cases received by DOL are 49,650. The district offices which render the recommended decisions

have rendered 36,638, and we've sent 20,312 to NIOSH. Now our numbers never seem to quite synchronize with NIOSH's number, partially because of our databases and partially just depending on what -- what -- almost what day we take the snapshot. And then the pending recommended decisions of about 3,100 are just our cases that are inside the pipeline within DOL at the district offices.

The Final Adjudication Branch, which determines and renders the final decisions based on the recommended decisions, have issued 33,924, and within their pipeline they've got about 2,700 cases.

Now the final decisions as far as claims goes, they've -- they've approved -- we have approved 17,501 and denied 26,166. Again, the primary categories for denied claims are listed there. Again, predominantly non-covered conditions or, further down, cancers not related or POCs less than the 50 percent required under the Act. The other ones are employees not covered, survivors not eligible, insufficient medical evidence to support the claim.

As far as the NIOSH referrals, we have 99 --

we're showing 900 -- 9,900 cases at NIOSH, and we've had completed dose reconstructions on 9,605 and dose reconstructions not required for 777. Those are a variety of cases. Some of those are -- I think include chronic lymphocytic leukemia, some of the other ones that we either sent or -- basically there's not a dose reconstruction that was required.

We've accepted, for the cases with recommended decisions, 2,136, and cases with final decisions, we've accepted 1,829; denied 500 -- or I'm sorry, 5,434.

These statistics do not include 848 cases that have pending recommended decisions and 66 cases that have -- that are currently pending payment.

The three facilities -- at least locally, I think -- obviously that are interest and we'll just provide quick statistics on are Oak Ridge National Lab or X-10, and we've referred 1,062 cases to NIOSH. We've had 460 returned; 100 of those were approved at the recommended decision level, 86 at the final decision level were approved, and DOL has paid out $12.6 million on 84 claims. There are two cases that

are pending payment.
K-25 we've referred to NIOSH 1,310 cases and we've had 540 returned as completed.
Recommended decision approvals for 75 cases, with final decisions that were approved for 54; compensation paid for seven -- about $7.9 million for 53 cases; there's one case still pending.
Total compensation paid, including SEC cases -- obviously K-25 is one of the statutory SEC sites -- we've paid out -- or Department of Labor has paid out $261 million -- almost $262 million for 1,749 cases.
The Y-12 plant is the largest claimant base -- for this area, anyway -- and we've referred 2,375 cases to NIOSH and have had 1,067 cases returned. At the recommended decision level we've had approvals for 318; at the final decision level 286, and a paid-out compensation of $41,325,000 on 276 cases. We have ten cases still pending payment.
So for Part B now as of October 10th, the compensation benefits issued, the total compensation that -- we've made payments for 15,972 to the -- at that -- I'm sorry -- with

compensation of $1,247,000,000, with an additional medical benefit payment of $75,437,000. For the NIOSH cases -- that was a total number. For the NIOSH cases we've made 1,763 payment -- payments, I'm sorry, and the compensation amount has been almost $264 million.

Now just a briefing -- last October the Congress amended the Act to add Part E to the mix for Department of Labor, really essentially taking the Part D program from DOE and transferring it, with some additional actions, to the Department of Labor. Part of that was a requirement to issue an interim final rule, which was issued on May 26th, which met the deadline that was mandated by Congress. Obviously in support of this additional activity, the Department of Labor had to add staff, which it has done and is doing at the district offices, the FAB offices -- which are attached to those offices -- as well as the national office. And also additional resources for the Resource Centers which were initially run by DOE and DOL, now are currently run just by DOL.

Also in support of that, obviously DOL has had to perform internal training. We've done that in two cycles. The first phase we completed in May of 2005. We are currently in a cycle now this month of training our field staff and our national office staff on Part E. Obviously that went hand-in-hand with the -- the issuance of the interim rules as we determined what was going to be involved in the -- in the process. We had a goal internally within the Department of Labor to issue 1,200 payments by the end of Fiscal Year 2005. We exceeded that goal and issued 1,535 payments.

Public outreach, there have been a number of town hall meetings at 35 sites, as -- as Larry alluded to, and NIOSH has been out there with us at most of the sites, discussing Part E and residual contamination. There's meetings in fact going on today and tomorrow at ETEC in California, and within the next two weeks Shiprock and Grants, New Mexico; Rocky Flats and Grand Junction, Colorado. And with the DOE goal -- or I'm sorry, the DOL goal of initially processing the large majority of 25,000 Part D cases that we received from the Department of

Energy, shooting for a target to try to get a lot of -- the majority of those done by the end of Fiscal Year 2006.

Final slide is the Part E claims we recorded as -- again, as of October 10th, three -- 35,091 claims. We've rendered recommended decisions to approve for 2,508; final decisions to approve for 2,106; and paid compensation of $205,243 on 6,810 cases.

And that's it, briefly. Are there any questions?

DR. ZIEMER: Very good. Thank you, Jeff. Let's start out -- Dr. Melius.

DR. MELIUS: Yeah, you entered -- published an interim final rule and accepted public comments on the Part E program. Where are you in terms of a final rule on that? Can you give me a general sense? I --

MR. KOTSCH: Yeah, I can give you a general sense, because I'm not intimately involved with that. I know the public comment period for Part -- for the rule ended -- I forget now, probably a month or two ago --

DR. MELIUS: Yeah.

MR. KOTSCH: -- and talking to our lawyers,

'cause I knew this question might be asked, they weren't going to commit to any time when they were going to -- when they were going to complete the rule, but it -- it's not -- let's just say it's -- it's more than a few months away, probably, 'cause they have a number of comments they have to resolve and other issues they have to address.

DR. ZIEMER: Rich.

MR. ESPINOSA: Yeah, the Subpart B that was 10,600 claims that were under non-covered conditions, would you happen to have a percentage or a hard number of how many of those cases did qualify for the -- E?

MR. KOTSCH: No, I don't have that with -- we can provide that in the future, but for Part B a lot of the non-covered conditions are things that are covered under Part E due to toxic exposures. You know, a lot of the respiratory diseases, coronary problems, the renal diseases, things like that, which I think -- other than -- the only ones that really don't ever -- will never be covered are some of the ergonomic type of things or back problems or some hearing loss. I mean there is some

hearing loss associated with certain exposures -- toxic chemicals. Some of those things will never be covered under either program, but I think the large majority of them should somehow be addressed under Part E now.

DR. ZIEMER: And you automatically switch those over --

MR. KOTSCH: Yeah, any claim -- well, any old claim, any B claim that came in that was automatically set up also as an E claim, once we got E. All new claims that come in are submitted to both sides of the program, and actually we're no longer dividing internally our -- our claims. They're not treated as B or E anymore. They're treated as a total claim and will go through both -- our -- that's why we're training our CEs that -- who work the claims from both sides, basically. Whichever side can go faster, we -- if we can compens-- compensate a person, we'll -- we'll do a Part E compensation, and then if a Part B compensation follows through NIOSH, we'll -- you know, that'll come later.

DR. ZIEMER: So it shows up in your statistics in both -- both columns, so does it look like

there's more claims being processed than there really are?

MR. KOTSCH: Not in -- not in these statistics.

DR. ZIEMER: Oh. Thank you.

MR. KOTSCH: I mean at the front end of the -- all -- the front end of those statistics are all Part B.

DR. ZIEMER: Okay. Roy.

DR. DEHART: Can't the radiation criteria -- do you have any data on appeals and success of appeals?

MR. KOTSCH: For the Part B program?

DR. DEHART: Yes.

MR. KOTSCH: No, and I think -- I'm trying to remember if that question was asked previously, and I -- I probably committed to supplying some data on that. I don't know if we did or not. I don't -- I don't know. Pete did it the last time. But we can do that. I happen to be one of the two people that have to review at least all the technical objections that are presented to the FAB, you know, as we -- as people raise technical objections and at the -- they -- they have to come to either myself or my junior person for -- for review.

DR. DEHART: (Off microphone) One of the reasons for the question, I think --

DR. ZIEMER: Is the mike on?

DR. DEHART: One of the reasons for the question, and I think the Board would be interested because it, in a sense, provides some kind of quality control for deliberations and actions.

MR. KOTSCH: There -- and I don't want to give you a percentage because I probably can't figure it out exactly. There are some portion of the rework requests that go back to NIOSH that are a result of technical objections that are raised by claimants to their -- at the stage of the recommended decision. That's the opportunity they have to -- or their first opportunity with the Department of Labor to raise an objection -- or even at the final decision they can obviously either ask for a reconsideration or a -- if it's after 30 days -- of a reopening of their case. And we do -- it's less frequent, but there are -- they do have an opportunity and they may bring technical objections up at that point, too. We've had some people that will object at the

recommended decision, they will object at the final decision, and then they will continue to submit reopening requests. But generally it's not -- they have not submitted additional evidence that really provides us a means to go -- you know, to go -- to say we have -- need to rework the -- the dose reconstruction, but we do receive -- like I said, at the recommended decision we have seen some, we can get numbers on that, that result in reworks because of technical information that we've received that -- or questions that we received that would result in a rework of the dose reconstruction.

DR. ZIEMER: Does that answer your question, Roy? Would you --

DR. DEHART: It answers the question --

DR. ZIEMER: -- like to see some of those numbers?

DR. DEHART: -- in the fact that he has no data. What would be helpful, if we could see the data --

MR. KOTSCH: Sure.

DR. DEHART: -- on present-- future presentations.

MR. KOTSCH: Sure, we can do that.

DR. ZIEMER: Thank you. Jim.
DR. MELIUS: I have a -- two -- or separate questions. One -- Larry may have addressed this 'cause I was obviously late, was I noticed in the statistics Larry presented that we're seeing a little bit of an increase in the number of requests coming in. Is there any sense to what extent that's being generated by these town meetings and outreach efforts that are underway, and any sense of -- are you seeing in those meetings claimants already in the -- now in the Subtitle E program, or are you also seeing new -- new potential claimants, I guess?
MR. KOTSCH: I don't know, and Larry I don't think was able to make that leap, either.
DR. ZIEMER: I think Larry indicated he expected more than they actually got. Was that not the case?
MR. ELLIOTT: We really haven't seen any dramatic increase in new claims being submitted as a result of all the town hall activity.
DR. MELIUS: Okay.
MR. ELLIOTT: Not to us; I don't know about DOL.

MR. KOTSCH: I don't know that it's that apparent to us at Labor, either, but I don't -- again, I'm not the one who crunches that particular data to see -- I know they do get inquiries at the town hall meetings and they do get people that -- 'cause there are resource -- the Resource Centers pick up information -- maybe the next time we can look through our resource information data --

DR. ZIEMER: Certainly the NIOSH curves look pretty flat for the last number of months and --

DR. MELIUS: Yeah, it started to go up a little bit I thought --

DR. ZIEMER: Well --

DR. MELIUS: -- but I looked at it quickly.

DR. ZIEMER: -- it looks like --

DR. MELIUS: Yeah, it --

DR. ZIEMER: -- some wiggles.

DR. MELIUS: -- could be (unintelligible) --

MR. KOTSCH: We might be able to make some correlations, Jim, with the Resource Center that's, you know, local for the, you know -- and see whether there was any kind of increase in activity following a town hall meeting.

DR. MELIUS: Yeah. I mean there's -- it's hard to tell 'cause, again, you know -- you know, the only -- we know that some people are frustrated with how long the process is taking so far, so there -- certainly it's not encouraging for people newly filing, and it may take a while until it's -- both the NIOSH program catches up and as this -- people start to see actually claims being compensated under the Subtitle E, or it may be that we've sort of run through who's -- you know, a large part of the eligibles because they're -- they're from the past, and I'm just thinking more, you know, how do you project out, you know, what's happening with this program in the future and -- and I think that has something to do with the strategy that, you know, Larry and -- you know, NIOSH uses to address these claims and so forth.

MR. ELLIOTT: I would just point out that since January the average submittal rate, NIOSH from DOL, has been around 220. It dips below 200, it comes back up above 250, but it's on average 220. And the town hall meetings really started last -- help me out here, Jeff -- I think late

last fall?

MR. KOTSCH: Right.

MR. ELLIOTT: So we really -- you know, it hasn't happened as to what I expected would happen here, but --

DR. MELIUS: Yeah, that's -- that's fair. My -- my second question is -- I believe Larry or I believe NIOSH shared -- shared with us a letter from DOL concerning some DOL deci-- decision -- policy decisions regarding some of the SEC sites, and I'm -- I'm trying to understand what the letter meant.

MR. KOTSCH: Larry, are you familiar with that letter?

DR. MELIUS: It's from -- you shared it with us a week or two ago. Was that -- a couple of weeks ago, a letter regarding some of the SEC sites and how you're going to parse and handle some of those claims -- or how DOL was, I believe.

MR. ELLIOTT: I don't believe I was the one --

DR. MELIUS: Okay, maybe it --

MR. ELLIOTT: -- that sent that out.

DR. MELIUS: -- came from DOL then.

MR. ELLIOTT: I will -- I will say this, that

each Special Exposure Cohort class designation that comes out of the Secretary of HHS is sent over to DOL --

DR. MELIUS: Uh-huh.

MR. ELLIOTT: -- and DOL has reacted to each one of those by reviewing the language and sending us a letter on how they're going to handle the cases within that class and whether or not there is any opportunity for dose reconstruction on a non-presumptive case.

DR. MELIUS: Uh-huh.

MR. ELLIOTT: And those have read differently, depending upon which class you talk about, but it didn't come from me.

MR. KOTSCH: Well, I mean I write those letter-- or at least I've written those letters so far interpreting how the HHS Secretary has defined a class, and then how we would approach the -- you know, basically defining the employee cases for that -- for that class and as well as whether we can determine dose reconstructions for the non-specified cases.

DR. MELIUS: So -- yeah, this may have been just a routine letter that either I noticed the first time or I received this type of letter

for the (unintelligible) --

MR. KOTSCH: Yeah, I'm sorry, I'm not familiar with what --

MR. ELLIOTT: Are you looking on the web site, 'cause we do post these --

DR. MELIUS: No, no, this --

MR. ELLIOTT: -- these letters on the web site.

DR. MELIUS: This was an e-mail.

MR. ELLIOTT: Okay, sorry.

DR. MELIUS: I believe, from some -- somebody. I'll look it up on my computer later, but -- if it wasn't special, that's good then, I'll...

DR. ZIEMER: Okay. Michael.

MR. GIBSON: This question's for either DOL or NIOSH. When you ask for additional technical or medical information from these claimants or their survivors, and you know, a lot of times -- sometimes the claimants are terminal at that point and aren't of the -- you know, sound mind, perhaps, do you have any ideas on how they're supposed to get this kind of technical or medical information when you guys have trouble getting the information from these DOE sites and getting -- getting dose reconstructions done and everything else? How

are these claimants and their survivors supposed to go out and get a doctor to write a letter and say yes, this place caused it or -- or -- or walk up to this big government entity called DOE and try to get information out of them?

MR. KOTSCH: Well, that's not -- I'll speak for DOL. It's -- obviously it's not an easy process for that claimant, especially if they are older, or even if they are -- sometimes even if they are survivors it's even tougher, especially if the employee's passed away quite a while ago. We have a lot of problems -- or the claimants have identified a number of problems where medical records are destroyed -- I don't know, it varies by state, but certain states will des-- you know, will allow their destruction 20 or 25 years ago. So sometimes people that -- if the claimant had a -- if the employee had a cancer like 40 years ago, they may not be able to -- if they -- if they didn't keep their own records to be able to retrieve those records, or their family physician may have passed away and passed his practice on to somebody else and either they didn't keep the

records or something else happened, but we have a lot of problems with claimants, and we try to help where we can to develop that medical information -- or to assist with information from the Department of Energy. But yeah, it's a -- it's -- it's a real problem and unfortunately it's not an easy one to address always.

DR. ZIEMER: Anything to add for NIOSH -- yeah.

DR. NETON: From the dose reconstruction side, the burden of providing the information for a dose reconstruction is really not on the claimant. It's on NIOSH to go to the Department of Energy and obtain the information. We do of course ask the claimant for any information they may have that they believe is relevant to a dose reconstruction, and in fact at times when a claimant does object to a dose reconstruction because we haven't done a sufficient job in a certain area, we'll -- we'll go back and -- if it makes sense, to go back to the DOE and obtain that information such as, you know, assertions that they worked with certain sources that weren't covered. We'll go back and try to see if those

sources were there in what rooms and that sort of thing. So the burden of providing the documentation for the dose reconstruction is really on -- on us and the Department of Energy.

MR. GIBSON: But --

DR. ZIEMER: But you were referring specifically to medical records, Mike, were you -- or other -- other records?

MR. GIBSON: Well, some-- sometimes other technical information's requested, but -- and maybe I didn't make myself clear. I understand that you guys are responsible for getting that -- the information for dose reconstruction, but we've seen the trouble that you have, the trouble SCA has in getting this information, so you can imagine how it compounds on the claimants and the survivors and, you know, it just seems to me that the -- the scuttlebutt I've heard from claimants, they -- they just -- they get frustrated and get ready to give up, and -- when it, on the surface, would appear they have a good claim. And so I -- I would just encourage both NIOSH and DOL to really look into some way to -- to try to help these

people get the in-- show them the path to try to get this information so that they don't -- they don't give up on their claim and -- and if the -- so justified, they're compensated.

DR. NETON: Well, I guess I'm a little confused. I mean we don't ask them to go get the information. We get it. If they -- if they inform us that there's information that the DOE should have on them, we will go back to the DOE and file supplemental requests on behalf of the claimants. There's -- there's really no requirement for the claimant to go work with the Department of Energy to get the data that we need for dose reconstruction.

DR. ZIEMER: What about on the medical side with Labor, do -- is the claimant expected to come up with --

MR. KOTSCH: Pretty much, the --

DR. ZIEMER: That may be the issue.

MR. KOTSCH: Yeah, the two pieces obviously to start the claim are the evidence of employment and evidence of the medical condition. And the onus is basically on the -- the employee -- or the employee or their survivors to supply that information. Now for the employment, our

claims examiners will assist, you know, through -- if they can't get it directly, they'll assist through the Social Security Administration trying to get some records from them. They'll at least provide some evidence of employment at a particular site -- again, because sometimes these dates of employment could be 60 years ago. For the medical it's a little more onerous, almost. I know Department of Labor attempts to intervene sometimes, but we're not always able to collect that information, either.

MR. GIBSON: I just -- I have been told of a claimant -- I have not seen the letter and I don't know if it came from DOL or NIOSH -- that requested information of the stuff the person was exposed to during their employment at the facility.

DR. ZIEMER: I think probably -- we do know that claimants are given the opportunity to provide such information if they know what it is, and I think we've also heard that that's often misunderstood, that they feel like the burden is on them to show what they were exposed to. And that's part of I think

preparation for the interview even. Is that not correct?

MR. ELLIOTT: That may be, but I think we need to be very careful here and clear in --

DR. ZIEMER: (Unintelligible)

MR. ELLIOTT: -- what aspect of the claim filing process we're talking about. This could be a Subtitle E case where they are asked -- the burden on the -- is -- is put on the claimant to provide that level of detailed information about what they worked with, what they were exposed to. That all goes to DOL's responsibility in determining eligibility of a claim. At NIOSH we don't -- our goal is not to put burden on the claimant. We're -- we're trying to work with the claimants and it's our burden to go find the information necessary to do dose reconstruction.

MR. KOTSCH: You're right, I wasn't -- I wasn't thinking Part E when I was responding. I was responding in Part B space, not (unintelligible) --

DR. ZIEMER: (Unintelligible) cases where they're asked for dose information (unintelligible) --

MR. KOTSCH: I -- I think they probably are. It's fairly new to me, as far as the process goes. I know we are developing information on the different sites, as well as the toxic materials that were at those sites. So if we -- if we knew the person's employment category, we could probably still make that link to exposure to different toxic materials at the site. But I -- I have to admit some ignorance as far as not knowing all the ramifications of Part E because I have not -- I get my training in a couple of weeks on all (unintelligible) --

DR. ZIEMER: Right, if it is a Part E and it's the -- it's the dose information, would the Department of Labor go back and try to obtain that on behalf of the client, or do they still put the burden on the client?

MR. KOTSCH: For dose dat-- information?

DR. ZIEMER: Aside from the medical, the -- the radiation.

MR. KOTSCH: Oh, the radiation dose --

DR. ZIEMER: On the Part E.

MR. KOTSCH: Yeah, that -- well, the Part E basically transfers over from the Part B program --

DR. ZIEMER: Be transferred over, so --
MR. KOTSCH: It's -- it's -- there's not -- it's not intended to double the --
DR. ZIEMER: Okay.
MR. KOTSCH: -- workload.
MR. GIBSON: This -- this information came to me second-hand. If -- would there be a -- a legal issue or anything else if -- if whoever this person is, if I can get a redacted copy of that letter from -- through this friend and bring it to a meeting -- the next meeting, would there be a problem with that so we could determine whoever generated and show exactly what the person was asked for?
MS. HOMOKI-TITUS: My only request would be that if -- if you're going to make it public here that you just run it by us to make sure that everything that needs to be taken out of it is taken out.
MR. GIBSON: Okay.
DR. ZIEMER: Thank you. Rich, did you have a comment?
MR. ESPINOSA: No, I -- yeah, on the silicosis cases, there's only specific sites that are covered under the B on this.

MR. KOTSCH: Yeah, silicosis really just applies to mining activities at the Nevada Test Site and up at Amchitka, you know, where they drilled the tunnels.

MR. ESPINOSA: Yeah. Well, my question is is if somebody applies -- if somebody didn't work at one of these specific sites but applies under a silicosis case, are they being referred to the E?

MR. KOTSCH: Part E will cover it -- or will at least address that -- that issue.

DR. WADE: I have a very general question, if I might.

DR. ZIEMER: Yeah, Lew.

DR. WADE: I mean there's enough that's transparent in the program now that we have some substantial numbers. When I look at cases that were referred to NIOSH and then that have been returned from NIOSH with recommended decisions, my calculator says about 24.3 percent of the cases have been accepted for compensation. I wonder what your reaction is to that number. I'm sure there were projections done early on as to estimating the cost to the program. What's -- what's the

reaction in DOL to that number?

MR. KOTSCH: I have to admit I don't know what the early numbers were -- were. I know DOE was -- and Larry might know better. DOE was I think initially projecting quite a bit lower than that, probably lower than ten percent, maybe, you know, into the single digits -- lower single digits. I think when we did our initial estimates, and I wasn't -- I have to admit, I was not at DOL at the time that those estimates were done -- when the Act was initially passed and OMB probably asked for an estimate -- I'll just say personally, I'm not speaking for the program at this point; I don't know exactly -- I think we're probably at a higher rate than maybe they initially projected. And I don't know whether -- I mean that's just my personal opinion, but Larry may have more programmatic --

MR. ELLIOTT: I'll only speak because I was here at that time, and DOE and DOL were talking about this and the numbers that they were talking were between ten and 15 percent compensability rate for dose reconstructed cases. And obviously we're -- we're seeing

much higher, and I think that's due to -- to claimant-favorable assumptions that we're making in our approaches that we use.

DR. WADE: I just wanted to get that on the record. Thank you.

DR. MELIUS: I would --

DR. ZIEMER: Jim?

DR. MELIUS: I would disagree with that, to a certain extent -- in fact, to a great extent. I think one of the problems with the early estimates, and I was around for those also, was that they -- DOE has always grossly underestimated to the -- the extent to which their workforce was exposed to radiation, and I think we're seeing repeated examples of that. And I think if you look at the history on -- on some of these sites in particular, you'll -- you'll find just -- just based on some of the external monitoring data, that they are -- DOE, you know, repeatedly claimed that there were very few people with significant exposures, you know, whatever level you want to call it. And I think we're finding that there were -- there were many more.

Secondly, those projections also based on how -

- out of the total workforce, and we're seeing only people that -- filing claims. And you know, claims -- people filing claims, it's a very complicated picture and we've just talked about it now with these latest outreach efforts and so forth, and people file claims -- it's not like the whole universe is filing a claim. You know, they have some -- some extent what they know about their exposure or believe about their exposure, you know, to some extent it -- it -- it's driven by success at some sites, which may be we're selecting out what are sites that have a -- a much higher exposure and therefore higher -- higher -- you know, favorable -- you know, claims rate or whatever you want to call that.

So I'd just be cautious in trying to draw too much from what we expected, you know, 'cause it was based on relatively little data, and I think on some data that was, you know, perceived differently by different groups involved.

DR. ZIEMER: Jim?

DR. NETON: I just have a slightly different take on that. I think what's driving these

large numbers, to a tremendous extent, is the missed dose calculations applied by NIOSH in dose reconstructions for respiratory tract cancers. In many cases claimants are being compensated for respiratory tract cancers when they have no evidence of any positive bioassay measurements at all. I'm not saying it's not reasonable. I'm just saying that the detection limit for the ability to document exposures to determine compen-- that they're non-compensable is very difficult for exposures to these actinide elements. And -- and you'll see that in that 24 percent, I would say the vast majority of those are respiratory tract cancers for folks exposed to actinides.

MR. KOTSCH: But I think, Jim, some of that is related to the way they've selected -- you've selected -- NIOSH has been selecting its cases, too.

DR. NETON: That's a very good point. These numbers shouldn't be considered hard and fast. Many of the respiratory tract cancers were -- were easier to process under the efficiency program that we enacted, and -- and that may be in fact why a large number are being

compensated.

DR. MELIUS: Can I just add that it would be helpful to -- rather than conjecture on some of this is to see some analysis of this, and if NIOSH will be willing to share -- do some of this analysis and share that information with us, I think it might -- it might be helpful at some point. I'm not -- not as a criticism, 'cause I understand you've got many other things to do, but it's -- you know, if it's going to become a point that we need to address in some way, then I really think we should -- let's get the data and let's talk from data rather than --

MR. ELLIOTT: We would be glad to work with DOL on that, but DOL needs to do this because we don't -- NIOSH does not make compensability determination; DOL does. We only provide dose reconstruction -- estimate of dose reconstructions here for them to use in that determination.

DR. MELIUS: Well, I think we could base it as well on estimate dose reconstruction.

MR. KOTSCH: I'll take that back, though, as an action item to address.

DR. MELIUS: Thank you.

DR. ZIEMER: Any further comments or questions on these reports?

(No responses)

Thank you, Jeff.

MR. KOTSCH: Thank you.

DR. ZIEMER: We're going to recess now until the public comment session, which will be at 7:00 o'clock back here in this room. So we look forward to seeing many of you at that time.

DR. MELIUS: I was just getting warmed up.

(Whereupon, a recess was taken from 4:45 p.m. to 7:00 p.m.)

GENERAL PUBLIC COMMENT

DR. ZIEMER: Well, good evening, everyone -- pleased to have you here tonight for the public comment session of the Advisory Board on Radiation and Worker Health. My name is Paul Ziemer and I serve as Chairman of the Board. I want to take a moment and sort of acquaint you with who the Board is or what the Board really does and what we don't do. We have a certain amount of limitations ourself, but let me kind of acquaint you a bit with the Board.

This Board is an independent body. We are not part of the government. We are -- all the members of this Board have been appointed by President Bush to serve in this capacity. We come from a variety of backgrounds. There are several that are technical people with backgrounds in things like health physics, radiation safety, nuclear engineering, some with medical backgrounds. Some are from the worker segment. That is the trades and that sort of thing. And under the law, this Board is set up to have broad representation of that sort.

There are ten members of this Board, eight of whom are here at the moment, plus -- eight, one, two, three, four, five, six, seven, eight, right. See, I'm the technical guy. I can count. Lew Wade is the Designated Federal Official, so he -- he is a Fed, and under the requirements of the Federal Advisory Board (sic) Act, we have to have a federal person sort of be a part of our deliberations. And we have Ray Green, who is our transcriber. Contrary to what some people think, Ray is not on oxygen. He is -- yes, some people have

thought that, what happened to that poor fella -- he is transcribing for us.

The Advisory Board is charged with overseeing, as it were, and giving advice on the dose reconstruction process. And since we are an Advisory Board, what we give is advice. Our advice can be ignored. It can be accepted. We always think it's worth accepting, but the people we advise don't always think that, so you know how that goes.

But one of the things that we do -- and we do this on a fairly regular basis -- is we come together and we meet probably an average of six times a year in different locations. We come together and we get updated on what NIOSH and Department of Labor are doing in the dose reconstruction and the worker compensation program. And we have the opportunity to give input to the Secretary of Health and Human Services on the program. So our function, in a way, is a sort of oversight/quality control function. We do like to learn where the glitches are in the program so sometimes we can help smooth the way, as it were.

We do not handle the individual dose cases.

That is the job of the federal agencies involved. Many of you here tonight have specific cases, and may have concerns about your case. The Board probably will not be in a position to answer your specific questions, although we would be in a position to help you find where you can get answers if that is an issue with you.

What we do try to learn as we hear -- and we hear a lot of people's stories. Many of you are here to tell us your story, and those are very important because from them we learn what's happening in the program, how is it going, how long have people had to wait for actions. Where are the glitches. And from that we can, in a sense, be of help to you, even though it's the federal folks who will deal with your case. So if you have an issue and say well, I didn't get this filled out correctly, or they didn't understand this or that, we will try to help you get to the right person.

But we are not the ones who review or -- or actually do the dose reconstructions. We are not -- we are not a review board in the sense

that we hear cases where people say well, I didn't get treated right; I want my case to be reviewed. We are not an appeals group. That is -- under law that is -- we're not permitted to do that.

Our function is to advise on the program in terms of whether the dose reconstructions are being done properly. And in the case of the special cohort petitions -- and there's one from Y-12 in process -- this Board also makes recommendations to the Secretary of Health and Human Services on that kind of thing. So I give you that as sort of background so you understand there are certain limitations in terms of what we're able to do in terms of your personal case, yet we still want to hear what your issues are and make sure that somebody is available to assist you in whatever way is appropriate.

So in some cases you may have questions -- why did this happen or why did that happen -- this Board may not be able to answer that for you specifically. But we will try to make sure that we get the right person to help you as the need arises.

I might also add -- I told you that we have a vast variety of -- of people on the Board in terms of technical and work backgrounds and so on. We come from different parts of the country. Some of the folks here have experience in facilities such as yours. I myself began my career at X-10 and worked some at Y-12. So this is kind of home for me. I get a little emotional about Oak Ridge. Okay. Yeah, look at my wife -- see, even -- she gets more emotional than I do. How about that? Okay. So I have a list of people who have asked to speak and I'm going to go just in the order given here, and the first one is Thomas Duncan. Thomas Duncan here?

UNIDENTIFIED: (Off microphone) (Unintelligible)

DR. ZIEMER: Okay, we'll -- we'll skip ahead and then come back. How's that?

Chris Elliott? There you go, Chris. Just approach the mike here.

MR. C. ELLIOTT: Well, I'll give this my best shot. Is that --

DR. ZIEMER: Yeah.

MR. C. ELLIOTT: My name is Chris Elliott. I'm

an affected employee or some people like to call us victims or whatever. My history is 21 years at K-25 in the fire service, approximately nine months at Y-12 early in the '60s for about four months in the biology division -- which I was working for X-10, but at the Y-12 site. And in the late -- '97 -- '96, early '97, as the (unintelligible) coordinator for fixed fire protection for Y-12 fire protection systems.

During all this time, especially at K-25, I sit here -- and bear with me, because my problems are all really in my head. I have been diagnosed with cognitive deficit, early dementia, frontal and right lobe brain damage from toxins and heavy metals, and major severe recurrent depression since -- I've been on disability from Y-12 from -- since 1997, February.

I've set (sic) here for two days and listened to the NA-- whatever that group is that -- the contractor group that's kindly (sic) bouncing off NIOSH's findings, and I wonder, since K-25 is a special cohort site, that -- is anybody -- not monitoring, but looking at the way NIOSH is

doing the dose reconstructions for the non-covered illnesses such as skin cancers from the people at K-25, which I have a case on that, and my wife also entered a case which was denied. But I wonder if the same methodology that's being kindly (sic) challenged to a point at Rocky Flats and Savannah River is being used at K-25, and is there any challenges or things going on there at that site to say yes, you're doing this right and no, we think you're doing this wrong?

My wife worked there for six years as clerical, and I know you can't do anything about this, but I want you to hear it. And her dose to her skin came up as 11.217 rem or a 42.17 percent of probability, which it has to reach 50 percent probability to get compensation. That was a little less than six years employment in the clerical environment. I spent 21 years in the fire service environment, as I told Mr. Zimmer (sic) there -- Ziemer. When everybody was running away from it, we were running toward it. Yet I had a basal cell carcinoma on my forehead and my whole body -- I mean the skin dose came up as 14.8 rem. That, to me,

in one way of looking at it, in 15 more years I only got three more rem exposure. To me, that's -- that doesn't quite balance out, you know. So that's one of the things that I -- I'm concerned about is the way they do the business of checking.

Well, I've heard high-risk jobs, bioassay, you know, in high-risk professions inside the plants themselves. We were in the fire service. In 21 years I never remember a bioassay being done on myself. The records say I had one, and I don't remember it -- which is not unusual, considering my mental capabilities right now -- but to me, I don't know why we weren't in a bioassay program because we were exposed to numerous releases, fires of materials and we had to go in and pull people out of releases and excursions and whatever. Y-12 is comparatively safe, as far as I know. I didn't get into much over there with the rats and the mice, that I know of. But we had a lot of toxins and the heavy metals and a lot of chemicals and stuff at K-25, which were very injurous (sic) to the people down there.

I worked my way up from a fire driver to the

chief of the department at K-25. But at the time I made chief, I was in the throes of this illness that I have right now, and I just could not keep it. It was something I had worked for all my life down there, and I had to give it up. And then a few months later, in October of '96, they decided my services were no longer necessary and laid me off and I found a job at Y-12. But I only lasted till February of the next year and had to go on disability. Tried to come back after six months. Y-12's own medical department would not allow me to come back, and I have been on permanent and total disability since '97. It's a hard thing to take, for somebody who's worked all their life, to go home and not be able to work and not get a paycheck, as such. You get a disability check -- but anyway, that's not really probably germane to all of this.

I was -- I will -- one thing I am proud of, I was a member of the original group at K-25 that started all this. Where you're at today started at K-25 with a group of about 50 employees who started showing up with cyanide, biocyanate in their urine, and we started

trying to get something done, get somebody to listen to us that there was something wrong. And that's when the study from Dr. Locke and Dr. Byrd* ensued. For about two years we went through ever (sic) kind of test I guess imaginable, and that's where a lot of my diagnoses came from was out of those testing. But I think this movement that's going still today started at K-25 in the '90s. So I'm proud of that. I'm proud of -- we stood up, and then other people started standing up and trying to get to right some wrongs.

I will say one thing -- and don't take this wrong -- there's some things that happened in this country that's horrific. 9/11 was horrific. I feel very deeply that the people suffered tremendous loss. This country did, too. But the government ran over theirselves (sic) to compensate the families of those people who were in the wrong place at the wrong time. We worked at a place that's been proven that people higher up knew what it was doing to us and were not informed. Places I ate in, smoked in, chewed gum in in my street clothes, in my coveralls, in my fireman's uniform, when

I left down there you couldn't go in there without double-C protection, double boots, double gloves, respirators. You couldn't even go in the building, and I went through those buildings numerous times with just street clothes on. You breathe a lot of dust and stuff like that and, like I say, I hate what happened at 9/11. But the people who worked at the plants in this country are just as much victims and are just as deserving of compensation than those people.

And I hate it, but that's the way I feel about it. We gave a lot to help win the Cold War, and some more than others. A lot of people who worked with me are no longer here. The process has outlived them.

And I just -- that's about all I've got to say, and I appreciate you and I appreciate what all you're doing, but there's a lot of people hurting out there and they need help. They don't need a lot of technical talk, a lot of -- I've got a lot of charts in here that I can't understand. I don't know what they mean. We need results, not technicalities. Thank you very much.

DR. ZIEMER: Thank you, Chris, for your comments.

Next -- it looks like Herman, Herman Potter? Yes.

MR. POTTER: Hello. My name's Herman Potter. I work for the United Steel Workers. I've been asked to come here to inquire about a letter that was sent to each Board member by (unintelligible), United Steel Workers Safety and Environment Director. He was -- he was wanting to know what actions, if any, it was taken on this letter that was sent, and I would like to read the letter, with your permission. It's (reading) Dear Chairman Ziemer and Advisory Board Members, Unions and workers -- worker groups have organized meetings with NIOSH and its contractor support staff to provide input into the site profiles being prepared for use by radiation dose reconstructors in the compensation program. This NIOSH initiative was triggered by a formal request from the Advisory Board. With the exception of several locations, we're growing increasingly concerned that this input is not being fairly considered by NIOSH or ORAU. We

believe that it may be appropriate for the Board and/or its audit contractor to evaluate the degree and extent to which the workers' comments were evaluated and were relevant -- and, where relevant, incorporated into the site profiles. This letter requests that the Advisory Board and, where appropriate, its audit contractor review the comments provided on NIOSH site profiles that were submitted by the local unions or worker groups, including at Hanford, INL, K-25, Portsmouth, Paducah, Rocky Flats, Fernald and Chapman Valve. These comments are contained in the TopHat database, but to date we are not even aware whether these have been reviewed by the audit contractor. For example, in the recent Hanford site profile review.

And it says (reading) Thank you for your consideration and -- and please contact Herman Potter if you have any questions.

And I might add that very recently, even -- basically a non-typical DOE site, NFS out of Erwin, Tennessee, we had U.S. -- United Steel Workers received requests and -- in assistance in their site profile. And we had actually --

we had actually provi-- started providing that assistance. And in that -- in that specific case, NIOSH and the -- and the contractor has been working with us to find out what information was provided to them by that contractor. But there is a problem that that contractor, on its initial -- on the initial request for documentation to review in order to prepare for that site profile, had refused to provide that information.

Now this -- this is not -- this is just very basic technical information. It's just procedures, bioassay procedures, things that should be in a Technical Basis Document. But that type of relationship or that type of action by the contractor does not lend -- does not lend credibility to this program.

But back to the letter, Michael Wright had asked me to actually approach you all with this and find out what actions have been taken, or if any are going to be taken.

DR. ZIEMER: Let me give you a preliminary response. I believe I got a copy of the letter, and I'm -- were the Board members copied? I just saw it earlier this week,

actually, but -- and -- and have not replied to that letter. But let me tell you generally, we are making concerted effort, and particularly with the help of our contractor, to garner the comments of workers in the work site. I know that NIOSH is also now doing the same. Whether the specific comments that you're referring to have been addressed, I don't know the answer to that. But we certainly will have that and I want to make sure that we follow up on this and -- as we proceed in reviewing those various site profiles. And certainly -- I'm -- I'm looking to see if any of our -- John, did your folks get a copy of that letter, as well? If not, we will provide it to our contractor.

DR. MAURO: (Off microphone) Yes, we are of that -- aware of the letter.

DR. ZIEMER: Okay.

DR. MAURO: (Off microphone) We have been in communication with NIOSH and their contractor (unintelligible) that information (unintelligible) TopHat database.

DR. ZIEMER: Right. The TopHat database is the -- the key. We will certainly follow up on it. If you're asking whether it's all been

addressed, I don't think we know that right now, and the answer is probably somewhere in between. My guess is some of that probably already has been looked at by NIOSH, but we will -- we will make every effort to make sure that -- that that does occur. We thank you for that input.

MR. POTTER: Thank you.

DR. MELIUS: Dr. Ziemer, the letter is actually -- what's the date on the letter? Can you clarify that first, Herman?

MR. POTTER: The letter's dated June 27th, 2005.

DR. MELIUS: Yeah, this is -- goes back quite a bit of time, and I think it came in just before one of our scheduled meetings. It -- actually I'd inquired about it at that meeting, said it would be on the agenda for the next meeting, and then we had sort of a -- I don't know what you call it, emergency meeting, but the off-schedule meeting, last one in St. Louis, and I would actually like to see it -- if we can't have time to discuss it at the meeting now, that we put it on the agenda for the next meeting and have a formal presentation from

NIOSH, who, you know, claims they're being more responsive and trying to incorporate these comments. We have a lot of concern about that and I think we should formally discuss it.

DR. ZIEMER: Thank you. So -- yes, and so please assure your colleagues that we will address these issues.

Randy Layman?

MR. LAYMAN: Yes, sir. Thank you all for having me back. We spoke briefly yesterday and I made (off microphone) (unintelligible). My father worked at the Y-12 site that has been referred to at this meeting. (On microphone) My father went to work at Y-12 in 1958 and I was conceived as a child in 1962. I grew up being known as what was called a carbide brat. That plant used to be Union Carbide, and it went to Lockheed Martin and Martin Marietta. Now it's BWXT. Tomorrow it might be -- you don't know and you don't want to know, and that's...

Well, anyway, I have a picture -- my father was a assembly -- production machinist, and you all are calling Y-12 the site, but as I was growing up, the sign out in front of Y-12 complex said

Y-12 Nuclear Weapons Plant. Okay? So in my mind and in laymen's terms, that to me don't mean conventional weapons. Okay? And I understand that back in the -- the late '50s and early '60s that Y-12 especially had huge Navy contracts. They built weapons for the Navy. In other words, some of these things that you see on TV, a warhead that would come from 4,000 feet deep in the ocean, break the surface and then hit a target 8,600 miles away, Cold War (unintelligible). It took a lot of technology, guys like yourselves. You metallurgists and you physicists and engineers used to get together and draw these things up. Well, my father was the man that built these things.

Okay, the site that you call it that you go out there and look at now has 100 machinists. Okay? In 1975 Y-12 employed 28,000 people, 12,800 were machinists. My father was fourth from the top in seniority, and that was a very good job. He took good care of us. We -- we had a fine brick home with a basement. But I was a freshman in college when my father died. Okay? And that was -- he -- he had me on -- I

wasn't on scholarship. He was paying for that and it was out of school for me and I had to learn to be a man. And myself and my sister and my brother, we're successful business people here in Knoxville, and -- and we're not up here begging for the money. We're okay. But here -- there -- there's one statement I want to make and there's a question, because I realized where my father worked when -- when you get down into the bowels and the guts of Y-12 weapons plant, I believe that you all meet fierce resistance. Meaning this: I believe, sir, that there's places in Y-12 that you can't go. Because now that they've changed the plant to the large production facility, they're even taking some of the most dangerous -- most dangerous waste from the Soviet Union and storing it -- guess where? Thirty-five miles from where you're sitting. You guys are up here and you have this meeting in this nice hotel, but I don't even know in this room who has the clearance to go into the bowels of Y-12. And it -- to me, it's like chasing a ghost. But some of those buildings are not there. The production has changed.

But I have a picture right here, and I want to pass it around and I want you to look at it. This is a picture of my father at 43 years old, and he died at 53. He went to work at Y-12 in 1958. My mother said in five years his hair was solid white. In ten years he was bald. I'm 43 years old and this picture I'm about to show you is my father working in a dry box at Y-12. He's 43 years old. I want you to look at him and look at me. Now I told you yesterday he went from 235 pounds and six foot two -- he played end at the University, but because of a knee injury his football career was over. But he fought in Korea. When he came back from Korea he went to work at the plant, was the kind of man he was. But can any of you go to a place in -- I'm sorry -- (off microphone) in Y-12 that has a machine that looks like this? Now when you look at this picture, look at my father, but ask yourself what is inside this dry box that he's making, and what component is in it and what's -- when it comes out here it has to go on a lathe and turn (unintelligible) high speed (unintelligible) and this thing right here is -

- is what I want to talk to you about about these shavings flying (unintelligible) and how safe is this. Sir, you're a physicist. You figure this out. But this is the only picture I can bring you as evidence (unintelligible) where my father's -- he died in January, but in -- in October of that year, before he died, he went from 235 but his death weight was 173. I want y'all to see that just for a minute. (On microphone) And out of these 28,000 people that worked at Y-12, I'm proud to say that my father wasn't a wandering generality. He was a meaningful specific. He was fourth from the top out of 12,800 machinists. He knew what he was doing. When there was a precision project to be made, they called on Bill Layman, and I believe it cost him his life because -- I mean I believe they tried at Oak Ridge to have safety. But if you'll look at this dry box right here, if I were doing a dose reconstruction I would take that picture, if I could go to the bowels of Y-12, and I would find somebody who knows about a dry box like that and I would say sir, isn't -- 2005, if we had a dry box like this in here and somebody

was turning metal of it, how long do you think they would live?

Let me ask you all this right here. I can't think of one machinist that worked at Y-12 for 25 years in my father's era that lived to tell about it. They're all dead of cancer. Look and see.

I got one more thing I want to show you. (Off microphone) When I said that my father was a meaningful specific, my father was (on microphone) declared Mr. Safety -- (off microphone) now I (unintelligible) Mr. Safety on his job in 1971. That means -- (on microphone) Y-12 has a safety program, and they're big on safety out there. But when you have an employee that goes above what he's supposed to do and offers suggestions to the plant he works in and those safety values are taken and making policy because he -- he -- he did things that was -- made safe on the job, so he wasn't out there trying to -- to -- to do something foolish with this -- (off microphone) in east Tennessee we call it hot stuff -- and he -- he told me (on microphone), he said I -- I just got into too much hot stuff.

So I just wonder, when you guys go down there to do the -- the dose reconstruction -- okay, the number one thing, if any of you know about Bear Creek Road -- okay, when I was a kid we could go down Bear Creek Road 35 miles west of here and you could drive straight by Y-12, K-25, X-10, the Lab and the whole nine yards. Now if you get in your car and you drive down there, the first thing you're going to encounter -- okay, just say if you send a lady out of your office working from NIOSH. She gets in her car in Ohio and she drives to Oak Ridge, Tennessee. The first thing she encounters in the street on Bear Creek Road is the military, sir. If she don't have the credentials to get in, she's going to be met, or he, with stiff resistance. Okay? Then what -- let's say she gets inside that gate. Do you believe -- you want me to believe that she can go in the bowels of Y-12 and dig in their archives of the people that's died out there? That, to me, sir, in a dose reconstruction set up that way would be like trying to -- if building an automobile was settling these cases, a dose reconstruction and

a coloring book -- I mean a workbook is like carving a ancient stone out of a wall. It's backing up. It's wasting money. And no disrespect for you all, but folks, the people that's died at Oak Ridge, the money it costs to have this meeting -- this is the finest hotel in our city. We could have done this at the Holiday Inn, and the money saved from this could have bought some shoes for some kid that's daddy died turning metal out there making weapons to protect all of you, and me. Think about it. I mean if you think a dose reconstruction going on for four years and you don't have any more answers respectively than you've got right now, and you're going to do it another -- another four years, all I'm -- I expect to get letters from you, four more years just like the past four years. We're about to get it to dose reconstruction. Once it does this, it does that. But it's -- it's -- it's really not going nowhere. In east Tennessee -- y'all might see me as a redneck hillbilly, but I'm telling you there's -- there's time to spin your wheels, and they've spun enough. It's up to you. And if you said President Bush ordered

you all to handle this, then why aren't you doing it? Why are you letting NIOSH tell you all that they're going to Oak Ridge and getting all these samples? They can't even get in, sir. That -- national security is threatened if your people go digging in the bowels of Y-12. Russia's most dangerous stuff that they can't handle is sent 35 miles west of here and kept in our safes at Y-12, and you all want to do a dose reconstruction? If you walk into those places and breathe it, you'll die. You can't go in the bowels of Y-12, sir. If you can, at least convince me of that. I'm talking -- my NIOSH numbers is 5502. My name's Randy Layman. You can look at my father's employment record. But if you'd seen him when he died, a big thick tongue and just -- just purple. He just went down to nothing. He not only had myelomytic (sic) leukemia, but they said -- they said his leukemia was in the bone marrow. It was in his blood. It was in the lymphs. It was -- he was consumed by it. And he worked even Friday -- my dad carried a lunchbox to work, sir, and his lunchbox didn't just have a -- a meal in it. They had a joke. At the

guard shack every day when they checked my dad's lunchbox -- Mr. Layman, we see you brought your medicine cabinet with you today -- because of the stress. And my daddy would joke about that, but when you're talking about ulcers on top of ulcers, your hair falling out, losing weight, getting weak, not knowing what's going on, but go to work on Friday -- and my dad hated the doctor, but my sister right here, he asked her to take her -- him to the hospital on a Sunday night, that he felt weak. Tuesday they diagnosed leukemia. Thursday they gave him a shot of chemotherapy -- and one more time I'm going to tell you, at this hospital right across the river, my daddy died on Friday holding my hand and telling me that he got this stuff from Oak Ridge. You can believe it or not, and your check is not going to make or break me. I'm standing on my own and I can make it. But you might tell some widow woman that because of this alphabet (unintelligible) the bowels of Y-12, and I was close to him, and right there's strict proof. And I feel like if you want a dose reconstruction, go down there and say I've got somebody that's Mr. Safety.

Look at this dry box. Would this fly at Y-12 right now? And the people will tell you no, we had to get rid of them a long time ago. Well, why was that? Because they leaked. Well, what was in them that could leak? Weapons grade uranium, and once this stuff's enriched, it won't go away.

There's things out there that I believe will never go away. You can't get rid of it. There's nothing you can do with it. There's vats of fuel. There's -- there's -- it's -- it's almost like we're at a stalemate, and to call it a dose reconstruction and keep going, to me, and with all due respect to you, I believe it's a waste of time. Sometimes it's time to cut your losses, pay the people that deserve it. If I deserve it, pay me; if I don't, don't. But stop the letters. Stop the high-priced meetings, and -- and -- and buy some kid some shoes that's daddy died out there trying to defend the United States and Israel. Do something right that you can feel good about. Don't listen to all this hogwash. But if you can't go to the bowels of Y-12, how can you do a dose reconstruction? I'll guarantee

you they won't let you in. How many Q clearances do you all have? And on top of that, how many of you -- and with this (off microphone) knowledge -- and with all due respect, how many of you can handle top secret material? You can't even get there. The Army's in the street. They'll stop you in your car if you don't have (unintelligible) -- bye-bye (on microphone) and that's how it works. Convince me different and I'll shut up. I'm only here for a few minutes to see you all. Life goes on for you and life goes on for me, but the fact stands, the man that you see working in the dry box, you can have it, but somebody take the -- if -- if I could go, I got the guts to ask them (off microphone) why did you do away with these machines, because -- I'll -- I'll tell you one more thing. (On microphone) N.C. State had a group of seniors that developed a new type of Geiger counter, and a man here mentioned K-25. I talked to a man last night that works at K-25. They thought they had the best hot-stuff readers in the world. Inci-- these seniors from U.T. -- I mean N.C. State brought their Geiger counters

or equal-to Geiger counters, and they started going off through the door. There was hot stuff all over that place. They found a fake floor with waste just dumped and built over it. That place is hot, real hot. Sir, can you go to the bowels of Y-12? Can you?

DR. ZIEMER: I cannot go to the bowels of Y-12.

MR. LAYMAN: Who can?

DR. ZIEMER: We have some on the Board that can.

MR. LAYMAN: Well, let's see what he can find. And would you get back to me, please?

DR. ZIEMER: And let me comment -- thank you.

MR. LAYMAN: Yes, sir. And I don't -- I'm not being hostile to you, but --

DR. ZIEMER: No --

MR. LAYMAN: -- you do -- I'm an enlightened person.

DR. ZIEMER: Yeah. Let me tell you that the -- the task of garnering the dose information on the workers is a NIOSH task. They have people that are able to garner that information. We also have folks on our contractor's side that have the appropriate clearances to go into the various facilities. Now I don't know if you

realize that actually if we're not able to get the dose information on a person, then we have a process -- and it may be that you're not familiar with that, but there is a process which essentially assigns worst-case dose to the individuals in the absence of information. And -- and it's a process that we're required by law to follow. We cannot ignore -- I understand your sentiments. You must understand that this Board and NIOSH are charged by law to follow certain procedures. It's a bureaucratic thing, admitted.

MR. LAYMAN: Sure.

DR. ZIEMER: But we cannot simply say well, we're not going to do this. We will, you know, ignore what the law says. There will be some frustrations in the process. We -- this Board, NIOSH, our contractors -- will do our best --

MR. LAYMAN: I appreciate that.

DR. ZIEMER: -- to -- to --

MR. LAYMAN: (Unintelligible)

DR. ZIEMER: -- try to determine, whether it's your own case or others, if we can reconstruct the dose in a manner which we believe is reasonable, it will be done. If we cannot do

that, NIOSH will say so. They already have cases now where they have said we cannot reconstruct this person's dose and therefore recommend they move into the Special Exposure Cohort.

MR. LAYMAN: When national security is at stake, there's -- there could become --

DR. ZIEMER: That could --

MR. LAYMAN: -- stalemates on that ---

DR. ZIEMER: -- happen. That could happen.

MR. LAYMAN: -- and I realize that.

DR. ZIEMER: If we cannot get the information, then we have some alternatives. We will do our best to do it in a fair way --

MR. LAYMAN: I appreciate you very much.

DR. ZIEMER: -- and you understand that we have some limitations on what we are legally able to do, but we will do our best to be fair, not only to -- to your father, but all other folks. We appreciate, you know, what -- the impact it has on individual families. You -- we know that people are not just numbers.

MR. LAYMAN: Yes, sir.

DR. ZIEMER: And we want to be cognizant of that as we proceed. We know -- you know, the

cases have numbers, yes, your numbers, but each case is unique. We're honestly trying to do our best to -- to be fair to all of those concerned.

MR. LAYMAN: Yes, sir.

DR. ZIEMER: And we -- we recognize that in many cases it's not an issue of just the money. It's an issue of fairness --

MR. LAYMAN: Sure it is.

DR. ZIEMER: -- and it's an issue of, you know, not -- not only fair treatment, but -- for example, what's -- were folks deceived, in a sense, by their own government --

MR. LAYMAN: Sure.

DR. ZIEMER: -- which is, you know, an issue we hear many times. So we're cognizant of that. We -- we will honestly do our best to address those.

MR. LAYMAN: Thank you so much. I appreciate that.

DR. ZIEMER: Yeah.

MR. LAYMAN: Thank you, sir.

DR. ZIEMER: Howard Lawson.

MR. LAWSON: Lawson, L-a-w-s-o-n.

DR. ZIEMER: L-a-w -- okay. Oh, law, yes, not

-- okay, yes, Lawson.

MR. LAWSON: Good evening, and my name is Howard Lawson. I work at BWXT, Y-12. I'm electrician by trade, and I'm also one of two full-time union health and safety representatives. And on behalf of the ATLC and the ATLC president and vice-presidents, let me tell you that we appreciate the work that the Board does. I know a little bit about your travel schedule, and it has to be sometimes inconvenient for you, at the best. And if there's any way that the ATLC can assist the Board in getting information to help workers and former workers at Y-12, we'll be happy to do it.

I don't have many complaints. I've got some -- some comments and suggestion, and one important question -- well, that's important to me -- that I wish you could answer, and I'll get to it last. But the first two things here are kind of superficial. The first is the meeting location. You're in Knoxville for an Oak Ridge meeting. It might better serve the claimants if -- if you could meet at -- in Oak Ridge. I know the old Doubletree, it's probably not as

adequate as this, but it'll make do.

DR. ZIEMER: And let me insert here. We -- that would have been our preference. We actually had trouble getting it scheduled for this meeting. This -- this was not our first choice, honestly, and we're hopeful that we can meet in Oak Ridge in a future time.

MR. LAWSON: (Unintelligible) I guess it's Doubletree now that --

UNIDENTIFIED: (Off microphone) (Unintelligible) before.

DR. ZIEMER: As we did before.

MR. LAWSON: Right, right. The other one is that -- the advertisement, getting the word out on -- on this particular meeting. I didn't see it because I had access to e-mails through the union, but one of the ladies was telling me that it was a -- a small ad in the paper in the classifieds, and particularly hard -- hard to find. If -- next time, if you could see it -- if you had, you know, a bigger advertisement, you might get a better turnout and a better participation.

Next, the phone interviews that the -- I guess it's one of the first steps that is -- is in

the dose reconstruction process, it -- if you could change the questions to -- to be more oriented towards the -- the buildings in Y-12 and the processes or the components that were used, the workers would -- would have better -- could give a better indication of where they worked and what they worked with, rather than -- I believe I remember one of the questions saying something about a specific radionucleide (sic). You know, most workers out there don't know what nucleide (sic) -- one from a -- one from another. And also it would be helpful if the interviewer could have some semblance of a working knowledge about the Y-12 site and they could get an idea of the exposures that the workers were exposed to, and the hazards -- in building say 9212 or 9206, as opposed to 9720-6. In other words, the difference in the hazards in the east end and the west end. This -- I heard -- I believe it was yesterday, about the HP, how -- how they are plentiful now, and I can attest to it that they -- they are, they're plentiful now. But in talking with some of the old-timers, the time frame through the late '60s, '70s and even into the

'80s, HPs weren't all that plentiful and available to the workers and -- and their job sites. Now whether they were adequate or not, I'm not -- I can't say, but they weren't all that plentiful then as they are now. And some of them back in those days were even paid for with X-10 money. Therefore they stayed mainly in the X-10 building. They were -- they didn't smell as good as the Y-12 building, but they weren't as contaminated as the Y-12 buildings, too. You know the -- the rat building and some more of them.

Okay, my -- my question that I mentioned, too, that I'd like to -- the Board to satisfy, deals with the use of -- of coworkers for dose reconstruction data. I don't -- I've got a little bit of a problem with that in that how -- how you would use the -- which coworker would be selected. They -- they give you some scenarios -- we're using electrician, since that's what I am, I know a little bit about. Today I might be relamping in a building -- a clean building like this and with say Joe. And then -- but the next day I'd be working with a different coworker in the 9212 head house

basement, and most likely I'm going to be in a full dress-out, anti-Cs, and a respirator. So for the purpose of the coworker dose reconstruction data, which coworker are you going to use? Would you be -- use the one where I worked with the -- changing the light bulbs in a clean area or would I be -- would you -- will it be -- use the one when I went to the head house basement? How -- how -- what's the process for determining which coworker is used for that re-- reconstruction data?

DR. ZIEMER: And perhaps we could ask Jim Neton or one of his folks to answer that. I can tell you in general what they would tend to do would be to find the one that had the highest dose of -- of the group and -- and use that as the assignment, but Jim, clarify for us.

DR. NETON: Yeah, you -- you raise a good question about this coworker data.

DR. ZIEMER: This is Jim Neton, who --

DR. NETON: I'm sorry --

DR. ZIEMER: -- is with NIOSH.

DR. NETON: -- with NIOSH. There's been some confusion about how we're doing this, and we're not doing -- using exact side-by-side workers

for the very reasons you mention. It's very difficult to demonstrate that these workers had identical exposures. So what we do is take the -- the samples for all workers who were monitored, and if we have no idea where the person worked or -- or what their exposure was and they should have been monitored, we will pick the high end of the monitoring data and use that to do the dose reconstruction. If we believe that the person was not in a position that they needed to be monitored, we will take the average value of all the monitored workers and assign that. So it's a lot more rough than -- than you'd think. It doesn't get down to specific job. It's all monitored workers, and we err on the side of conservatism and claimant-favorableness to give the higher exposure. I don't know if that answers your question.

MR. LAWSON: (Off microphone) It answered a little bit (unintelligible) confusion. Say -- say we have -- we -- we have secretaries that are on the east end, and they're monitored. Even up until just a few months ago, they -- they were in the urinalysis program. They are

obviously on the low end of the scale. They're going to get virtually nothing. And the carpenter that's working in one of the process buildings, he's -- he's going to get the max. Now -- but to reconstruct it, where do you go from there?

DR. NETON: Well, it depends on the individual case, but in general I could say that if a secretary who -- they were monitored? If there's monitoring information, we'll use the actual monitoring information to reconstruct the dose. But if a secretary were not monitored and -- and our investigation reveals that they should have been -- in other words, they had potential exposure -- then we would more than likely use the average value of all the monitored workers at the plant. This is not 100 percent the way we do it, but that's what we would do if we couldn't determine and we believe that the secretary had potential. If a carpenter were not monitored and he should have been monitored, and we believe that there was a large potential for exposure, we would pick the highest exposure of all the monitored workers -- not the highest, but the -- towards

the high end, what we call the 95th percentile of the extreme end, and say we don't know; we're going to use a highest value because, again, we don't know and we'll be conservative and select that.

DR. ZIEMER: Okay. Thank you. Ken Silver.

MR. SILVER: Good evening. I'm Ken Silver, Department of Environmental Health, East Tennessee State University. My comments are about the draft Los Alamos site profile. I have two requests -- I'll be very brief; you have other working people waiting to talk.

DR. ZIEMER: Yes, but that's -- that's fine. Go ahead and proceed.

MR. SILVER: Very briefly, two requests. Please go back to New Mexico soon for a Board meeting and put the draft LANL site profile on the agenda. And two, before the meeting in New Mexico -- within the next year, please -- see to it that ORAU provides a detailed response or rebuttal to my written comments on the draft LANL site profile, which OCAS was kind enough to post on the web site.

My comments don't come from the ivory tower. In October 2002 you had a Board meeting in

Santa Fe at the Inn of Loretto and I'm proud to have been part of the social movement that helped liven up that meeting. I didn't write my comments until NIOSH and ATL held a meeting in Espanol in New Mexico June 18th of this year in response to a request from UPTE* Local 1663, and I spent the better part of the late '90s from the Openness Initiative until 2001 going through public source documents on Los Alamos historical processes, emissions and exposures. There are very, very serious problems with the LANL draft site profile in terms of using readily available public information that someone with a large contract ought to be able to get. If I could get it a few years ago from public sources, hey, what's the problem here? Secondly, LANL has not made available a very important source of information, the occurrence reports collection that is in technical area 35. It's the mother lode of nose swipes, bioassay data, spills, accidents, contamination incidents from 1944 into 1991. I had access to it, no security clearance, from 1996 to 1998. In my comments I developed an estimate of the number of occurrences that the site profile

missed, somewhere on the order of 250 occurrences, that could be documented if NIOSH and ORAU got into that collection.

And because you're a federal advisory committee, you're probably aware that public interest science, which is responsible for many of the health and environmental protections we today took for -- take for granted, grew up right here in front of federal advisory committees in the 1970s. So I thought well, can we take a public interest science approach to this draft site profile? What does a public interest scientist do? You look at the docket, the cited sources, and independently evaluate how they were interpreted. I couldn't even get to first base. There are 254 cited sources in the LANL site profile; 41 percent of them are not available to the public, period. I sat down at the computer terminal at Los Alamos's main library. They're not on the library shelves, they're not on the open net health-related database of DOE, they're not on the Energy citations database, they're not in the Los Alamos Historical Documents Recovery Project, the Zimmermann Library at UNM.

Roughly a third is simply not available. Another 17 percent have copying or page charges. Another six percent from NTIS, and you know how much they charge. So more than half of the basis of the site profile cannot be subjected to a public interest science approach.

So the working people have a lot of really interesting things to say about what's in the document from the standpoint of how doses are being assessed, as we speak, and the injustices that are occurring. So please get back out there soon.

DR. ZIEMER: Okay. Thank you for that input, Ken.

Next we'll hear from Thomas Smith, Y-12 -- Y-12 and K-25, I guess.

MR. SMITH: And X-10.

DR. ZIEMER: And X-10, okay.

MR. SMITH: I don't know where to start, really. I used to have a friend who worked for the Oak Ridge Associated University -- in fact I dated her, so she better be a friend -- and she used to tell me -- now this is a few years back, but she used to tell me you don't want to

work in that building; too many people are dying and too many people have cancer, and this is what my statistics show. Well, of course she's no longer with ORAU, but I'll be honest with you, this will not get it. That's a TLD, a dosimeter. That won't get it. I guarantee I could -- I can prove it won't work. It didn't work with me. I had cancer, and I thank God I don't have cancer any more, they cut it out. But if you get alpha beta particles in an open wound, you're going to get cancer. And I'm not a doctor, but I know for a fact that happened to me.

If I could just read a little bit of this. This is a letter of denial, of course, and this is -- I appealed the case and this is my denial letter, and the interviewer was real nice. I've got nothing bad to say. I've been treated very, very nice. This says (reading) After a review of the above evidence, it is sufficient to establish that Mr. Thomas M. Smith has skin cancer and the onset of this disease occurred after his initial exposure to radiation in covered employment.

Okay, findings and facts. This is the same

page. (Reading) Medical evidence establishes that Mr. Thomas M. Smith developed skin cancer after he began employment at K-25/Y-12 plant, and after his initial exposures of radiation to that employment.

And this is the dose reconstruction estimate, which was too low. That's the reason they denied it. There's no way a TLD could indicate cancer in me. It says (reading) Mr. Thomas Smith does not meet the criteria of an individual with cancers to have sustained a cancer in the performance of duty.

Okay, I'll get away from that and I'll tell you how I got the cancer. I was -- I was a lineman, and we had stripped some hardware off of some poles west of the 9212 building. In fact it was real -- you know, relatively close to the building. And as a lineman, you put -- you put your gloves -- get this thing adjusted. You put your glove -- you've got to work with gloves. You put your gloves in your hardhat, that's how you take care of them. That's how you find them when you want them. I cut my head. Granted, I didn't turn it in. It was just a small gash and I -- I cut it when I got

into the truck. I hit my head. I didn't have a hardhat on. So months went by. Well, the cut would never heal. Then my hair started to fall out and I got a little concerned. People started to notice, so I went by and talked to Dr. Zimmerly* in medical, and he recognized it as probable cancer. So he set up a -- an appointment for me. They did a biopsy and it was basal cell carcinoma.

Okay. Of course I was angry, mad at myself, too. But they then -- then I got to thinking about well (unintelligible) get cancer? I'm still wearing the same gloves, still using the same hardhat. So I go to health physics -- or radcon, rather. They checked my gloves -- and I've got witnesses, people that were in my crew were standing right there -- and radcon said these gloves are hot. I said well, check my hardhat, and the hardhat was hot, but not as hot. So naturally I changed gloves and I changed hardhats. That's where the cancer came from. A particle got in an open wound and caused cancer, it's as simple as that.

And every time I've talked to anybody I've told them the same tale. The cancer could not be

traced back to a dosimeter. It could not be -- it could not, in a condition like that, say you know, that I -- you know, I always wore my TLD. I've been going in and out of that plant for well over 30, 35 years and my -- my numbers just didn't show up high enough, so they said we're sorry, we can't do anything about it. And I'm not complaining about the money, like this gentleman here. You know, my God -- my God'll take care of me. I'm not worried. But you know, if they'd just admit hey, okay, we're sorry. That's all I want to hear. You know, keep the money. Give -- give it to widows and -- and small children, the people that need it. I don't need it. But that's my issue and that's my story. Thank y'all.

DR. ZIEMER: Thank you very much.

MR. LAYMAN: (Off microphone) Sir, can I say one more thing?

DR. ZIEMER: You bet.

MR. LAYMAN: (Off microphone) (Unintelligible) this badge?

DR. ZIEMER: Of course.

MR. SMITH: I don't know if I'll show it to him or not.

MR. LAYMAN: (Off microphone) Is it hot? (Unintelligible) --

MR. SMITH: It might be, I was in the bowels of Y-12 today.

MR. LAYMAN: (Off microphone) I glow in the dark anyway. This right here is a modern dosimety (sic) badge compared to what my father had. My father had one of the oldest ones, and if this thing is bad, then my badge was ancient. If you -- if you took one of those old ones in there now, I mean it -- it'd be off the page.

MR. SMITH: Actually -- actually I don't think this is -- this is probably okay. This will do its job as far as detecting, you know, alpha, beta, gamma, but --

MR. LAYMAN: (Off microphone) What about (unintelligible)?

MR. SMITH: No, no.

MR. LAYMAN: (Off microphone) (Unintelligible)

MR. SMITH: No.

DR. ZIEMER: No, these are not for -- these are not chemical detectors.

MR. LAYMAN: (Off microphone) Those are still dangerous.

DR. ZIEMER: Oh, yes, of course.
MR. SMITH: Strictly radiation. Thank you a lot.
DR. ZIEMER: Thank you very much. Next, Edith Livingston. Edith? Is Edith here?
UNIDENTIFIED: (Off microphone) (Unintelligible)
DR. ZIEMER: Oh, okay.
UNIDENTIFIED: (Off microphone) She had her question (unintelligible).
DR. ZIEMER: Oh, she did? Okay. Okay, very good.
Ida Humphries? Is Ida here? Occasionally people sign this thinking they're signing the registration sheet rather than the sign-up sheet, so that happens on occasion.
Kitty McNamara? Kitty.
MS. MCNAMARA: Thank you for the opportunity to speak. I'm the child of a Y-12 worker, the grandchild of two Y-12 workers and -- my grandparents got there when it was still Tennessee Eastman, that's how long ago it was. They came here -- moved here from Massachusetts for what they thought was going to be a golden opportunity to provide for their children after

the depression.
I don't want to go into a long story, but I do have some concerns. My grandmother worked K-25 and Y-12 as a secretary, typist -- clerk/typist, those were her titles. However, on several occasions she shared with my parents that she actually went down into the plant with her boss. That wasn't her assigned place, but it was several times a week. Unfortunately, she died in 1956, about 18 days -- 17 days after her first grandchild was born.
My concern is, you know, we talked about doing the averages and everything, but this was a lady who developed colon cancer in her fifties and died from it. Parents lived long lives, whole family history. If these dosimeters don't, you know, reach the same -- you know, the level that they assume, you know, how's that going to affect us?
Also I had a concern and I stressed it earlier today to the young lady who was doing the interviews out here that when my father worked there he -- he was put on a medical retirement in 1974. He was a machinist and then an inspector. For years he never talked about

anything that went on there. I mean they were held to confidentiality. But the last couple of years before he died, he finally started kind of opening up and he shared with us stories of literally waiting in water an inch to two inches deep at their boots, that you could see the radioactive materials and particles floating around in. Talked about going up and they would check him, and they would just say well, go take a shower and get back on the line, or take your badge off and go back to work, or just go sit down for 30 minutes and go back to work.

So my concern is a lot of these dosimeter readings may have been skewed just by the fact that they wrote them down wrong. My dad voluntarily participated in the mercury studies that were done by Emory and by Michigan -- I believe it was University of Michigan. He went in there and they were pricking his fingers, and he kept telling them he didn't feel anything. He didn't feel anything in his toes and his feet. His toes would turn black -- I mean like he'd walked in coal dust -- and they would say you're lying to us; you have to be

feeling something. Now this was a -- my daddy, if he got a cough, he started this -- I got the flu, you know, I mean total no tolerance to pain. But he could sit there and take this and never -- I mean wouldn't feel a thing, could not pick a coin up, could barely hold a coffee cup because of the fingertip -- no feeling. But yet his studies from the mercury all came back no sign of mercury poisoning, no sign of mercury poisoning. This is -- and this was even in the '80s and early part of the '90s, so these are things -- you know, I understand the frustrations of people here because this is what we dealt with.

My dad was burned in a beryllium fire. He was the first person to ever cut it, and it burnt -- it caught on fire, burned him. He, for the rest of his life, from where his glove start to where his coveralls started, in his neckline where his coveralls were, and on his face around his mouth and chin area burned. He had -- looked literally like cancerous lesions. I called it like leprosy. For the rest of his life.

They had let-- we had letters that said --

where they sent stuff off and said well, this is not consistent with someone being exposed to beryllium, yet he was the first one to ever really work with it. He was called a malingerer. It's in writing. He was called a hypochondriac. They kept telling him he had chronic dermatitis. This man had chronic dermatitis, as they call it, from 1959 until the date of his death on March 3rd of 1998. Never would go away. Couldn't -- nothing they could do.

He's been turned down -- or my mother has been turned down on appeal. And actually in my letter -- my -- and when I testified at the appeal, I said the same thing you did. My dad was on the line giving his life for this country. They were more than welcome to give millions of dollars to people who just happened to be in the Towers, but they told my mom your husband's life is not worth $150,000. We're fighting for my grandparents now, just hoping maybe we can get something for my mom. My dad retired at 47 on medical. They took his life -- or his medical insurance out of his life insurance to keep those premiums paid. When my

father died my mother got a grand whopping total of $9,000, and she was at retirement age. So these are things we've had to deal with. I do have concerns, and maybe you all can answer this, about -- what about the mercury exposure combined with the others? Are they going to open up things on beryllium besides just chronic beryllium disease? What's going to happen if we can't find medical records? That's what we're running into. This happened in 1959. You know, we can't find -- my dad's doctors were dead and gone by the time the federal government finally decided to pay attention to this.

And I also wanted to ask about the hazards and the concerns for family members. You know, I can't help but think if my dad got all this exposure what he may have brought home. He was burned in November of 1959. My sister, who was conceived and was born a year later in November of 1960, has had chronic problems with her skin, same thing. Certain chemicals that she gets around, she -- she was a hair dresser. She went to school and couldn't do it because her skin broke out in these big blotches.

She's had chronic blood dyscrasia problems, can't put a finger on what's causing it. My dad was actually diagnosed with ITP at one time, but you know, never anything really came of that and we, there again, can't find records.

My sister that was born a year after that has had a form of lupus as a child, has had chronic problems. She's right now going to probably about six different doctors on a weekly, monthly basis. They can't figure out what's going on with her.

My mom, a year after this sister was born, so three years after my dad was born -- or after my dad was burned, had to have a hysterectomy for a pre-cancerous cervix. So I just -- that's a question I -- you know, I guess that's my question. Where's this going to leave us as far as, you know, the dosimeter reconstructions, you know, when you've got all this proof but nobody'll actually say yeah, more -- more likely than not, you know.

And another thing is, I was listening to some of these people were talking, like your wife with the 42 percent. You also have to look at

the but for. Yeah, you're going to have some other exposures in life, you know, that you may know -- I mean ever -- ever (sic) day we open up the newspaper and read where Sweet 'n' Low or red dye or something's going to cause cancer because it did in rats. But people may get through that, but for the fact that they worked at Y-12, or K-25 or somewhere else. They would have never gotten cancer with these other minimal exposures, but that on top of -- so I have a hard time with this setting a -- you know, okay, if it's not 50 percent, then it didn't happen. Thank you.

DR. ZIEMER: Thank you. And perhaps -- just some general comments. You must understand the way this law is structured, it doesn't take -- it doesn't take into account the possibilities that you raise, which are recognized by many scientists as important questions. Multiple exposures to things like radiation plus mercury, for example, or any -- any combination that you wish to talk about. Not only is the science on -- we're pushing the science on the radiation alone. When you add some things like other contaminants, let us say, first of all,

the science there is very sparse. And secondly, the law as it's structured does not even allow us to really do that, although there's, you know, been an indication in the past that conceptually that's what one would like to be able to do. We -- we can't actually do that. So in fact we do not, in a sense, take that into consideration.

Actually I think the only other time something is taken into consideration is smoking does come into the picture in the cases of lung cancers that we address because smoking is such an overpowering issue when you have lung cancer that if -- if a smoker gets lung cancer and is exposed to radiation, that sort of hurts their case because smoking is -- part of that is attributed to -- I think that's probably -- and Jim Neton can help me out. I think that's the only case where we consider any kind of a mixture. Isn't that correct? Yeah.

So yeah, but what -- what you say, we recognize is probably very important. And it's -- in a sense, we and our laws are at a loss as to how to address that at this time. That doesn't give much comfort to those who feel like that's

an issue for them, but that's in fact where we are on that. So we're not, in a sense, allowed to take that into consideration when we do our determinations, so...

And -- oh, the other thing you --

MS. MCNAMARA: (Off microphone) (Unintelligible)

DR. ZIEMER: And likewise the law does not extend to -- you mentioned the possibility of family members getting secondary exposure, as it were. That's not -- also is not covered in the law, though one would recognize there could very well be cases where that might be an issue.

MS. MCNAMARA: Do you know if there's any indication that that might be looked at? I mean I worked in an oncology office for a few years --

DR. ZIEMER: I'm not aware of --

MS. MCNAMARA: -- and he had a bathroom strictly for our patients --

DR. ZIEMER: Oh, yes.

MS. MCNAMARA: -- and employees and visitors were not allowed to use it --

DR. ZIEMER: Sure, sure.

MS. MCNAMARA: -- because of the potential, you know, exposure. So --

DR. ZIEMER: Right.

MS. MCNAMARA: -- you know, and I'm not saying necessarily for huge --

DR. ZIEMER: No.

MS. MCNAMARA: -- monetary pay-offs like they're paying the workers, but you know, it would be nice to at least be recognized as a possibility that, you know, we --

DR. ZIEMER: I'm not aware of any legislative efforts to address that. And ironically -- this is a little bit off-subject, I suppose, but ironically patients who go to their doctors and get radiopharmaceuticals, either for various scans like PET scans or for therapy using radioisotopes such as radioiodine, are in fact allowed to carry very large amounts of radioactivity back home under those conditions -- legally.

MS. MCNAMARA: Uh-huh, I know.

DR. ZIEMER: Probably much higher levels than one would expect to come out of any industrial process. That seems rather ironic, but that is the case.

Now, Tom Duncan -- Thomas Duncan. We finally get back to you on the list.

MR. DUNCAN: (Off microphone) (Unintelligible) or not.

(On microphone) I'm a Y-12 worker, machinist -- in the bowels (unintelligible) machinist. I spent two years working dry boxes. I had the record for having the most jobs at Y-12. I've been a machinist, MBS equipment operator, (unintelligible) operator, janitor, machine cleaner -- I've been laid off five times and never left the plant. Kind of like a mule, you know, you don't get rid of a mule. Don't care what you pay them, just -- you know.

I've sit (sic) in on y'all's meetings so I don't want to get way off into left field on some of this stuff, but y'all talked about (unintelligible) some of this stuff about breathing today, whether you do it through your mouth or your nose.

DR. ZIEMER: Yeah.

MR. DUNCAN: If you ever -- I have to be real careful what I say. I still carry a clearance. You know my boss, Ruddy*, he got in trouble for something similar to this, I guess. But it has

its own odor, you know. People don't realize that part of it. When it catches on -- on fire, whatever, you know, it -- I don't know if you've got little kids. When a kid runs up, you know, you're filling a gas tank up and they stick their nose -- boy, that gas smells good, you know. But you know -- you know it's bad for them, get away from there, you know. And you know, the closer you get to it -- it's like a skunk. If you're far away from it, it's got a distinct smell. The closer you get to it -- if you get sprayed by a skunk, you'll throw up. And if you go by the Golden Corral, you smell the odor of the charcoal. It's got its own smell. So you have to put that in the category of uranium's got its own smell. And so I -- I've been out there for 27 years. I'm not 50 years old yet, so far. I can't draw no retirement, have no benefits. I'm on vacation today, been on vacation this week. I got a letter from some lady -- Miller is her last name -- invited me to this meeting 'cause I -- you know, I hadn't heard too much about y'all people. The way I heard about this compensation program, a surgeon that removed

body parts -- had some cancer from my head to my chest -- he referred me to -- I was in the same building as this Workman Compensation outfit was, you know. He told -- he told me the cancer I had was -- I asked him about it and he said, you know, maybe what kind it was or whatever, you know. He said well, Mr. Duncan, you don't really act like you're right stupid. Ain't you ever heard of radiation before? I said well, yeah, you know, a few films at work and stuff. And he said I had a cyst and some other stuff on some body parts, they -- they took it out and he -- it was around Thanksgiving. He said don't -- don't plan on having a big Christmas. He didn't know where it's at. And that -- you know, of course I got lucky, and -- you don't get rid of cancer. I still got it. It's not like a cold, takes a long time -- I had some radiation treatments. I smoke. I've had a full body count. My lungs are real clear. A guard stopped me one day, said Duncan, you ought to quit smoking. I said well, I'm leaving right here and going down to the Butler building. I don't know if you know what that building is,

but it's where they -- beryllium. I said, you know, (unintelligible) beryllium. And I better get -- I'm getting way off-track here.

Some of the other things I wanted to talk to you about was -- you was talking about office workers, you know, we -- back when I first started there, you know, department heads, my foreman, people you trusted to keep you safe, that's their jobs, they get paid for it. You know, you can eat this stuff; it won't hurt you. You know, drink plenty of coffee, you piss it right out. I -- I -- you have a physical every couple of years. I don't -- they give you a sample box that's -- you check your stool with. I'm trying to be real -- anyway, it's all voluntary. So they give me one. I read the instructions several times, just couldn't make it through it, so I never give a stool sample. Urine samples, you know, they're pretty well mandatory. You know, if you skip one, you know, they'll get on you every once in a while, you know. And if, you know, if you happen to forget to take it home and do it on the weekends, you know, if you run up there and you'll drink a lot of water, you

can just -- you can get rid of your -- you can get your two bottles and you're out of the woods, you know. You're not subject to termination, not unless you do your urine samples.

Our monitors -- worked in a area -- the counts are getting too high, boys. When you load these parts, I don't care if they're black, put your (unintelligible) monitor off -- you know, your personal (unintelligible) monitor off. You've got regular (unintelligible) monitors hanging over the machines all the time. I fired up one job and they wanted me to run the job and it had a tag on there, you know, it'd been out of service for two years. I said hey, wait a minute, you know, you got to get this thing going before I want to start firing this thing up and that. And I got whipped, whatever you want to, for -- you know, matter of fact, I've been -- I got -- I got a badge. I used to have a TLD badge, you know, the blue badge on there. I had to go see the shrink because I was too safety conscious. That was the shrink's analysis, I guess. He said I'm going to move you out of the real hot area and put

you down in the whipping post, what they call it. And -- they don't -- he done -- and he said -- he said he done me a favor, and he probably did, and I have no regrets about that whatsoever. I still work in the security area and I still manufacture weapon components, not the hot stuff, but they -- they's several things that -- that goes along with it. Yeah, I'm getting way off-track.

The office workers, I was going to tell you, we had a secretary in that shop, you know, where -- back in the late '70s, you know, fires were everyday occurrences, you know, the smoke. They called the fire department. Fire department hooked -- you know, when the -- ceiling's a lot higher than this. When they get down about head level with the smoke, they'd make us all evacuate. That includes the secretaries. You know, we -- they had a secretary there in the office and we had department heads. We had all these engineers (unintelligible) the hall. You know, they had to go up there and we had to all go outside and stand at the little red signs. And you know, all the engineers, you know, same thing. Here

comes all these fire department guys running up there, you know, in their little suits and you had a big drum, you know, melting into the ground and, you know, they take care of that, you know. So I just wanted to mention to y'all, you know, y'all are wondering whether people that don't work with the material ever (sic) day, they -- they got their -- they got their little dose, you know. And the fire department, I -- I got offered the fire department truck driver's job once and I said y'all wait a minute, you know. I don't want to be going toward them fires, I want to be going away from them. You know, I don't want to be driving no truck, so you ought to really consider -- like machine cleaners, I was a machine cleaner for a while. You got coolant, and some of them parts that goes from the foundry, they have to go through a process of cleaning. Well, sometimes that cleaning process gets broke down far more than what you'd think and so you bring black parts up there. And all that oxide gets in the coolant and the machine cleaners, they have to -- they have to take care of that coolant coming in and

out, and that stuff was -- you know, I seen it was a lot hotter than just the actual -- but -- stuff I was working with. And I -- I -- you know, when they didn't clean the parts real good, they was sitting up there black, them -- them little gals come along with them little meters, come along and hit me once when I was working with it and I had to go to the shower three times. She says you come back again, I said, you know, we're going to have to get you out of here, you know, 'cause, you know, my hands are clean but -- we were just talking about some kind of rolling mill someplace else, some other part of the country, you know, and they was taking torches to the thing. It's possible, you know. That's -- that'd be the quickest and easiest way to separate that material. And now you can't do it to -- I'm going to stop there, but cost-wise, you know, it's possible. You know, somebody's got enough sense -- you know, they got -- to do it that way, yeah, that'd be one way of doing it. This time I -- I got one other little complaint. It's going to be a year before they even think about looking at the most -- looking

at my case. And I don't know if I got a year. And I got a 23-year-old boy in college. She's got a 22-year-old boy that's in vocational school. And I got a ten-year-old little girl right back there right now. But what -- tough sometimes, you know.

I work for the government, and if I get a job, you know, it don't matter -- sometimes -- I just wonder if this (unintelligible) people are planning on retiring the day they get the last one done. That's what wonder. You know, some of them -- I talked to a gal and she said well, we're mandated to get so many out. When I first started, they said we've got 5,000 cases we've got to review, and when I come back several months later, they still had 5,000 cases they had to review. Now it wasn't -- you know, it ain't according to who I talk to. They hadn't done one case. But I got some information from NIOSH the other day and they had done quite a few, you know, but they -- NIOSH has got a big stack full, you know, and I was wondering if they could -- my categor-- categorize instead of just going by numbers, categorize them, you know, for the people that

-- living that might need help right now than survivors ten years down the road, you know. That might be something they want to look at. My -- my medical bills has quadrupled in the last year, and actually I got a letter the other day when they removed some cancer from the side of my head, and it's something I have to update on my little report, you know, out here where -- respirator man here, and I don't mind that so bad. That's the outside part. When they remove body parts, that's -- that's when I really worry. You know, you only got so many body parts. And I talked to several coworkers that been there -- at -- one of them got colon cancer and one of them's got cancer on his kidneys and their application was denied. And they say that -- you know, I'm missing a thyroid now and some other little body parts. They say oh, you don't have to worry about it, Mr. Duncan, you're -- you're on that list of where the cancer is. And Linda Hamby, she passed away last year. Her -- her cancer was on the list. It was on the brain where they can't remove the brain, so -- and same thing, she left three kids, said it was on

the brain. And (unintelligible) -- I'm carrying my cancer for five years. That's what the doctor estimates. He said if you'd carried it another year, you'd have had to lose your brain, too. So I was just lucky.

And by the way, there's a Indian doctor down at the Y-12 medical -- when I come back off the life-threatening injury -- or life-threatening disease, he found a cancer in my throat. I give him all the credit for that. So I'm -- I'm going to let y'all go home, hear.

DR. ZIEMER: Thank you, Tom, for your comments. Incidentally, you referred to the backlog of cases, and I -- I don't know if you were here earlier, but NIOSH is making a very concerted effort to take tho-- get that backlog down, and they're actually making good progress. Interestingly enough, new cases come in nearly as fast as they get old cases out of the way, so sometimes what looks like a steady number of cases doesn't mean they haven't done work, and there are -- I think NIOSH earlier this year completed dose reconstruction on their 10,000th case. So they are moving them through actually quite -- quite well, but there is a backlog and

they're trying very hard to address that, as well. And so we appreciate your -- your comments on that.

That completes the public comment period for this evening. We -- additional comment? Sure.

MR. LAYMAN: (Off microphone) (Unintelligible) just one more?

DR. ZIEMER: Sure, yeah.

MR. LAYMAN: (Off microphone) I don't want to anybody (unintelligible) --

DR. ZIEMER: No, that's fine.

MR. LAYMAN: I know it's been a huge couple of days. I'm going to be here with you guys again tomorrow. It's --

DR. ZIEMER: Good.

MR. LAYMAN: I know this is -- you know, it's -- it's grueling at times and you guys have done a super job with your concentration and the effort you put into this. But I want to say one more thing.

When I was a child, on Sundays we could go out to what we called Carbide Park, and there was a big lake. The Clinch River about 35 miles west of here, and it was beautiful. And where you

have a nuclear facility, you need water for cooling and various things.

Well, when I become 15 years old, they put a sign up on that lake that said no fishing, and that was a lake that we -- we swam in when we were children. Okay?

About five years after that, and you can go down there tonight, and all over that lake there's huge signs that not only say no fishing anymore, but no body contact, because they dredged, and when they dredged and dug in the bottom of the Clinch River, which is -- runs right by Y-12 five miles downstream, within the silt they found mercury.

DR. ZIEMER: Yes.

MR. LAYMAN: It's full of mercury.

DR. ZIEMER: Right.

MR. LAYMAN: You -- you can't even go down there and stick your toe in it -- you know what I'm saying?

DR. ZIEMER: Yeah.

MR. LAYMAN: So -- I mean wherever you guys live it might be safe. I pray to God it is. But 35 miles west of here, maybe what you go out there and see now is one thing, but in the

mid-'70s, this place out here rocked, and they did a lot of things for the Navy, but there was a lot of people, a lot of Cold War casualties. And I look at them as heroes. These men here that are live are heroes. My father and the dead ones, too, we'll never forget them.

DR. ZIEMER: Yes.

MR. LAYMAN: They just -- they ran 28,000 people out there 24 hours a day. It was productions. The Soviets were building their bombs, we were building ours. It was -- it was a counter thing to keep peace, and a lot of men felt like that -- that it was needed, and some of them -- like you said, some -- some gave it all. And they offered me and my brother jobs at Y-12 after my dad died. Some guys came out from the plant and we kind of looked at each other and -- I could work at Y-12 right now myself, but I'm a salesman here in town and I like what I do. I have a flexible schedule, because a lot of people that go to work at Y-12 it's like going into prison.

DR. ZIEMER: Right.

MR. LAYMAN: There's no windows, and they have certain things to do and there's a lot of

safety and guidelines and a lot of do's and don'ts. There's some things you can't touch and some things you better not touch. There's consequences.

But somebody needs to be held accountable on the money that has been spent. Think about it. Do an analysis on how much these dose reconstructions has cost to this point, then you add your workbook program. How much is a workbook going to cost to complete? And if you take a workbook down there to Y-12 and you start saying guys, we're doing a workbook -- well, their -- their job is national security. They're not going to open up their bellies and let you fill out your workbook. And -- and if you did have a workbook, what good is it going to do? I don't understand that. I'm going to have to sleep on that one. But I'll see y'all tomorrow and I hope we talk again.

DR. ZIEMER: Okay.

MR. LAYMAN: Good night, everybody and (unintelligible) --

DR. ZIEMER: Thank you very much for your comments.

MR. LAYMAN: Thank you.

DR. ZIEMER: Again, we thank all of you who've participated tonight, and others who've been here just observing. The Board will reconvene tomorrow morning -- 8:30. And we have a fairly full session. We actually have completed I think for this meeting our Oak Ridge stuff, but you're all welcome nonetheless to come back 'cause there are many other related facilities that are being addressed. So good night, everyone, and we'll see many of you tomorrow.

MR. LAYMAN: Is there a special cohort meeting tomorrow?

DR. ZIEMER: Yes, it's not on Y-12, though. The special cohorts on the agenda include National Bureau of Standards and Linde Ceramics.

MR. LAYMAN: Thank you so much.

(Whereupon, the meeting was adjourned at 8:40 p.m.)

C E R T I F I C A T E 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 October 18, 2005; 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 4th day of December, 2005.

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STEVEN RAY GREEN, CCR

CERTIFIED MERIT COURT REPORTER

CERTIFICATE NUMBER: A-2102