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

TWENTY-SIXTH MEETING

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

VOL. I

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the Shilo Inn Suites, 780 Lindsay Boulevard, Idaho Falls, Idaho, on August 24, 2004.

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C O N T E N T S

Legend of the transcript:

[sic]	Exactly as said
[phonetic]	Exact spelling unknown
--	Break in speech continuity

P A R T I C I P A N T S

(By Group, in Alphabetical Order)

BOARD MEMBERS

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Professor Emeritus
School of Health Sciences
Purdue University
Lafayette, Indiana

EXECUTIVE SECRETARY
ELLIOTT, Larry J.
Director, Office of Compensation Analysis and Support
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Professor of Medicine
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MELIUS, James Malcom, M.D., Ph.D.
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Albany, New York

MUNN, Wanda I.
Senior Nuclear Engineer (Retired)
Richland, Washington

PRESLEY, Robert W.
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Clinton, Tennessee

ROESSLER, Genevieve S., Ph.D.
Professor Emeritus
University of Florida
Elysian, Minnesota

AGENDA SPEAKERS

(in order of appearance)

Ms. Laurie Ishak, NIOSH
Mr. Pete Turcic, DOL
Mr. Tom Rollow, DOE
Ms. Liz Homoki-Titus, OGC
Dr. John Mauro, SC&A
Dr. Joseph Fitzgerald, SC&A
Dr. Jim Neton, NIOSH
Dr. Paul Ziemer, Chair

STAFF/VENDORS

Cori Homer, Committee Management Specialist, NIOSH
Steven Ray Green, Certified Merit Court Reporter

AUDIENCE PARTICIPANTS

ANDERSON, BETTY A.
BEATTY, EVERETT RAY
BODNAR, LOUIS Z.
BRAILSFORD, BEATRICE
BRANDAL, LYNDA
BRASWELL, TODD
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CHANG, C.C.
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EGBERT, H. DOYLE
ELLISON, CHRIS
FRY, DAVID
HEISTER, MELANIE B.
HENSHAW, RUSS
HOSS, LARRY A.
JENSEN, CLINTON
JONES, BERTHA
KATZ, TED
MCCURDY, PEGGY
MCCURDY, WILBERT
MILLER, RICHARD
OSTROW, STEPHEN L.
OSWALD, ELEANOR
PETERSON, HENRY K.
POWELL, STEVE
PRESLEY, LOUISE S.
QUINN, JOHN D.
RICH, BRYCE L.
RINGEN, KNUT
ROCKWALD, LYNN
ROHRIG, NORMAN
SCHAEFFER, D. MICHAEL
SCHAUER, DAVID
TENFORDE, THOMAS S.
TOOHEY, R.E.

P R O C E E D I N G S

(9:00 a.m.)

REGISTRATION AND WELCOME

DR. ZIEMER: Good morning, everyone. I'd like to call the meeting to order. My name is Paul Ziemer. I'm the Chair of the Advisory Board on Radiation and Worker Health.

This is the 26th meeting of this Board. We're pleased to be here in Idaho Falls. If you'll indulge me, I'm going to begin with a little story.

My first visit to Idaho Falls was in the mid-sixties. I spent a week here early in my career, and at that time had two daughters. I subsequently ended up with four daughters, but at that time I had two daughters and my wife and two daughters accompanied me here. Now Linda, who was at that time the youngest daughter, had a special doll that went with her everywhere. And if you think back to the mid-sixties, the popular doll was a doll called Heidi-ho. So Linda brought Heidi-ho with her and she -- we told her where we were going and from that point on this town became known as Heido-ho Falls. And even to this day, when I told Linda where I was going

this week -- and Linda's in her forties now -- she said Oh, you're going to Heidi-ho Falls. So we're pleased to be here in Heidi-ho Falls for this meeting of the Board.

I need to give you several pieces of information. First of all, we ask that everyone -- Board members, staff people and members of the public -- please register your attendance with us. There's a registration book at the entryway. If you haven't done that already, please do that sometime this morning and we'll have a record of your attendance here with us.

Also you will find on the table over here on my far left copies of various documents, including today's agenda, plus various handouts from this meeting as well as documents from some previous meetings of the Board, and please avail yourselves of those material, as well.

If you're a member of the public and would like to address the Board during the public comment session, we ask that you sign up, also. There's a sign-up booklet back there at the registration table. The public comment period today will be an evening session. It begins at 7:00 p.m. We welcome any of you who wish to

participate to do so at that time. The meeting at that point is very informal, and you're welcome to address the Board at that particular point.

Also, I call your attention to the fact that on the agenda for Wednesday, the second day of this meeting, we inadvertently omitted the public comment period from the agenda. We always have a public comment period every day of our meeting. And in addition to the evening public comment session, we certainly welcome additional comments for individuals who may not be able to attend Tuesday evening. And you'll have to insert that into the agenda. The plan will be to do the public comment period Wednesday right after lunch, so that would show up at 1:30, just prior to the Board working session. So if you would insert that in your agenda, please, and the time for that will be dependent on the number of individuals who sign up and wish to speak at that point.

I believe that's all of the general announcements and information that I have. I'm not going to introduce the individual Board members to the -- those who are here observing,

but you'll see the placards that have their names and you'll be able to identify who the various participants and members of the Board are.

I do want to, however, introduce the Designated Federal Official, and that's Larry Elliott. And Larry, I'll let you add any comments you wish at this time.

MR. ELLIOTT: Thank you, Dr. Ziemer. On behalf of the Secretary of the Department of Health and Human Services, the Director of the Centers for Disease Control and Prevention, and the Director of NIOSH, I wish to welcome all the Board members and the public to this meeting here in Idaho Falls. We have a very full agenda and I look forward to a productive and informative session. Thank you.

DR. ZIEMER: As is usually the case, the first item on the agenda refers to the minutes of the last meeting, and some of the Board members did not see these minutes until last night or even this morning, perhaps, in some cases. The minutes are rather lengthy -- 68 pages, small print, singly-spaced. I ask the Board if you wish to take action on the minutes now or, as has become your custom, do you wish to defer action

until tomorrow's work session?

MR. ESPINOSA: Tomorrow.

DR. ZIEMER: I hear one tomorrow.

DR. MELIUS: Yeah, I -- definitely tomorrow. I haven't even received them yet, so...

DR. ZIEMER: Okay.

DR. MELIUS: I have to catch up with my materials.

DR. ZIEMER: They should be -- oh, you haven't got your packet even?

DR. MELIUS: My packet, no.

DR. ZIEMER: Okay. It's probably at the desk. We'll make sure you get it. Okay, we will definitely defer action on the minutes until tomorrow. Again I'll remind the Board members, look particularly at those parts of the minutes that -- where you are specifically identified as making comments or making motions to make sure that there's accuracy and a good reflection of what was done, and we'll have an opportunity tomorrow to take specific action on those minutes.

PROGRAM STATUS REPORT

We'll move on then to the program status report. This month's -- or this meeting's report

is going to be given by Laurie Ishak from NIOSH. Laurie, we'd be pleased to hear from you now.

MR. ELLIOTT: While we're loading up her presentation, let me introduce you to Laurie Ishak. She is a Presidential Management Fellow, just recently come to NIOSH in the Office of Compensation Analysis and Support, and she's serving as a communications specialist with us, and I'm sure that you will see more of her in the future.

DR. ZIEMER: And this is a test.

MS. ISHAK: I'll see if --

DR. ZIEMER: Thank you, Laurie. We're pleased --

MS. ISHAK: -- I can pass with flying colors.

DR. ZIEMER: -- to have you here.

MS. ISHAK: Thank you. Well, good morning -- or for those of you still on eastern time, like myself, I should say good afternoon. As Larry mentioned, my name is Laurie Ishak. I am a Presidential Management Fellow, a recent addition to the OCAS team, and it's a pleasure to be here this morning and I look forward to my future work with both OCAS and the Advisory Board.

Now we'll move on to slide number two. As

you can see, slide number two represents the amount of submittals from both the Department of Labor and the OCAS rate of production. The blue line is representative of claims received from the Department of Labor. The green line represents the number of draft reports to the claimants, and the red line represents the final draft dose reconstruction reports to the Department of Labor.

I want to take a moment here to point out a tremendously misleading visual effect of this graph. This sharp downturn at the end of the graph occurs because it only takes into account up until August 13th, so it looks like there's a drop-off right there at the end, but there really isn't. We strongly anticipate that when the numbers come in at the end of the month they'll be consistent with the numbers from the previous months. And with the green line we anticipate not only consistent numbers, but we anticipate much higher numbers, as well.

Now looking at the past few months you can see by the green line that we have increased production every month. And in April and in June we broke the record of 500 dose reconstruction

reports sent to claimants. While it does fall short of our goal of 200 dose reconstruction reports to claimants a week, it does indicate two important facts. One, our team is remaining consistent. As you can see from the green line, since March our team has steadily remained above the 400 mark in dose reconstruction reports sent to claimants. Secondly, as the green line clearly indicates, over the last few months our team is steadily increasing production every month. So you see both consistency and progress.

Also, by looking at the blue line on this graph you can see that the number that -- for the most part, the number of submittals from the Department of Labor is also decreasing. We're averaging 200 to 250 claims a month from the Department of Labor.

Now to mention the red line, you can see that the number of final dose reconstruction reports to the Department of Labor is also increasing. However, it is important to note that OCAS has little control over the red line. Once we send out the dose reconstruction reports to claimants, we cannot send a final report to the Department of Labor until they sign the OCAS-1 form and send

it back to us. But overall you can still see from the graph that the number -- the trend is increasing.

So in summary of this graph, you can see that as Department of Labor submittals decrease and OCAS production increases, the gradual decrease in backlog cases becomes an even more tangible goal.

Now I move on to slide number three, which shows the cases received from the Department of Labor by district. As you can still see that we've received the majority of our cases from the Jacksonville district, which is -- includes both the Savannah River Site and Oak Ridge National Laboratories. Together those two sites combined make up almost 6,000 claimants, so most of Jacksonville's claims right here come from those two sites.

You can see that Seattle comes in second with 5,186 claims; Cleveland comes in third, 3,485 claims; and you've got Denver coming in with 1,871 claims.

Now we move to slide number four. Slide number four represents the number of the Department of Labor cases received by quarter.

It's kind of a summary of the first line graph that we saw and just presents the information in a little different way for you. Now again let me start out by pointing this visual discrepancy here at the end of quarter four. Quarter four -- the fiscal year quarter four doesn't end until September 30th, so there's going to be a lot more information added there. So remember when you're looking at this graph, it hasn't decreased. It only includes numbers as of August 13th, so I'd like you to keep that in mind.

But you can see, this chart starts out at quarter one of '02 and goes through quarter four of 2004, and you can see that there's a general downward trend of cases received from the Department of Labor.

Let's go on to slide number five. Like slide number four, this slide represents the line graph that I first showed you in a little different way. Again -- I hate to harp on this matter, but this little visual drop right here is only because it only takes in the numbers for the first two weeks of August. It doesn't mean that production has dropped. And by the time we get the numbers in at the end of August, we expect

those numbers to be as high, if not higher, than the previous months.

I like this chart because it kind of shows how hard we've been working. You can see that between February and March there was a huge increase in production, and you can see that since April we have continuously increased production every month. And in June we broke the 500 record of dose reconstruction reports sent to claimants. In total we have sent 4,588 draft dose reconstruction reports to claimants.

Now you can see here in slide number six -- again, same presentation of the information in a different format than the line graph -- and this represents the draft reconstruction reports -- I mean the dose reconstruction reports sent to the DOL monthly. And this chart, like I said, coincides with the slide number two with the line graph. And again you see that drop-off right there, keep in mind it's only the first two weeks of August and that's why you see that drop-off.

But you can see here that some -- to point out again that OCAS has little control over the bars on this graph because we currently have 400 to 500 average OCAS-1 forms out a month, so we

can't send any final dose reconstruction reports to the Department of Labor until we get those OCAS-1s back signed, and then send them off to DOL. And we're averaging about 400 to 500 OCAS-1 reports out a month, so you can see the trend there. And you can see that, while we don't have much control over it, there's still a general upward trend in the increase of the reports -- final reports sent to the DOL. And as of August 13th we have sent out 4,097 final draft dose reconstruction reports to the Department of Labor.

Slide number seven represents the DOE response to requests for exposure records. As you can see, we have sent out 16,653 requests for exposure records covering 14,981 cases. At the risk of pointing out the obvious, let me say that the reason there are more requests than there are cases is because many of our claimants may have worked at multiple sites. Therefore you might have more requests than you do what represents the actual cases.

The responses from the DOE total 15,985 covering 14,226 cases. Again, more requests because claimants may have worked at multiple

sites. I also want to point out that the slide uses the word responses received, and not necessarily information received. And that's important to remember because sometimes when we get responses back from the DOE there may not be information about exposure history on there. But these are the number of responses we've received from the DOE.

And on the bottom you can see the age of outstanding requests. Anything 60 days or more, 90 days or more, 120 days or more, 150. And as an FYI, for the site that we're at now, the number of requests that we've sent to DOE for Idaho National Engineering Laboratory -- we have sent out 669 requests for exposure history. We have received from the DOE 651 responses, which equal about 90 percent of the requests that we sent out. There are 18 requests outstanding for greater than 60 days, which equates to about 3 percent of the requests we sent for the Idaho site.

All right, slide number eight pretty much breaks down the telephone interview statistics. Here you can see cases for which at least one interview has been completed is 16,230. And you

can see "one" is emphasized because in several claims you might have multiple claimants and therefore more than one interview has to be completed. But you can still see that there's a large majority of cases where we've completed one interview.

And then the interview summary reports sent to claimants, you can see the drafts equal almost 22 hundred (sic) -- 21,813. And currently we're doing about 200 to 300 interview -- telephone interviews a week, with about 20 staff members working on that.

We now have slide number nine, and slide number nine breaks down the number of telephone interviews conducted by month as of August 13th. The blue bars represent 2002, the yellow bars are representative of 2003, and then you have the green bars which represents 2004. Again, this chart shows that we are currently achieving approximately 200 to 300 phone calls a week on the telephone interviews.

All right. Slide number ten provides you with the dose reconstruction statistics as of August 13th. The first bullet shows you that there are 5,123 cases staged for dose

reconstruction, "staged" meaning that ORAU has gone through the file and that the DOE response has been received and a profile has been done.

The second bullet highlights that there are 1,466 cases that have been assigned for dose reconstruction. The assigned number of cases differ from the staged number of cases because while the file on its face might look complete, the information is actually not complete. For instance, the DOE response may not have any information on exposure history, or the site profile might not be complete for that individual claimant.

Now the third bullet shows you that the dose reconstruction draft reports sent to claimants is at 4,588, and then the final DR reports sent to claimants, DOL and the Department of Energy is 4,097.

Now this next chart breaks down the number of cases completed by NIOSH tracking numbers, and you can see the tracking numbers ranging along the bottom from 1,000 to 17,000. Now we're currently working with ORAU to reduce the cases with numbers below 5,000 by 20 percent in the next ??? period. There's a group at ORAU who's

actually working on these cases going through case by case to see why they can't be completed and to try to complete those in a timely manner.

Now I move to the next chart which shows the amount of administratively closed records as of August 13th. As you can see, the numbers are relatively small -- along the top there -- and most of the-- or all of these become -- the dose reconstruction becomes administratively closed when we don't receive the OCAS-1 forms back. Now remember, we don't have the authority to close a case. We only close the dose reconstruction process, send that to DOL and it's their responsibility whether or not to then administratively close a case.

Now the next graph I have here, slide number 13, depicts the number of reworks that we're getting back from the Department of Labor. Currently that number is staying at 7 to 8 percent a month being sent back to be reworked. The green bars are representative of the dose reconstructions received from the Department of Labor to be reworked, and the blue bars represent the reworks that we finish and send back to the Department of Labor.

Now it looks like on this chart -- and it may not be obvious. It looks like on this chart that the numbers of reworks is increasing because obviously the green bars are increasing. But what's not apparent from this chart is that we're also sending more reports to the Department of Labor, which means that the percentage is still staying the same. We're still getting about 7 to 8 percent back, not that we're getting back any more reworks than we were getting before. So the percentage is really what matters, and I don't think that's too obvious from this chart so I wanted to point that out.

Now let's look at slide number 14 -- we're kind of moving into a new area here -- the SEC petitions. As you are probably aware, the final rule 42 CFR 83 was published on Friday, May 28th, 2004. And this rule describes the process through which HHS will consider designating classes of employees to be added to the Special Exposure Cohort rule (sic).

Now the requirements for classifying a group under the SEC are intended to ensure that petitions are submitted by authorized parties, are justified and receive uniform, scientific and

fair consideration. You can see here that we received the first petition on June 15th, 2004, and that was actually personally handed to Larry Elliott at the meeting in Burlington, Iowa, so a little bit of background information on that first petition. Now we have nine active SEC petitions as of now.

Now you can see on the next slide what the breakdown is of these nine petitions. We have one from the Hanford site, three from the Iowa Ordnance Plant, one from K-25 at Oak Ridge, one from Los Alamos, one from Mallinckrodt, one from Paducah, then we have one various multiple facilities rounding out the nine active SEC petitions we have.

Now the SEC petitions that we have are currently in the process of being qualified, making sure that they qualify as a SEC petition, and we work with the claimants to make sure that it's done right. Under 42 CFR 83.6 through 83.11 there's a detailed process through which a claimant has to go through to file a petition under the SEC as an SEC class. Now we work with those groups to make sure that they're providing all the information, so there have actually been

several conferences -- phone or e-mail -- with some of these claimants to make sure that they're getting in the petitions in the format to meet the current rule.

Also you can see that for each qualified petition, once it becomes qualified, then we publish a notice in the Federal Register which will notify the public of NIOSH's decision to evaluate a petition. Now remember, it's a multiple-step process. First we have to qualify the petition. Now that's not saying once we qualify the petition that it becomes an SEC class. We're just saying that the petition, on its face, is appropriate and then qualified. Then we provide a notice to the public, and then we go through the process of seeing if it evaluates or if it qualifies as an SEC class. And again, all of our petitions are currently in the process of being qualified.

And then lastly, all qualified petitions will be evaluated by NIOSH in accordance with the provisions of 83.13 or Section 83.14.

All right. This last slide number 17 shows the number of phone calls and e-mails received from OCAS -- or received to OCAS and ORAU. Now

you can see that OCAS is receiving -- or has received 32,276 phone calls, and you see that ORAU has 111,616 phone calls. And there's also, you know, a big discrepancy between those two numbers, and a lot of that occurs because it is ORAU's responsibility to conduct the telephone interviews, so they're going to be getting more phone calls trying to set up these telephone interviews, conducting the telephone interviews and doing follow-up calls concerning the interviews. And most of the OCAS phone calls that we receive are status requests, people wanting to find out the status of their claim. And this last number -- last bullet will show you the number of claimant e-mails to OCAS is at 3,466.

This next chart is going to point out some of our accomplishments, and the first thing I want to point out is that the number of final dose reconstruction reports sent to the Department of Labor exceeds 4,000 now. It's hit its milestone of 4,000 and continues to grow, and as of today we've sent out more than 4,000.

You can also see that we have sent out activity reports. We're still doing that. We

sent out over 19,000 activity reports in July. And the activity reports, just to refresh your memory, is -- the first two page-- it's about five pages, typically. The first two pages are claimant-specific information where it gives the claimant information about their specific case. And then the next three pages are hot topics, if you will. Every claimant gets pretty much the same in the last three pages, and it covers information that maybe a lot of claimants have called in about to the PHAs or something that we want to share with the claimants. And like I said, we sent out over 19,000 of those in July.

We also continue to have the web-based status requests from claimants. We started that program, setting up the status base, in March. And since then we get about two to three web-based requests for status a day. Since then we've sent back 73 denials for requests. What happens is they might not have the specific information because of the Privacy Act. The status-based -- web-based status request requires specific information, and if they send the form -- the request without giving us specific information, we cannot send them back the

information. But Chris Ellison, our communications specialist, looks over each of those denials personally to make sure that we can't actually give them the information and that the computer's not making some sort of error. Then we send back a denial and, you know, telling them that they're missing some information, and then they have every chance to send back another web-based request for status -- or to call in, as well.

And we also have -- I want to add a point here that's not on the slide of accomplishments. Actually I have two more to add in here, and the first one is that under subsection (d) of the EEOICPA -- I still get tongue-tied on that one -- under subsection (d) it's our responsibility to appoint physician panel -- or physicians to the panel for the Department of Energy. So far we added 73 new physicians, bringing the total over 300 physicians that we have appointed.

And then I also want to mention that we have worked with ORAU to change our conflict of interest policy. Now it includes site profiles, as well. So if somebody has worked at a site and they're conducting the site profiles, the lead

site -- person doing site profile cannot have worked at the facility where the site profile is being done, and that's a recent addition to our conflict of interest, which -- make it a little stronger.

And then we also have OCAS staffing updates. We had a few changes here, including myself. We'll go through this quickly. This is the OCAS organizational chart. The yellow squares represent positions that are filled. Then you've got the white spots, white boxes where there are open positions that you can see on this chart.

First I'd like to announce that Jim Neton has moved from Technical Program Manager to the Associate Director for Science, as you can see on that chart, and Jim will be monitoring existing and emerging scientific issues relating to dose reconstruction and risk models.

We also have two new fellows to the program. First Heidi Deep is -- joined us as the ASPH Fellow, and the second you have myself, Laurie Ishak, joined as a Presidential Management Fellow, so you have two new fellows added to the program.

There are also ongoing interviews for the

research epidemiologist and the health communications specialists. The announcement for the Technical Solutions team leader has been closed, and there's also going to be two new positions for health physicists and one for the technical program manager to replace Jim after his move.

So that concludes my program status report and I am open for any questions that the Board may have concerning some of this information.

DR. ZIEMER: Thank you, Laurie. Let's open the floor now for questions. Jim Melius.

DR. MELIUS: Yeah, I have several questions. On the DOE -- requests for information from DOE, some of the past meetings you've presented information on which sites have the largest backlog. You didn't this time, though. Could you tell us -- update us a little bit on -- there were some sites that have been problematic in the past and it seems to me the numbers have gone down, so -- just trying to figure out if that's across the board or if there are still particular sites where there are difficulties getting information from.

MS. ISHAK: Well, I received some information

as of August 15th, 2004. I think typically the numbers are going down. I know that there was a problem with the Los Alamos National Laboratory sites, and of course I wasn't a part of the last meeting, but I'm not sure if that's the site you may be referring to, and there was a database problem with that site. We have currently worked with the DOE with the Los Alamos site and we've kind of corrected some of the problems, so that should be speeding up the requests that sent out there for that information.

Now I have -- my list is kind of long. Is there any site-specific questions --

DR. MELIUS: Well --

MS. ISHAK: -- or are you just asking for a general trend --

DR. MELIUS: -- just -- no --

MS. ISHAK: -- and some of the problem sites? I know it was Los Alamos, but that's been --

DR. MELIUS: Yeah, particular --

MS. ISHAK: -- corrected.

DR. MELIUS: -- sites.

MS. ISHAK: Okay.

DR. MELIUS: If you could share that maybe for future updates, just -- it would be easier if

we could just see the presentation that's -- you know, matches up with what we've received before.

MS. ISHAK: Okay.

DR. MELIUS: I also have a question on the backlog issue and this program -- I think you talked a little bit about last time, also -- or Jim Neton did -- about this program to focus more resources on the early cases. Now again I think you've made some progress on those cases, but not a lot, and you seem to -- it seems where you get stuck around -- you get a quarter of the cases done in each thousand and then it seems to slow down. And I don't know how many are out -- how many are out for review and so forth so that the number actually may be higher. It may be a third of them or something. But what -- what's the process and -- and so forth? It seems to me that you're doing 20 percent a quarter for those first -- seems to me you're not getting at those very easily. I know it's hard, but I'd be curious how you're doing that.

DR. NETON: Laurie, if you don't mind, I'll field that question.

MS. ISHAK: Okay.

DR. NETON: We are aggressively pursuing the

backlog and -- and in particular the cases with numbers -- ID numbers 5,000 or less. Laurie mentioned that we have incentivized (sic) ORAU, in the last performance award ??? period which ends this September 11th, to reduce the backlog of claims below 5,000 by 20 percent. We believe they're on target in doing that and are going to be very close, if not meeting that -- that incentivized goal.

Starting September 11th will be the two-year anniversary of the contract of ORAU and we are working closely to develop the incentive language for the next six months, and it will be heavily incentivized to eliminate the backlog below 5,000. In other words, we're going to try to continue to complete all the cases below 5,000. Now whether that's a reality or not, I don't know. There may be some issues -- and this may come -- become a little clearer when I talk about some of the things that we're doing with ORAU to develop coworker profiles and such so that we can start attacking those cases. 'Cause frankly, up until this point, we haven't had the technical tools, the ability to work those cases and that's why they're sitting.

DR. MELIUS: Okay. Wouldn't some of those -- if I could just continue on this -- wouldn't some of those cases also be SEC candidates because -- I mean at what point are you going to, you know, determine that you can't do a dose reconstruction? I mean you're going to make them wait until --

DR. NETON: Well --

DR. MELIUS: -- you know, till you've exhausted all...

DR. NETON: Well, I would -- I'm kind of getting into my presentation on tomorrow --

DR. MELIUS: Then that -- then that's fine --

DR. NETON: -- relating to certain dose reconstructions.

DR. MELIUS: -- if you'd rather -- if you want to answer that tomorrow, that's fine. I don't --

DR. NETON: I think I'd be better prepared in the context of my presentation.

DR. MELIUS: That's fine. That's fine. I'm just raising the questions that came up now.

DR. ZIEMER: Do you have any additional questions?

DR. MELIUS: Somebody else can go if they

want --

DR. ZIEMER: Henry has --

DR. MELIUS: -- but I may have some more.

DR. ZIEMER: Okay. Henry?

DR. ANDERSON: You were first.

DR. ZIEMER: I'm sorry, I didn't see -- Mark Griffon, then Henry.

MR. GRIFFON: I have one just -- just preliminary one, which is you gave a lot of case statistics -- claims and case statistics.

MS. ISHAK: Uh-huh.

MR. GRIFFON: But I didn't see -- you mentioned how many dose record requests have been made for Idaho, but you didn't mention how many claims have been submitted for Idaho and I thought that the audience might be interested in that -- claims for Idaho and the completed cases for Idaho.

MS. ISHAK: I actually don't have that information with me. It is on our public web site.

DR. NETON: (Off microphone) Those two numbers (Inaudible) or whatever.

MS. ISHAK: Okay, equal to the DOE requests, and those numbers --

DR. NETON: (Off microphone) (Inaudible) cases.

MS. ISHAK: Okay. If you'd like to hear them --

MR. ELLIOTT: I think -- I think Pete Turcic will speak to the statistics locally and regionally, as well as nationally, so I think that's where you'll find -- you'll get his presentation and I think that's -- we were relying on him to present numbers like that.

DR. ANDERSON: Yeah, my question is, it looked as though -- where you're processing about 500, it seemed, dose reconstructions a month, and do you see that as kind of now the -- your basic status? I mean are you up to speed and sort of running ahead at what you'd do is be kind of maintenance mode of this -- this is what your plan is and that's -- that's where you're at and now it'll just continue along at that, or are you -- is the goal of -- to get it up to how many a...

MS. ISHAK: Well, our original goal and still our goal is 200 a week. And we finally hit the 500 mark, which we see as clear progress. And I think that, seeing the charts from the previous

months, that getting to 500 was an accomplishment. And then of course we would like to get to 200 a week, and I think that we're moving towards that way. Again, we expect the numbers in August to be a little bit higher than they were from even the previous month, so I think the trend upward is not only what we're hoping for but what we're expecting in the next few months.

DR. ANDERSON: So you do expect it to -- to ramp up to the --

MS. ISHAK: We do.

DR. ANDERSON: -- 800 a month, about, roughly. Yeah.

MS. ISHAK: That's what we're aiming at. We're expecting that climb up there, and I think the trend shows that's where we're getting. So we went from 200 to 400 to 500, and --

DR. ANDERSON: Yeah, yeah, it seemed to be sort of that -- 500 and I wondered if you'd --

MS. ISHAK: Yeah, we expect that to --

DR. ANDERSON: -- reached sort of a -- yeah.

MS. ISHAK: -- go up, clearly. Clearly expect it to -- and like I say, we expect the numbers for August --

DR. ANDERSON: That's a lot of paper.

MS. ISHAK: -- we expect the numbers for August to be higher, as well.

MR. ELLIOTT: We hope that this is not a plateau.

DR. ANDERSON: Yeah, that's what --

MR. ELLIOTT: It's our full expectation to reach 800 a month or 200 a week. And if we can't do that, we're asking serious questions as to why and trying to investigate exactly what is preventing that accomplishment from -- from being recognized and achieved.

DR. ZIEMER: Gen Roessler.

DR. ROESSLER: I think Mark was ahead of me.

MR. GRIFFON: Go ahead. I've got another one, but...

DR. ROESSLER: Laurie, your last slide was informative, but I have two questions about it. This is the organizational --

MS. ISHAK: The organizational chart?

DR. ROESSLER: Yes. One is -- it would be helpful I think to the Board to see names associated with those boxes so that when we hear presentations we can see where the person fits in with the organizational chart.

It would also be helpful -- now I can read that, but I can't read it in the notebook. Maybe I need new glasses, but --

MS. ISHAK: It was difficult to get all those boxes --

DR. ZIEMER: You know what that's a sign of though, don't you?

DR. ROESSLER: I know that's what --

DR. ZIEMER: Okay.

DR. ROESSLER: But most of us are in that position, probably, so it would be helpful to have this chart readable as a handout, and with names on it as much as you --

MR. ELLIOTT: We will provide that. We will provide you a chart you can read and we'll have names in the boxes.

MS. ISHAK: It's hard to get all those boxes on a slide. We worked a long time on that.

DR. ZIEMER: I want to interject here -- I'll take my prerogative as Chair to interject a question. On the nine or ten SEC petitions -- is it nine?

MS. ISHAK: It's nine --

DR. ZIEMER: Nine?

MS. ISHAK: -- active.

DR. ZIEMER: Can you remind us of the time table when -- when your review is -- on adequacy is completed, what's the time period in the Federal Register and what's the time period before the Board sees these? The procedure calls for the Board to review all these petitions, and when will we expect them to first hit the Board?

MS. ISHAK: I think Larry better would answer that question right now.

MR. ELLIOTT: That was not a planted question, but it was a welcomed question. Yes, we're -- we're dealing with nine right now. We actually have a total of 13, but those -- the others are representative of requests that were sent to us by mail before the rule passed, and some of those are duplicate of the nine.

We are diligently working hard at evaluating all nine, at the same time qualifying all nine. As Laurie pointed out, we -- the first step in the process is to work with the petitioners to qualify the information that is initially presented and make sure that it is in the form required by the rule to move it to the next step.

I anticipate and I expect -- and I'm fairly adamant in this expectation -- that at your

October Board meeting in San Francisco -- prior to that Board meeting we'll announce in the Federal Register that several petitions have been qualified and are proceeding under research evaluation and a research evaluation report will be presented to the Board in October at your meeting in San Francisco. It's my expectation, my anticipation, that the -- two of those nine are very critical to us because we've done a lot of work on those two sites, the Iowa Plant site and Mallinckrodt site. And as you know, in our site profiles we had sections reserved where we had minimal, if any, data. And so that gave us an advantage and a leg up to start our work in evaluating those particular profiles and -- with regard to whether a class should be established for those two sites.

At the same time, we're not sacrificing the other petitions. We're working on those in an evaluation effort at the same time as qualification, so I think for Mallinckrodt we'll be presenting to the Board a research evaluation report that speaks to the early years, the 1942 to '46 years, and -- and I hope to see that announced in Federal Register before the Board

meeting and we will present that evaluation report for the Board's review and comment and decision in October.

The Iowa site presents us a little bit different set of problems in that the information that we're seeking to evaluate for that particular petition and a class that might come out of the Iowa site is constrained by national security information. We need our Q-cleared eyes on that information to determine its relevance, or lack of relevance, to the petition. And I'm fully prepared and ready -- as the rule provides, at my discretion -- to determine that it may not be a timely retrieval of information if it's bound by security constraints to move forward with a designated class for that particular facility.

So just to give the Board some insight into your future endeavors here in October, I fully expect that you'll be seeing one, if not more, evaluation report on SEC petitions.

DR. ZIEMER: Thank you. Mark, then Roy and then Jim.

MR. GRIFFON: This question's related to some-- Jim just gave a response about making up

for the backlog, and I guess the phrase that struck me was he said that there will be -- "heavily incentivized" I think is the term he used, or heavy incentives for clearing that backlog. I'm wondering if that means a contract modification with ORAU and -- and is ORAU currently within -- within their existing -- you know, we had a five-year budget, I guess, that ORAU had initially. Are they currently operating within budget, over-budget, you know, sort of -- I was wondering what the status was on...

DR. NETON: Okay, there's two questions there. The first question is what did I mean when I said heavily incentivized, and I guess maybe I -- heavily is relative term, I suppose. What I meant by that is ORAU's contract is -- includes a provision for a cost plus an award fee. That award fee is awarded every six months or evaluated every six months, and there's a pot of money available based on some pre-set amounts when the contract was awarded. The higher the score, the higher the total number of dollars out of a total work fee that they can receive.

The cost plus award fee provision is in the contract, but -- so it does require a

modification every six months if we do tweak it. But we anticipated that when the contract was awarded that we could not have a generic set of award fee every six months to be meaningful. You know, for instance, the first award fee period we had had a lot of information related to start-up -- start-up timeliness and that sort of thing. So in this last period we have modified the contract to incentivized by more award fee points directly tied to finishing cases below 5,000. I can't -- I can't give you a dollar figure or anything, but that -- that's the -- that's the idea behind that.

And in the next six-month award fee period we're going to more heavily incentivize finishing cases below 5,000, in addition to incentivizing reaching 200 dose reconstructions per week. So that's -- that's what that's about.

MR. ELLIOTT: If I could add to that, this current cost performance award fee that we have negotiated with their contractor addresses not only the backlog of the first 5,000 cases and trying to get those cleared and answers given, rightfully so, to the claimants, it also addresses this rework stream -- process stream,

if you will -- which was not in the previous cost performance award fee and we felt it needed to be recognized, it needed to be incentivized, and it is a separate process stream that we don't want to overlook or miss. So when reworks come back to us from the Department of Labor -- and I want to make a comment on why we're getting reworks.

In a lot of cases -- the majority of the cases it's because the claimant -- the circumstances of the case have changed. Another cancer has been recognized and diagnosed or additional employment has been developed by the Department of Labor, and we have to factor that back into a revised dose reconstruction. The minority of those reworks deal with how we did our work. And I don't have a percentage on that, but it's a very small -- small percentage.

The other incentivized aspect of this performance award fee that we're currently working under deals with our goals, our Government Performance Results Act -- GPRA -- goals, our -- our program target goals of 200 a week, trying to get 8,000 -- at least 8,000 done in a year's time. I know those two numbers don't equate, but -- but we are -- we're -- we're

incentivizing 200 a week to get to 800 a month, with the hope that by the end of a year's worth of time we can show progress and hopefully achieve 8,000 completed in a year's time. And as you see, we're not there yet.

So we've tried to put those incentives before our contractor and we'll continue to modify these performance award fees on a six-month basis to try to target aspects of the program that need attention and -- and devotion and energy.

DR. NETON: Okay, I think that answers the first question. The second question was where is ORAU in relation to their original budget estimates in the contract. They have gone over fairly significantly in cost on this contract in relation to the original budget. We are in a process right now of renegotiating where -- where that might be, but I don't have the figures available with me to discuss where they're at in particular, but -- but they will be over-budget.

DR. DEHART: Roy DeHart. The question I have goes back to the SEC petitions. Among those activities or sites was K-25, and K-25 is already recognized as an SEC site. I was wondering if there's any clarification as to why another

application -- or is it premature to even begin to ask that question at this point?

MS. ISHAK: My -- Jim, did you want to answer this question or...

DR. NETON: Yeah. I don't recall the specifics, but it's more than likely related to covered exposure outside of certain time periods. I mean I think K-25 had -- you know, the SE-- the original SEC sites had certain prescribed time constraints, and I think it is either outside of that -- it must be related to that. That's the only condition I can think of that would...

DR. ZIEMER: Jim?

DR. MELIUS: Yeah, I have two questions. One quickly, the conflict of interest on the site profiles for ORAU, is that the same conflict of interest policy as exists for the other -- for the -- you sort of described it briefly, but is it the same as for the other dose reconstructions?

DR. ZIEMER: I think Jim Neton can --

DR. NETON: Yes, I'll answer that. This was just signed I believe Friday, very timely. It took some going back and forth, and -- you know,

legal --

DR. ZIEMER: Incentivized.

DR. NETON: -- folks involved, but in essence what we've done is it's exactly -- ORAU has placed language in their conflict of interest policy that is -- parallels almost exactly the exact language for the dose reconstructions. And in fact, we took the opportunity at this time, since we had it opened up, to add the same type of provisions for evaluation of SEC petitions. So you know, we were trying to be a little proactive there and be ahead of the curve, so principal reviewers on SEC petitions cannot have previously been employed at the site and that sort of thing. It's out there on our web site. I have copies that --

MR. ELLIOTT: Aren't the copies in the Board's book?

DR. NETON: They should be in your book under my site profile presentation.

MR. ELLIOTT: Okay.

DR. MELIUS: Second question has to do with the SEC petitions. Are those going to be -- do you have a task order with ORAU for doing the technical work on those or are those being done

internally? What's the plan on that?

DR. NETON: Oak Ridge Associated Universities is -- is doing the bulk of the work on this. They are actually performing almost all the technical work. But NIOSH, just like with the dose reconstructions, maintains full responsibility and review over the final product. We work very closely with them. It's an iterative process, very much like dose reconstructions. Drafts come over, we vet them internally and review them and cycle them through the process. But they have right now -- I believe there's up to a dozen health physicists available to work on the SEC process within ORAU. Now they're not all actively working right now because the work load's not there. But they have been identified as sort of a matrix type process that they'll be available to work on them.

DR. MELIUS: So that's a separate task within the contract, or -- I'm just --

DR. NETON: Yeah, the original contract itself -- I mean the title of the contract was dose reconstruction and SEC petitions or something. What's happened now is ORAU, to track cost and progress under that task, has created a

task ten within their organization that will -- Dave Peterson*, a former NIOSH employee, is heading up that task for ORAU and so it's tracked as a separate task at this point.

DR. MELIUS: And so that won't -- it's not going to be a problem in terms of contract issues (Inaudible) --

DR. NETON: No, this was totally envisioned within the scope and the budget of the original contract language.

DR. MELIUS: Okay. Do that. I don't know if now's the time, but it certainly may be during the work session. We as a Board are going to be presented with SEC petition, you know, review -- I forget what you call it; evaluation, I guess -- at our next meeting. We need to, I think, sort of think through how we're going to review that and what procedures we want in -- in place and so forth, and I'd certainly like to talk about that.

DR. ZIEMER: During our work session we can address that issue specifically. I think it's appropriate that we do so.

Incidentally, as we talk, a copy of the ORAU team conflict of interest policy now has been distributed to the Board members, a document

dated August 23rd. And I presume these are also available to the public if -- if others wish to see them, so they'll be on the table.

Okay, additional questions? Laurie, thank you very much.

MS. ISHAK: Thank you.

DR. ZIEMER: You have passed the test and --

MS. ISHAK: That's good to know. I'll sleep well tonight. Thank you.

STATUS AND OUTREACH – DEPARTMENT OF LABOR

DR. ZIEMER: The Chair feels like we've barely gotten underway and the schedule already calls for a break, but we're a little ahead of time. I'm going to exercise the prerogative in suggesting that we proceed with Pete Turcic's presentation, if that's okay with Pete.

So, status and outreach report on -- from the Department of Labor, Pete Turcic. Pete?

MR. TURCIC: I just want to give you an update on the status of the program at the Department of Labor, and to date we've gotten up to -- we've now exceeded 57,000 claims. And of that, the largest proportion, again, remains to be cancer claims, with some 40,000 -- over 40,000 cancer claims. Beryllium sensitivity has kind of

leveled off at about 2,500. We get very few beryllium claims anymore, as well as the chronic beryllium disease. It kind of leveled off at 3,700. Silicosis remains at about 1,100 claims, and RECA has stabilized at about 6,200. Most of our RECA claims now are reworks that the Department of Justice is doing on previous claims, you know, under the new regulations. They modified some regulations. And fortunately our -- the category of non-covered conditions, that has -- we've seen a dramatic drop in that and we're attributing a lot of that to, you know, some of our outreach efforts where we tend to -- we don't get as many -- anywhere near as many non-covered conditions as we used to.

Looking at the overall -- the status of the overall cases, the status -- the pending cases at NIOSH, there's been a significant reduction there, showing that we're down to 12,490 cases at -- at NIOSH. And pending at our district offices we have a working inventory of about 2,600 claims at any given time. And pending a final decision, the claims of -- the claims that have received a recommended decision, awaiting a final decision, either a hearing or a review of the record, is

about 2,300. And we've made final decisions issued in nearly 25,000 cases now of the total of 42,000 cases that we have received.

Some of the program statistics, the recommended decisions -- and again, the split -- to date we've had, you know, nearly 14,000 claims -- recommended decisions to approve benefits and 22,000 to deny benefits. Final decisions, 13,000 to approve and about 18,000 to deny. And payments issued, 11,600 payments for -- in 875 -- nearly $875 million of benefits and nearly $40 million in medical benefits paid.

DR. ZIEMER: Pete, while that slide is up, could I interrupt --

MR. TURCIC: Sure.

DR. ZIEMER: -- since the slide is here, could you clarify now on the final decisions, the 13,046, for example, that's a subset of the 13,800 --

MR. TURCIC: That's correct.

DR. ZIEMER: Okay. And likewise on the denies then?

MR. TURCIC: Well, it's -- it's -- that is a subset, but there could be a few cases -- there's not a whole lot, but there may be a recommended

denial, but then when it goes to a final decision, it's reversed at the FAB, but that's a very small number.

DR. ZIEMER: Thank you.

MR. TURCIC: The breakdown of -- and this -- there is some changes in -- in this chart. This is starting to change some. The final decisions to approve, 13,800; 18,000 to deny -- the non-covered conditions as a reason for denials, that has been going down. In fact, in -- in the last year it's been probably less than 2,000 added in that category. And naturally the cancer -- the 1,922 cancer not related, the POC of less than 50 percent naturally has been, you know, going up. And -- now this gets to also the issue on the backlog. As I said, there's been a significant reduction in the backlog. But we've been -- we've been averaging in the neighborhood of 200 to 300 cases per -- you know, claims a week, and with the non-covered conditions going down, you know, that means that of those 200 or 300 cases, more and more will be, you know, going in for dose reconstruction as time goes on. So that's, you know, something to think about as time goes on and whether the 200 is going to -- a week will

really cut into the -- into the backlog.

The status of the NIOSH referrals -- again, 4,597 cases have been returned from NIOSH with 4,375 with completed dose reconstructions and 222 did not need dose reconstructions. Cases with -- of those, cases with recommended decisions, 733 recommended decisions to approve benefits and 2,686 to deny benefits. Of those having final decisions, 660 with final acceptances and 1,534 with final denials, and 80 -- about $87 million have been paid in benefits in compensation from -- directly from cases from NIOSH with dose reconstructions, so that's -- that's starting to grow dramatically and increasing now on a weekly basis.

Now just look at what happened in the last year -- as it turned out, the Ohio meeting was about the same time -- and to show what -- I mean I think we want to really compliment NIOSH on a -- on a job well done and what was achieved. In that last year, from -- since the Ohio meeting, DOL -- we sent an additional 3,400 cases to NIOSH for dose reconstruction. NIOSH returned 41 -- over 4,100, so that made a significant reduction in the -- in the backlog that NIOSH needs to be

complimented on.

Of those, the recommend-- in the last year the recommended decisions, 618 to accept benefits and 2,539 to deny. Final decisions, 560 to accept and 1,496 to deny, and that's what the status of the -- what happened over the last -- the last year, since last August.

Now I just want to take some time to maybe give a better understanding -- now that we have, you know, thousands of cases that have come back and gone through the process -- of what happens because I don't think there's -- you know, I think it would be good for the Board to understand what happens when a claimant gets a recommended decision based on a dose reconstruction and what can they appeal. And so once we get a case back from NIOSH and we've been meeting our goal -- our goal is to, once we get a dose reconstruction back from NIOSH, to issue a recommended decision within an average of 21 days after receipt of that dose reconstruction report, and we've been exceeding that standard. So we have been -- we -- we have been issuing -- we've, you know, recommended decisions in -- within three weeks after receiving a dose reconstruction

report.

At that time the claimant is given the opportunity -- they can request the -- a hearing, an oral hearing. If they so choose, but only if they choose, the hearing can be a telephone hearing. They can request a review of the written record and state objections. Or they can waive objections. And if they waive objections, then we immediately process the claim. Usually that's an acceptance. We'll process it and in a very short period of time we can, you know, have a final decision and issue -- issue payment.

And to explain what happens in the review process, the review of the dose reconstructions at our Final Adjudication Branch -- first let me just talk about the scope. And again, this is all in the regulations. The regulations specify what portions -- what is the scope of the review that the Final Adjudication Branch would do on a objection of a dose reconstruction.

Number one, we will look and it is DOL's responsibility to adjudicate factual information. And that's very important because, you know, for consistency and, you know, lot of -- lot of times claimants will claim that something happened.

Well, there has to be a -- we have to weigh that evidence, and there has to be some probative evidence, some reason and rationale to accept that as a factual piece of information. So we will accept objections on factual information. You know, if a claimant comes in and says an incident occurred or a practice occurred, NIOSH did not address it in the dose reconstruction, we will adjudicate that issue and we will weigh the evidence and make a determination of the veracity of that evidence and whether that evidence is accepted or not accepted.

Then we also look at the application of methodology, and that's a fine line between -- there's a fine line between application of methodology and actual methodology. But the methodology is basically a regulatory issue and would need -- an objection to it needs to be handled through the normal channels of, you know, objecting to a regulation. The normal court channels of, you know, here's what NIOSH put in the regulations; here's the methodology that is used. If there's an objection to that, that challenge needs to go to a court. That challenge cannot be addressed in the final adjudication

process. However, the application -- you know, it could be -- they can come in and argue that the wrong model is used. And then we would go to NIOSH, we would look and make sure and -- and again, any factual information, any objections raised are addressed -- would be addressed in the final decision.

Based on those objections, the potential outcomes is that the -- at -- the Final Adjudication Branch could affirm the recommended decision. They could reverse the recommended decision. Now they cannot reverse a payment, so the rules that go on that is that the claimant -- the FAB would never take an acceptance, reverse that to a non-acceptance, without doing another recommended decision that would explain in detail why the denial so that the claimant could object to that denial.

But there have been cases where -- you know, if it's a denial -- recommended denial, the FAB -- goes to the FAB; it could be reversed, made into a -- an acceptance, without going back to the claimant. And most -- most frequently, if there is an issue, it would be remanded, either to the DOL district office for another

recommended decision, or to NIOSH for handling some issue.

More than likely it would be a factual issue. If a claimant made a factual objection, the FAB accepted that factual objection, we would remand that case back to NIOSH -- and that is some of the reworks. But like, you know, Larry pointed out, most of the reworks are a new cancer, a second cancer was diagnosed, you know, in the intervening time. But there have been some remands where it would be remanded because the claimant was able to raise a factual situation, a set of facts that we would then remand it back to NIOSH to have a rework to address that set of factual information.

And then naturally the claimant -- at that point in time, at the final decision, they do have a further review -- appeal. They have the option -- at that point in time they have 30 days in which they could ask for a reconsideration. Now a reconsideration would be that that case would go to a separate -- a different claims examiner, hearing rep, who would re-look at the whole case and make sure that they would come up with the same conclusion as the first hearing

rep.

After that, they can request a reopening to my office, and it is a discretionary reopening. It could be -- well, they have a year to show, you know, new information, but there's no time limit on -- at any time then I have the discretion to reopen any case based on new information or if situations, you know, have -- have changed.

Just a review of some of the objections that we have gotten to this point, so far -- and this is in the last year, in FY 2004, so it's not even a whole year -- we've received requests -- 420 requests for hearings. We have conducted 311 hearings. We've received 653 requests for review of the written record, and that's where the claimant may file an objection but just ask for a review of the record. And to date we've done 567 of those. And we've received 2,925 waivers of objections.

And here you can see what's happening with our hearing -- requests for hearings. As you can see, our requests for hearings are increasing as -- as we expected. And to be quite honest -- I mean prior to this last year, most of our

hearings were -- I object that, you know, heart disease is not a covered illness. Now we're starting to get a lot more substantive, you know, objections and requests for hearings. And NIOSH just did a great job of a training of some of our hearing reps with a more in-depth training and explanation of the dose reconstruction process so that they'll be able to better address those issues when they come up in the hearing process.

DR. ZIEMER: Pete, just a question here from Larry.

MR. ELLIOTT: Are all 420 of these dose reconstruction cases specifically?

MR. TURCIC: That's the majority, but there -- there would be a few that, you know -- that might be RECA cases or -- or beryllium.

The waivers -- again, it's pretty constant. We've got -- been getting about 1,000 waivers a quarter.

The NIOSH cases that have been remanded, just to cover some of those issues -- total remands, 328. Recommended decisions -- of those, 75 had recommended decisions to approve benefits, and so far 36 of them have remained as final approvals. Then there were 263 that were recommended

decisions to deny, and to date the status of those, two of them have been changed from a denies to final approvals, 37 remain final denials, 216 are still pending final decision, so that means that they've been remanded. They're either back at the district office for further development -- it may be development of employment, it could be development of a -- you know, there -- there could be a -- we could have gotten an indication that another cancer -- so there could be medical development, it could be employment development or it could be, you know, sent back to NIOSH for -- for a rework for some other reason. And eight of them have -- are cases that were closed or withdrawn. Most of those would be that the claimant has passed away and there -- we're in the process -- either in the process or we cannot find a survivor.

And just briefly and, you know, maybe at a -- at another meeting if you -- if you want, I can go into, you know, more details -- just some of the issues that we are getting at the hearing level, objections at the hearing and review of the written record on dose reconstruction cases. Probably the vast majority were that information

was provided in the interview and not addressed. To date, the vast majority of those are that it -- the issue was addressed in the dose reconstruction. It -- we probably, you know, need to do a better job of, you know, putting a few sentences to explicitly say how, you know, so really, you know, the claimants may not be able to read -- if you're not a health physicist, you may not be able to see how it was, but it -- it really -- vast majority of the cases, that they were.

There have been several cases that it was not, and those cases have merely been remanded for NIOSH to rework and to address that -- that specific issue. So here -- this is an example of a factual situation where, you know, the process -- there's a process to address these issues and work through them.

We have a number where cases -- objection have been made saying that unmonitored dose was treated as missed dose, and we're working through a -- through a number of those cases to -- to see and -- you know, exactly what the status and -- and whether that's the case. And there -- there -- again here, you know, oftentimes it's a

confusion as opposed to, you know, whether something was done or -- or how it was done.

In several locations we got objections that exposure from ingestion was not addressed. And again, the final -- you know, one case that I'm aware of that it really was, because of the -- you know, the monitoring, the -- the biological monitoring, so that would be addressed -- in a case like that, that would be addressed and explained -- further explained in the final decision addressing that objection. Each of the objections in our final decisions are addressed specifically.

Another -- we get incidents were not addressed, and again, the process -- I don't, you know, have the breakdown but I'd be glad to give a more detailed explanation at a future meeting.

Another one that's growing is inappropriate cancer model used. Now that goes directly to methodology. You know, that's a direct methodological issue, and so -- I mean we would adjudicate the por-- the part that -- what was the diagnosed cancer, was it appropriately -- based on the diagnosed cancer, the ICD-9, was that all appropriate, and then how does that, you

know, fit in -- you know, into which model needs to be used.

And one that we're -- this is a new one that we're, you know, working with NIOSH on, and what's happening is in the use of the efficiency model, the worst-case scenario, sometimes it goes to such an extreme and -- I mean that's another issue that we need to look at, that are we getting assumptions that are really too far in the other direction. And you know, that really gets to accuracy, also. But an issue we're dealing with now is -- and procedure and how we're going to come down on a policy issue is that when you get -- you may get a 40 percent or more based on efficiency model. Then another cancer is diagnosed. You send it back for a rework. NIOSH does a rework, now they're no longer maybe using the efficiency model and now the combined comes out at 20 percent, of the two cancers. So that's an issue we -- we have a number of objections raised on that we're working through.

And just briefly, some of the statistics from the local area, 1,179 cases filed; 40 recommended decisions to approve, 487 to deny. Final

decisions, cases -- 37 to approve, 395 to deny. There have been 14 payments made and -- for compensation of $2.1 million.

The status of the NIOSH referrals, 707 -- 153 have been returned. Of those, nine have been accepted -- have recommended decisions to accept, 114 recommended decisions to deny; eight with final decisions to accept and 51 with final decisions to deny.

Looking at the denials, the number of denied cases -- now this is total, it's not just the dose reconstruction -- is 395 cases have been denied. Of those, 51 were because the probability of causation was less than 50 percent; 235 were the conditions was not covered; 48, the employee was not covered; 53, insufficient medical evidence; and eight that the survivor was not eligible.

And with that I'd take any -- try to answer any questions you might have.

DR. ZIEMER: Thank you, Pete. Let's open the floor now for questions. Richard, then Jim.

MR. ESPINOSA: In concerns of the outreach, I'm just wondering what the Department of Labor is doing to get out the word of the SEC rule?

MR. TURCIC: Of the SEC rule?

MR. ESPINOSA: Yeah.

MR. TURCIC: We've -- naturally we've talked about any -- any outreach meetings, any public meetings we have, we talk about the SEC petition route. But we have not had any outreach that targeted specifically and only SECs.

DR. MELIUS: Interested in a little bit more information on this issue -- I guess you call them remands and Larry calls them reworks.

MR. TURCIC: Uh-huh.

DR. MELIUS: I think they're roughly the same. Is that --

MR. TURCIC: No, no, they're -- like Larry said, most -- most -- a rework -- usually a rework would be a situation such as an additional cancer diagnosed, and basically it would be just to send it back so that that additional cancer could be included in the dose reconstruction.

A remand would be -- there's a factual -- information that may have changed or a call made on a factual situation, and then that would be sent back to include that specific -- and address that specific issue.

DR. MELIUS: So then the -- that was for --

some of the confusion. The data that Larry -- or was presented here about -- from the NIOSH program on reworks, does that include the remands or is that --

MR. TURCIC: Probably.

DR. MELIUS: Okay.

MR. TURCIC: And that's relatively new. I mean this is something new.

DR. NETON: I'd like to address that issue 'cause I deal every day with these. The real cut-point in my mind is a rework is typically before even a recommended decision goes out. Oftentimes we'll send over the dose reconstruction. In the time -- from the time that it was sent to us for dose reconstruction, gone back to the claims examiner, they're making a recommended decision, they notice that an additional cancer has come up or the employment is different or anything like that -- this is before the claimant ever sees a draft dose reconstruction or a recommended decision.

Once it goes to recommended decision, though, then you get into the remand area where a statement of factual accuracy has been challenged or something like that.

MR. TURCIC: And the remands can take a multi-faceted -- you know, there could be a number of things that require a remand to NIOSH. For example, if there is something in the medical evidence that would indicate a -- say a cancer that was not originally identified, then in the final decision process that information comes out, that could be remanded to the district office to further develop the medical evidence and then return it to NIOSH for a dose reconstruction for that new -- that additional cancer. Or it could be that the district office counted employment that they shouldn't have, or did not count employment that they should have. And again, that same process. So the -- the reason for the remand could be, you know, a -- a number and it could be something that happened at the DOL district office, it could be a change in a situation or it could be a change in the factual information.

DR. MELIUS: But I think -- well, I understand that. I think -- there are a couple of areas, though. One Larry mentioned earlier, or someone did, in terms of there -- there are some quality assurance issues that you're dealing

with with -- NIOSH is dealing with their contractor. And so I'm assuming some of these are -- someone's not doing something right or something's getting through the system. Is that -- I'm trying to get a handle on -- I think those numbers are small, but you implied that it was a growing issue and that --

MR. ELLIOTT: Well, I was indicating that in our cost performance award fee, incentive there, there -- we had -- we drew attention to what we were calling reworks.

DR. MELIUS: Yes.

MR. ELLIOTT: When ORAU sees them, they don't know whether it's a remand or a rework. Not all remands -- or not all reworks are remands. If we catch it during our review or we catch it in conversation with the claimant during the OCAS-1 phase, before they sign it, we deem that as a rework. If DOL has the case and it's a recommended decision and it's caught at that point, it's a remand and it becomes a rework if it's brought back to us for rework.

DR. MELIUS: Right.

MR. ELLIOTT: So -- does that help? I mean --

DR. MELIUS: No, it helps. It's just that we're mixing a lot of numbers here and it's --

MR. TURCIC: Yeah.

DR. MELIUS: -- there's different levels at which -- some of it's new factual information. Some may be errors that are made in the process -- doing that.

I would also be interested in further information -- maybe this is for another meeting -- on some of these what I call more policy-related issues where there's this -- the one you mentioned with the additional primary cancer causing some difficulties. I don't know if -- are there other sort of -- that are --

MR. TURCIC: Yeah, I --

DR. MELIUS: -- issues that are -- that you're having to decide that -- that, you know, reflect on the dose reconstruction process. We've had some earlier issues with the -- I don't know if it -- it was one of -- it was the third question I usually get to ask and now down to two, and is the -- is the issue with phosphate processing and so forth with -- you know, what is a -- exposure related to this program as opposed to an industrial exposure and how that gets

counted.

MR. TURCIC: Yeah, those are policy, Jim, and that -- and exactly -- we're still trying to work out the policy framework to apply and to have our FAB apply in these cases where the -- you know, a second cancer may end up the combined POC less than the -- you know, the first, using the efficiency model. And so we're looking at, you know, what -- what assumptions and what can happen to assumptions as it goes through that -- as it goes through that process.

MR. ELLIOTT: This is a very complicated issue right here. I mean -- and I want to make sure everybody in the audience understands what we're talking about.

Through our efficiency measures, when we attempt in that effort to show that it's totally unreasonable that a cancer was caused by a radiation dose experience, let's say -- and let's take prostate for example. I started seeing some cases coming through in my review queue that were at 40 percent for prostate, 44 percent. I started raising a flag. I raised it with ORAU, I raised it with DOL. I talked to Pete and I said we've got to get our eyes on this because I am

concerned that we're going to see a case or two come back at us from the FAB, after a recommended decision, where additional cancer has been identified and we go back and reconstruct a dose on the prostate and the new cancer and our new probability of causation resulting from that reconstruction is lower than what the claimant saw in their first report, and we need to be very cognizant of this as a concern to the claimant and confusion to the claimant. Because we're trying in our first attempt, through efficiency, to show that it takes a lot of dose to get a prostate cancer over the 50 percent bar. And so if we come in at 44 percent and then we have a skin cancer, and then we resharpen our pencil and do a reconstruction on both cancers and it comes back out at 38 percent, they're going to go "What?" So that's the issue and that's what we're dealing with and we're working together to try to make sure that we avoid confusion among the claimants, get out point across, make sure the science supports the dose reconstructions that we're doing.

We're concerned, as Pete indicated, what our assumptions are in the efficiency process when we

see a non-radiogenic cancer come in with a relatively high POC that might be truly a lower POC if we'd done, you know, the full-blown dose reconstruction to get down to a very accurate, if you will, probability.

DR. MELIUS: Well, just -- I guess -- at least I, and I don't know if other members of the Board would, but I think some discussion of that at the Board level 'cause -- does it relate back to the process to what's in our regulations, whatever, and it also I think goes -- sort of the other side of this issue of sufficient accuracy. We've been -- you know, as relates --

MR. TURCIC: We'll have a --

DR. MELIUS: -- to the SEC.

MR. TURCIC: By -- by the next Board meeting we should have a precedent case on that issue, and I'd be more than glad to say at least where DOL has come out on it and what the precedent-setting case --

DR. MELIUS: And maybe --

MR. TURCIC: -- established.

DR. MELIUS: Yeah. Maybe if NIOSH -- you know, if you could present also and where -- where these issues are coming up and -- what is

it, sort of new factual information, when is it new -- is this efficiency issue.

DR. ZIEMER: Thank you. Roy DeHart.

DR. DEHART: Just a point of clarification on the NIOSH case -- cases that are reprimanded (sic) to them. In the slide you showed 328 cases that had been forwarded to them and that 75 of those cases had gone to a decision for approval. Is it NIOSH that is making that decision?

MR. TURCIC: No, what that means is that of those cases 75 started out as a recommended approval, then it was remanded. Of all -- of all those cases, of all the remands, 75 of them was a recommended decision to accept benefits. It was then remanded by the -- by the Final Adjudication Branch.

DR. DEHART: So something had happened in the review in Department of Labor that questioned --

MR. TURCIC: Exactly.

DR. DEHART: -- the approval.

MR. TURCIC: Exactly.

DR. ZIEMER: And this is before the claimant sees the recommended decision.

MR. TURCIC: No, the claimant would have seen the recommended decision.

DR. ZIEMER: Would have seen it.

MR. TURCIC: Yeah. It could be a number of things. I know that we've had cases where the district office used the incorrect ICD-9 code for one of the leukemias.

DR. ZIEMER: So this makes it a little more difficult for you since the claimant has seen the recommended --

MR. TURCIC: Right, exactly, so we had to -- we had to remand back because, based on the code that the district office used, the incorrect code, then the incorrect model was used for the -- for the IREP. Once the --

MR. ELLIOTT: Or the organ was -- reconstructed to the wrong organ. We do not develop the claim with regard to the cancer diagnosis. That's the Department of Labor's responsibility. They give us a set of developed facts and that's what we're required to use in our work. And if that changes once the -- the claim has gone back over to DOL and they've -- they have a different set of eyes look at it, whether it's at the FAB level or at the recommended decision level by another new claims examiner, that could get kicked back to us.

MR. GRIFFON: I think I have a fairly straightforward question. From early in your presentation you -- you mentioned that your backlog had significantly gone down, and I was just wondering what the current backlog is of cases, and how do you define backlog? Is it more than 30 days old, more than 60 days old or --

MR. TURCIC: No, what -- what -- what I was referring to there was the cases pending at NIOSH.

MR. GRIFFON: Oh.

MR. TURCIC: If you look the previous year, that's down by, you know, nearly 1,000 cases.

MR. GRIFFON: Well, how about the -- how about the other question, your claims received backlog, is there --

MR. TURCIC: We have --

MR. GRIFFON: -- a backlog --

MR. TURCIC: No, ours --

MR. GRIFFON: -- there?

MR. TURCIC: Ours is just a working -- we're at the point where we have a working inventory; 99 percent of our cases have either a NIOSH referral or a recommended decision within well less than 120 days. So the 20 -- we -- we

normally have about 2,300 to 2,500 cases at any time that are under development. You know, the cases come in and, based on the 200 to 300 a week, you know, you're talking about less than a three-month working inventory.

DR. ZIEMER: Tony.

DR. ANDRADE: Yes, a quick question. When a second cancer's -- is diagnosed and that comes up as new information, is this sent back to be reviewed by a physician as to whether or not it is likely that it was metastasized from the first cancer?

MR. TURCIC: Yeah, all -- we -- when we say a second cancer is diagnosed, then that -- as part of that diagnosis, that must be a primary. We don't send metastasis -- the only time we would send metastasis to NIOSH would be if it was a metastasis of unknown primary, and then, you know, the procedures are that they would run all the potential -- all the probable primaries for that given metastasis.

DR. ANDRADE: Then I would just like to submit this statement for the Board to consider, perhaps chew on. There are many processes that -- that are -- workers have been involved in. A

lot of those involve manufacturing and processing of materials that include both chemicals and radiation. And so primary cancers can result from either chemical toxicity and/or radiation. Hence, even though we try to be very clear and very meticulous in reviewing these cases, it seems to me that that's always going to be a questionable -- that's always going to be a question mark. And that is perhaps one reason why I submit we will never ever really be fully satisfied that we can differentiate between the two and, because you use efficiency measures in one case, it tends to -- it tends to build a gray area. And if you -- if you do have to go back and do a rework, I can understand why a POC may actually come down and be lower.

MR. TURCIC: Absolutely, uh-huh.

DR. ZIEMER: Thank you very much. It's time for us to take our break. We'll recess for 15 minutes.

(Whereupon, a recess was taken.)

STATUS UPDATE – DOE PART D PROGRAM

DR. ZIEMER: We're ready to reconvene. The next item on our agenda is a report from Tom Rollow of Department of Energy. We're pleased to

have Tom with us again. Tom is going to report specifically on the subpart D program, which is the DOE's worker assistance program, I think is the terminology. So Tom, we're pleased to have you back with us today.

MR. ROLLOW: Good morning. Thank you. While Jim Neton -- well, I was going to say while Jim's getting this set up I'll tell you a short story, but I'll tell you the story anyway.

I spent most of my 30-year career working in the safety business. I started out the first half of my career working for the father of nuclear power. I was on Admiral Rickover's staff in Washington, D.C. And even though we did nuclear design work and nuclear operations, anybody that ever worked in the Rickover program knows that safety is job one. And in the latter half of my career I have the opportunity to work for DOE, about the last 14 or 15 years, in the safety office doing safety things. And so I have a hard time walking into a room without looking for things like fire exits and stuff.

And so when I walked into this room today and the first thing I did -- this drives my wife crazy when we go to dinner parties -- but the

first thing I did today was I walked in and I surveyed the doors, and I think of things like okay, if you go through that door, what's behind that door? Is there a hallway and a 50-foot run this way and then out to the left? What's behind that door, which looks like -- sounded like a loading dock when the truck backed up so I think we're okay to get out that door over there.

When I figured out all the fire exits, my mind started wandering to the ceiling, and I looked at these light fixtures. Anybody want to take a guess how much those might weigh? I think it's fortunate that the room is set up this way, that most of the weight would land on the floor, not on the chairs. Except for --

DR. ZIEMER: They're very light. That's why they're called "lights".

MR. ROLLOW: Thank you, Dr. Ziemer. I'm going to give you a status today of Part D or Subtitle D of the EEOICPA program. This is of course the sister program to Part B, which most of your attention is addressed towards. This program covers the Department of Energy operated program, which is aimed at providing assistance to apply for Workers Compensation, and generally

includes not only the illnesses that the Part B program includes, but is extended to any illnesses caused by toxic substances.

I apologize for the size of the print here. Hopefully most of the Board members are sitting close enough that you can actually read this. I noticed in the handouts not only would you need a magnifying glass, but you'd probably need some trifocals to read it in the handouts. But for us it's all about production. It's been about production for a year and a half. The bottom line is that we feel that DOE now has a good handle on production and we are moving along and cooking pretty good right now, and so I wanted to share with you some of these observations.

The right-hand side in the box is our weekly statistics. They're actually on our web site. If you're ever interested you can go to our web site and look at these on a weekly basis. But we are still producing positive and negative physician panel determinations at a little over 100 a week. We are preparing cases for panel -- cases currently in the physician panel process are cases going to panel, we're preparing those at over 100 cases per week and we've hired a lot

of employees over the past couple of months. I'll show you the -- kind of paint the picture for you as to -- as to how that sets up, and we expect to be at well over 300 cases prepared for panel this fall, in the next probably four to six weeks. And we expect to be -- our goal is to be -- be issuing -- get -- getting cases back from physicians panels in excess of 100 cases per week right now, and moving that up above 300 cases per week by next June. And it looks like right now we'll greatly exceed that goal and I'll talk a little bit about that, also.

The bottom line on this slide is that there's about three categories up there that have to do with case preparation. And we basically develop cases in this part of the process -- the process kind of goes from bottom to top, the top being completed. We develop cases and send them out to the applicants and allow the applicants 30 days to look at the case file to see if they want to add anything or make any changes to it. And there's also a 15-day review in there for the employer. But the case is basically developed and the DOE work is largely completed at that point.

The next step in the process as you move up this chart is cases currently in the physicians panel process. They're either at the physicians being reviewed or they're in a queue waiting to go to the physicians, and you can see there there's another 3,000 some-odd cases in that category.

And then there's cases completed, and of course cases are completed by either finding people not to be eligible or they have a positive finding or a negative finding, are generally the categories. And if you add all those up, DOE has -- has processed or completed its work -- largely completed its work in over 7,000 cases. We have of course 25,000 total applications to date for this program. That's kind of the big picture.

Let me just show you something graphically here because it's all about resources. And as I talked to you before, DOE underestimated the scope of this program early on. And you know, other organizations also shared in that underestimation -- not to make excuses, but we didn't -- we didn't rustle up the resources necessary to properly set up and manage this program early on, and so we're still playing

catch-up on that.

The chart on the left-hand side has to do with preparing cases, those 7,000 that I just showed you on the previous slide. The chart on the right-hand side has to do with physician determinations, getting the physicians' determinations. The Y axis here goes from zero to 200, so they're on the same scale, so you can just let your eye kind of drift across and you can see that we're still preparing cases faster than we're getting them through the physicians panel.

But if you look on the left-hand side where we're preparing cases, you can see where we had inserts of resources, courtesy of the Congress, to give this program a boost. And basically in about September, October of '03, a little less than a year ago, we received reprogramming approval from Congress for $9.7 million, which we were able to add to our budget and we increased production of cases threefold. And I shared this with you before, I think.

We just received -- in June received another reprogramming of $23.3 million. We actually asked for $33.3 because that's what we needed to

do to make our goals, but for several reasons Congress allowed us to have $23.3 million. And you can see the solid line on the left -- left-hand side of that dotted vertical line is remarkably going up, and then on the right-hand side it's kind of -- they're kind of confused there, but there's a dotted line that goes even higher. This is the metric that will actually get up well above 300 cases per week, probably in the next four to six weeks.

Now what happened to get us here? We basically hired about 200 case processing people over the last 12 weeks in Washington, D.C. And -- and the reason that that actually -- that curve takes a little dip right there where it says $23.3 million received is because we took some people off-line to train the new people, so there's some inefficiencies associated with training the new people and we're starting to shoot back up. And my contractors tell me that they're confident that actually by the end of August they should be over 300 cases per week. I would give them a few more weeks beyond that.

On the right-hand side is physician panel determinations, and physician panels have always

been a challenge for us because we needed -- we've had a hard time getting the resources, getting the physicians or the physician time -- the FTE, if you want to call it that -- especially when they're working on a part-time basis. We made a couple of changes to the program. I think I mentioned last time I met with you folks, we changed the physicians panel rule to allow a single physician to make a determination. And that single-physician determination is if it's a positive.

So the first look at any case is done by a single physician, and if that physician finds in the positive, then that physicians panel review is done and that person will get a positive determination. If that first physician rules in the negative, then it would go to a second and to a third physician, if needed, to make sure that we get the two out of three negative. Or if it got another two positives, then it would turn into a positive determination. That change alone has made a dramatic increase in our physicians panel production, and you can see that shown there on the right-hand side.

We estimated that mathematically we would

roughly double our production, given no new physicians, and we're coming pretty close to tripling our production with that change. Our physicians give us feedback that hey, now I don't have to coordinate with two other physicians across the country electronically. We have several physicians -- from five to seven every week that are working in Washington full-time, and they're, you know, very, very much more efficient. In fact, we give a lot of the second and third reviews to the physicians that are in Washington because the coordination is much simpler when you're sitting across the table from the person you need to coordinate with. So we're seeing some tremendous increases there.

And I'll talk later on, too, about the great job that NIOSH and the American College of Occupational Environmental Medicine have done in recruiting new physicians for this program.

This chart is a chart of cases unworked. I can't -- I can't paint it any prettier than that. In September of '02 we had about -- a little over 12,000 cases -- applications for this program, and we had not started working those cases. When I took over this program in -- gee,

I forget when it was now -- March '03 I guess it was, that number had actually grown to about 13,000. We turned the tide -- I can't quite read that -- turned the tide around October to November of last year and are starting to work those off, and you can see this rapidly approaching zero. And this means that there are still about -- at the time of this chart, about 7,000 -- I think the number's actually down to about 5,000 today -- there's about 5,000 cases that have come in -- some of them could have come in last week, some of them could have come in six months ago, but they're cases that basically have not been worked yet. We haven't requested documents from the sites and started that process.

We're in the process now, based on the reprogramming, the $23.3 million that I showed you that we got last June, we're requesting all data on all cases from the sites, and that'll drive this number to zero and move all those cases into a currently-worked part of the process.

We have what we call a path forward plan. I think I might have shared this with you last

spring when I last met with you. It basically has four elements to it. The bottom line is that this is the plan that's going to get us to reducing the backlog of Part D cases to zero by the end of calendar year 2006. At that point in time we'll be where the Department of Labor is today, and that means working cases as they come in the door, working them as fast as we can to get them back out the door. But to work the backlog off will take us to the year -- into the calendar year 2006.

Now that's not 25,000 cases that I have today, but it's about 33,000 because there'll be another 8,000 cases that'll come in over the next couple of years while we're working off the backlog, so that's the total number we're talking about.

The four-part plan -- first part is regulation changes, and that's done. Basically it was changing the number of physicians on the panels from three to one, which I've already talked about, and also the -- to do multiple reviews for the negative physicians panel determinations.

The second element, down here in the lower

left-hand corner, is legislation. We need some -- what may look like minor changes made to the legislation, but they'll help us dramatically, one of which is to remove the pay cap on physicians. I've mentioned this before, that we're limited to a certain dollar amount or a certain executive schedule amount that's not reflective of the market value of these physicians' time, and we've had some challenges getting physicians to work for this program at that low pay cap. Also there's some language in the legislation currently that kind of restricts our hiring authority for physicians, and so we need some changes there to expand that hiring authority.

There's also a requirement that we have an MOU, a memorandum of understanding, with every state before we process applications in those states, and that -- it's kind of an artifact of the program. At one time we thought we were going to actually do evaluation for every state's claims, and at that point in time we would need to have the agreement from the state to do that. The program is not designed that way now, and hasn't been run that way for two or three years

since our rule came out, so the MOU is really unnecessary. And we've got a couple of states that are a little bit reluctant to enter into the MOU with us because they're not sure of their liabilities. And so if we remove that requirement, I can -- I can commence processing claims in those -- those states.

The third element is budget. I mentioned it's all about resources. It's about DOE's late start identifying the resources, but it's about the challenge -- the uphill challenge that we've had in the last 18 months getting the resources agreed to, I guess I'll say, by Congress. The reprogrammings we did this past year were all moving money inside the Department of Energy from one type of an account to another type of account, but you still have to have Congress's approval to do that, and there's a lot of steps you have to go through to make that happen. It's been very slow in coming. Not blaming Congress at all, it's just a very detailed bureaucratic process. We needed in '04 $33.3 million to accomplish what we wanted to accomplish, and we've only gotten $23.3 in that last reprogramming, so I'm still $10 million short.

We have to do a little bit of quick dancing to figure out how to catch up that in later years, in '05 or '06, but we're still holding to our commitment to process all backlog claims by the end of calendar year 2006.

Our '05 budget that we've requested, the President's budget that's on the -- it's in Congress now requests a budget of $43 million for FY '05. And with that budget we'll have sufficient funds to continue this -- this path forward plan.

The fourth and final element in the lower right-hand corner, process changes, many of which have already been implemented. We continue to look for opportunities to optimize and be more efficient in our processes. We've brought in outside reviewers. Others have brought in outside reviewers for us, but we learned from those, such as the GAO reports. But -- so we've made those -- those increases in production. We're looking to produce what we call a tiger team to do a top to bottom scrub of the program here in the near future, something that we really ought to do probably about once a year, look for opportunities to make changes. We reprioritized

claims. I think I probably touched on this the last time I met with you, but basically to put living applicants before survivor applicants because living applicants get the greatest immediate benefit from the Workers Compensation program. And then we also have reconstituted the advisory committee, although that committee probably will not have its first meeting until after some of the uncertainness of the fall Congressional schedules clear, so the advisory committee will probably meet in October or November time frame.

This is just simply a chart to show you how we'll work off the backlog, and you know -- as you recall, I mentioned about 33,000 applications will be the end number. This is how those applications get worked off. Basically a small number in July '04 -- well, I say a small number but we've got about 3,000 under our belt now and we'll work them off on that schedule. This requires us to process somewhere between 300 and 350 applications per week between now and the end of calendar year 2003 -- 2006.

Switching gears for a moment, there was some discussion earlier about the support that DOE

provides for NIOSH and radiation dose information. We do track that and -- and NIOSH tracks it very closely, and actually this is their data that they provide to us. We take great pride that we have much improved over -- from a year to two years ago. One percent is still one percent that we're not getting done within the 60-day time period that we agreed to provide them data, and we continue to -- to attack those. And I think there's been sufficient discussion earlier today on some of the reasons for those differences, but they have to do with database. In some cases we can't find the data and so people are still looking for it, when at some point they may need to just give up and say we can't find the data on this individual. And then there's a couple of cases where we're still waiting for records to be -- to be found or retrieved from archives to provide that -- that data.

I talked about additional physicians. NIOSH has provided DOE with a total of 250 physician panel nominees -- and the number may be plus or minus. I apologize to NIOSH if I don't have the number exact today. About 190 of those are

actively working. The other 50 to 60, for various reasons, are not working. In some cases it could be the pay, but in other cases they're just busy with their own personal agendas right now and so they've asked not to review cases. Some never started. There's just different reasons, which we try to deal with and increase that number.

We did just receive 73, 77 -- something in the seventies -- new physicians from NIOSH just in the past few weeks that are a result of new recruiting activities through ACOM, and I think that's really working out well. And I understand that NIOSH has another 20 potential appointees that they're reviewing right now at NIOSH, so the numbers are getting up there. And also I'm happy to say that a significant number of these new physician nominees are interested in working full time, and boy, do we really get out bang for the buck out of the full time physicians, more than having to mail the stuff back and forth across the country.

It's all about money and compensation. And although the DOE is not -- does not pay claims and the DOE is not in control of how claims are

necessarily paid, except that we can order our contractors not to contest them, we do track the money. And this is where the claims actually sit today. These are not large numbers, so we've basically completed our work on 7,000 cases. About 3,000 are complete in the program. These are not large numbers, but the pipe is full of product and it's just starting to come out the downstream into the pipeline, if you will forgive me for using that analogy -- 378 people as of this date, which was July 31st, have received positive determinations from our program. That's over 400 now, but it was 378 then, and at the time this snapshot was taken, 87 people had applied for Workers Compensation. And we -- we actually -- when people get a positive, we call them up after they get the letter, explain to them what the letter said, ask them if they understand how to apply for state Workers Compensation. In many cases it's go back to your employer and -- and file a claim with your former employer, and we walk them through those processes. Of the 87 that have applied, 31 at the date of this slide had actually received some compensation, either medical or a settlement

payment.

We are concerned and we will continue to be concerned and continue to work the gap between the 378 and 87. Some of that's time lag, but some of it is people don't want to apply for Work Comp. Sometimes they're exhausted from the process, and that's not good and we need to get them beyond that. In other cases, they -- they have knowledge that there's not much benefit there for them because either they weren't out a lot of medical expenses or they're survivors that have reached majority age that won't see a lot of benefit from the program. So there's -- there's reasons for that gap, but we continue to study that because we want to encourage as many people as we can to apply for -- for state Workers Compensation.

This is the dollar amount, and I wish I had a little more granularity on this for you. I can -- I can kind of talk you through a little bit of it, but at Oak Ridge we've paid out $415,000 and as -- I'm just remembering from my memory, I think that's about a dozen applicants. Pantex, $895 -- I'm going to assume that's one or two and it's probably small medical payments. At

Savannah River Site, $161,000, and I think that was like less than five applicants. I think there was one case in there that was up around $100,000. At Hanford, $62,000, I think that says. I just don't remember the numbers for Hanford, but I'm thinking it's low -- low teens, so these must be low awards. And then Rocky Flats, $62,000, and as I recall for Rocky Flats, I think that's four applicants and it's medical payments for Rocky Flats.

We hope this chart gets big quickly, and we'll continue to -- to track that. So we've paid out thus far over about $703,000 in -- in claims. And also we have about another $750,000 in reserves for future medical costs, so thus far the liability for these 31 applicants is up around $1.5 million.

There's always questions about locally here at INEL (sic), what are the numbers here. Total cases we've received here is a little less than 1,000 cases for INEL. We've completed 139 of those; 29 of those were positives. If we go back to the chart for Work Comp payments, you saw no Work Comp payments for Idaho -- for the Idaho Engineering Laboratory, and as best we can tell

thus far from our communication with applicants, none of our positive applicants here have yet applied for Work -- Workers Compensation as a result of the EEOICPA program. We do think we have information, and we're still clarifying that, that about three or four of the people that got positives, three or four of these 29, had received Workers Compensation payments prior to the existence of this program, so in addition to having already received compensation, they may have applied for the program just to get the paper and the physicians panel determination that -- that clearly shows that the DOE work was responsible for their illness.

We have a total 180 cases for Idaho that are currently in the physicians panel process, so we'll be seeing those come out in the next 30, 60 days kind of time frame; 87 cases are still awaiting development, and we expect those to be pushed to zero in the next month, month and a half.

With that, I'll be happy to answer any questions.

DR. ZIEMER: Tom, do you see many cases where

individuals start out in the Subpart D program and clearly should be in -- into the dose reconstruction, NIOSH, that you kick the other way, and vice versa? How -- how much is there back and forth between --

MR. ROLLOW: We've done some data matches with the Department of Labor over time, and I think our data matches are somewhere in the 90 to 95 percent -- people in our program are also in the Part B program, so there's about a 90 to 95 percent data match.

Generally the resource centers are where most of them do the applications, and the resource centers serve both the Department of Labor Part B, as well as the Department of Energy Part D, and so the people in the resource center counsel them -- what kind of illness do you have, where did you work? Oh, gee, you might want to apply for this other program, also. So I think we're getting a lot of good front end service on the application process to take care of that. But yes, we do see on occasion where there's an individual that just is in the wrong program.

Of course, my prog-- everyone -- almost

everyone that's eligible for the Labor program is eligible for my program, but not vice versa. So we see a lot of referrals come over from the Department of Labor.

DR. ZIEMER: Roy?

DR. DEHART: Tom, last time I raised a concern about the radiation issue, that physicians who are reviewing these cases in Part D may not have the background, and yet have a case that is a cancer case with radiation implications. What are we doing to assure that the physicians are aware of this NIOSH program, that they know how to interpret the data that's coming through NIOSH? Not every case that I've seen has been reviewed because the applicant has chosen to move forward with Worker Comp rather than wait till there has been a dose reconstruction.

MR. ROLLOW: All right. Several issues there. I'll take them one at a time. First of all, originally in this program -- let me back up.

A subset of applicants for this program are also getting dose reconstructions done at NIOSH for radiogenic cancers. And originally in this

program those cases were sent forward to the physicians panels for the physicians to determine if they felt that their injury -- the applicant's injury on this was caused by their work. Obviously it would have been easier for the physicians, if they had the information from the NIOSH dose reconstruction, to make that decision. We changed that policy about six or nine months ago. Some of those cases still did go through the program. In some cases -- a few cases, people got a positive determination from our program for radiogenic cancer and they had not yet gotten a determination from the Department of Labor. In some cases they would get a negative from our program, and what we do there is if the dose reconstruction comes through and if the Department of Labor gives them the equivalent of a positive for that program, they would be reconsidered in our program. So we're trying to be applicant-friendly there.

The second part of your question, though, refers more directly to the physicians. And the physicians now -- a larger population of physicians who are not necessarily experienced at radiogenic cancers, and we are continuously

trying to provide resources and information to those physicians to satisfy their need to make these decisions. And the most recent request, which we've actually been working on for a couple of months now, it's not fully well-resolved or developed, is to provide them some training in the details of the NIOSH dose reconstruction -- and I assume that's what you're referring to. We are working with NIOSH to try to figure out what we can do in that area to provide them more information on those NIOSH dose reconstructions, and it'll probably be in the form of either national conference calls or televideo, VCR tapes or that kind of information.

DR. ZIEMER: I didn't see the order these came up, so let's just go around the table. Rich, and then Mike and Jim.

MR. ESPINOSA: Two questions. Under the MOU and the states that are reluctant to get under this -- basically I'm kind of concerned on what are the specifics, and also applicants apply for Workers Comp. Does the state statute of limitations have anything to do with the big change in numbers? I mean there's 376 and only 87 that have applied?

MR. ROLLOW: Right, those are both very good questions. First of all, as far as the MOU goes, let me just give you an illustrative example that worked out well. The State of Florida we did not have an MOU with until about two months ago, and I think our issue there was just a lack of communication and understanding with the State of Florida as to what their liability would be with our program. Generally our program -- I want to say pays its own way through the State Comp system, because most, if not all -- well, most -- 99 percent of DOE contractors do what's called retrospective insurance. And that means that at the end of the year they end up paying -- reimbursing their insurance companies for the cost of a Work Comp claim and the U.S. Department of Energy ends up reimbursing the contractors for the cost of that claim, so the money actually comes out of the DOE's pocket. And so the states in many cases have little to worry about where there is what's called a so-called willing payer.

Another state where there's a challenge is in Missouri. There's some questions about the Mallinckrodt facility as to whether there's a willing payer or will be a willing payer at the

Mallinckrodt facility in Missouri, and so the State of Missouri is a little bit reluctant to sign an MOU and -- and -- and sign on to some new liability that they're a little bit unclear of, and so that's -- that's the issue in the state.

Your other question was...

MR. ESPINOSA: Applicants apply for Workers Comp. There's -- there's...

UNIDENTIFIED: Statute of limitations.

DR. ZIEMER: Statute of limitations.

MR. ESPINOSA: Statute of limitations.

MR. ROLLOW: Oh, statute of limitations. We are not -- we're -- when we order our contractors not to contest a claim we're also telling them not to raise administrative defenses, which the statute of limitation is. In most states they'll leave that up to the -- and I'm going to -- I'm going to define this wrong, and you -- some of you are experts in workmen's compensation, but in most states the states would leave that up to the employer and the employee to resolve a settlement on a claim. And so we're -- statute of limitations does not enter into the case.

In some states, however -- for example, I'll use Ohio as an example -- where there's a state

fund so that the State of Ohio is actually the insurance company, they're required by law to raise statute of limitation defenses in these claims. And so we may have some problems in Ohio. The first few claims are just starting to hit Ohio soon, working very closely with Ohio to figure out creative ways to not only help them get around their statute of limitations that they're required -- the defenses that they're required to raise, but also look for creative ways that we can reimburse the state, and we're getting close on that.

We're getting close in two ways. One way is that there's some legal things we can do in our insurance arrangements in the state of Ohio. And secondly, there may be some legislative fixes that might be made on the Hill, in the Congress, on that subject.

MR. ESPINOSA: How is that working out with the -- well, say contractors -- site contractors that are not self-insured?

MR. ROLLOW: Right now, as far as I know, for the claims that have been filed in the DOE system where we have a contractor that we can make a do-

not-contest order, I know of no contractors that have raised a statute of limitations administrative defense. And if we find those, we'll go work those on an individual basis. We'll go remove them, basically.

MR. GIBSON: You mentioned Ohio, and I noticed on your slide nine the cases that have been paid. Have there been any cases at all paid in the state of Ohio?

MR. ROLLOW: Ohio -- there sort of have, and let me explain to you how that works. You're probably familiar with the settlement fund for -- the Fernald Settlement Fund I think it's called in the State of Ohio -- where there's a program that actually we modeled a lot of our program after. It's where physicians look at illnesses that Fernald workers may have received from their work at the Department of Energy facility in Fernald. And a lot of those claims have -- have received positive findings from the Fernald Workers Settlement Fund, and then have gone forward to the State of Ohio and been paid -- not as a direct result of the EEOICPA program, but those workers may have been paid for the same illnesses that they've applied to our program

for. So the State basically has paid that out of the State fund. DOE at this point has not reimbursed that State fund for those payments, and has not yet found a legal way -- we're working with Ohio, on the phone with them twice a week right now, but we have not found a legal way that we can reimburse them for those compensation costs. So I know those claims have been paid. I do not know whether any Portsmouth, Ohio facility or Mound facility claims have actually made it to the State process.

MR. GIBSON: So that the Fernald payments were based on a out-of-court settlement from a lawsuit.

MR. ROLLOW: Well, no, no, the payments -- let me clarify that. The settlement fund pays for the physicians to look at the cases, but does not pay the compensation cost. The State fund pays the compensation cost. So the State of Ohio Workers Comp fund, that $2 billion fund, that great big insurance fund, if you will, paid the claims, not the settlement fund.

MR. GIBSON: But under EEOICPA, there have been no funds -- no claims paid in Ohio.

MR. ROLLOW: That's correct. We're working

with the State to find a way to get around the state law, basically, in Ohio.

MR. GIBSON: So in essence then, there's no willing payer in the state of Ohio.

MR. ROLLOW: We're willing, but -- but -- I mean -- this is -- it's kind of a -- a challenge of words here. The Department is willing, but the state law does not have a way to get around it right now. And I think we'll end up with a solution to that soon.

MR. GIBSON: Lastly -- and I've brought this up before because of these cases pending and stuff -- does ??? still -- is ??? still resistant to transferring this -- this portion of the program to the Department of Labor so that it -- you don't have to work with each state and these people can get their compensation?

MR. ROLLOW: Yeah, we're -- of course what you're referring to is the Senate Defense Authorization bill, which has adopted an amendment, I think sponsored by Senator Bunning*, which would transfer the program to the Department of Labor, make some rather dramatic changes to the nature of the program, and also -- basically transfer it and make some dramatic

changes to it. The opinion -- the position of the Administration -- the Department of Labor, the Department of Energy and the Executive Branch of the government -- is that this would not be a good idea to transfer the program from Department of Energy to the Department of Labor.

The reason are several-fold. One is the Department of Energy, as I'm showing you here, has fixed the production problems, so the numbers are coming up in those areas and we have a plan to work off the backlog. Secondly, it's very inefficient to uproot a program from one agency and move it to another agency. And then thirdly, there's some tremendous challenges, complications -- and some of them may not even be workable, the way the legislation is written -- for the Department of Labor to actually run the program, the way the legislation is written. And it's a little more complex than I probably ought to be -- ought to go into with you here today.

MR. GIBSON: Well, I -- you know, with all due respect, it just seems to me, with -- you know, $20, $30, $40 million requested next year for this program and $700,000 put out to workers, it obviously seems like there's some serious

impediments with this.

MR. ROLLOW: And -- and I don't disagree with you about the slow start. I think what we all -- do ask you to focus on the fact that the pipeline is full and there's product coming out the tail end of it, and you will see that go up dramatically over the next few months.

DR. ZIEMER: Okay. Mark?

MR. GRIFFON: Yeah, I'm trying to understand the -- just -- just to get a sense of this production that you described. Your one table, the second slide, versus a couple of the graphs -- I mean if I look at -- if I'm looking at this right, it seems like there's about 25,000 cases overall.

MR. ROLLOW: Uh-huh.

MR. GRIFFON: And the backlog is around 22,000 -- I guess it depends on how you define backlog.

MR. ROLLOW: How you define backlog. We're working --

MR. GRIFFON: Cases that haven't gone through the physicians panels.

MR. ROLLOW: There's 20,000 cases currently

being worked -- 5,000 that are not being worked, but 20,000 are currently being worked.

MR. GRIFFON: Uh-huh.

MR. ROLLOW: Of those 20,000 currently being worked, DOE has finished assembling the case file on 7,000 of those.

MR. GRIFFON: Okay.

MR. ROLLOW: Has finished assembling the case file, so the case now is sitting either in an applicant's mailbox waiting to be reviewed by the applicant, or it's sitting at a physicians panel or waiting to go to a physicians panel, or it's complete and done.

MR. GRIFFON: Okay. And -- and there's -- and if I'm looking at this right, there's been about 1,100 that have gone through the physicians panels?

MR. ROLLOW: That's correct.

MR. GRIFFON: Because I -- I'm trying to interpret this total cases completed. It seems to me that -- that set of ineligible applicants over -- I'm sorry, I need a magnifying glass --

MR. ROLLOW: Yeah.

MR. GRIFFON: -- or cases withdrawn by applicant --

MR. ROLLOW: See if I can --

MR. GRIFFON: -- if those two categories -- I think those are kind of exhausted right at the outset, I would think. In other words, that -- that you're -- you're rolling them into the total cases completed --

MR. ROLLOW: Right, but -- but --

MR. GRIFFON: -- but I think they don't go through the physicians panel at all.

MR. ROLLOW: That's right, but -- but --

MR. GRIFFON: That's a one-time hit, I believe. Right?

MR. ROLLOW: But not unlike the Department of Labor program. I mean ineligibility, once that's determined, that is a completed case.

MR. GRIFFON: Right, I don't dispute --

MR. ROLLOW: Obviously it makes more sense for us to try to disposition those at the front end of the process, and we do try to pick up as many of those as we can when they first come in the door. In fact, what we've actually done is we've rolled back to the resource centers where we take applications, and we're trying to do a little better job there of figuring out if people really are eligible for the program before they

apply -- make sure they worked during a covered time period, worked at a covered DOE facility, and that they're actually ill -- or have an illness.

MR. GRIFFON: I guess -- I guess what I'm trying to -- to understand is that those seem like one-time hits out of the 25,000.

MR. ROLLOW: Yes, absolutely.

MR. GRIFFON: And when you roll them into that percentage completed by the -- com-- you know, already complete process --

MR. ROLLOW: Uh-huh.

MR. GRIFFON: -- it looks a little inflated there at 12 percent. Really 1,100 have gone through the physicians panel. So I'm trying to get a sense of how -- it looks like you're scaling up significantly on the physicians panels, and I understand you've hired a lot more physicians, so that --

MR. ROLLOW: Uh-huh.

MR. GRIFFON: But if I look at the -- one of the graphs right, your sixth overhead there, it looks like you're going to be up to around 800 cases per month --

MR. ROLLOW: Absolutely.

MR. GRIFFON: -- going through the physicians panels, and that's a realistic estimate you've looked at?

MR. ROLLOW: Yeah, we -- we -- our -- our plan with -- that we -- that we put in front of Congress for our last funding committed to doing 300 -- 300 cases per week -- actually 15,000 cases in a year, which averages 300 a week; 200 cases per week starting -- for the first year up to the panels, and only 100 cases per week through the panel. And that first year started last June and would end next June. We actually expect to be up to 200 cases per week totally completed, out of the panels, probably in the November time frame, because we're getting sufficient numbers of physicians and physician hours right now. So we'll -- we'll greatly exceed that goal.

MR. GRIFFON: And you said you've hired 200 or so other case processors?

MR. ROLLOW: Right.

MR. GRIFFON: Are those -- what -- what kind of entities* are those?

MR. ROLLOW: Well, a case processing team consists of a medical person of some type,

generally a nurse, and then that nurse is supported by technicians and administrative helpers that get the information together, work with the sites to retrieve the information, assemble it according to certain protocols, and then the nurse -- or the nurse equivalent; I think they're all nurses in our program -- actually have the final say on the case before it moves forward to the final part of the process.

MR. GRIFFON: Are there any industrial hygienists or health physicists in that team of 200?

MR. ROLLOW: I have several on my staff, the DOE staff. Most of our -- a large number of our nurses are -- have occupational medical experience, but not necessarily industrial hygienists. So I would have to say probably not.

MR. GRIFFON: Okay. And I have one other question, but this is switching gears completely. It's -- out of your budget I'm curious how much -- I think it was either in NIOSH's presentation or in this one there was a discussion of when NIOSH requests information of -- from DOE --

MR. ROLLOW: Uh-huh.

MR. GRIFFON: -- I think you -- does that go

through your office? Am I correct about that?

MR. ROLLOW: Well, it -- it --

MR. GRIFFON: Data (Inaudible) --

MR. ROLLOW: -- my office facilitates it, but we've arranged it so they communicate directly with the sites, so we've cut out the middle man.

MR. GRIFFON: Okay. But does that come out of your budget, the --

MR. ROLLOW: Yes, I --

MR. GRIFFON: -- cost of that down at the site level?

MR. ROLLOW: -- I pay for that service, that's correct.

MR. GRIFFON: And that -- this is -- this will come up maybe later in our discussions, but does that also cover the cost of our auditor -- audit contractor requesting records?

MR. ROLLOW: I don't know -- I don't think NIOSH is providing any additional funding to our sites to support your auditor, so I'd have to say that right now either the auditor's -- servicing the auditor at our sites either comes out of my funding or it's coming out of the sites' overhead.

MR. GRIFFON: Has that come up yet to your

office, to --

MR. ROLLOW: Not to me.

MR. GRIFFON: -- your attention, to --

MR. ROLLOW: Not to me.

MR. GRIFFON: Hasn't come up as an issue yet.

MR. ROLLOW: I think it's probably better addressed by NIOSH and -- and by the contractor. I have -- my people have had some discussions, I think at Savannah River Site, to make sure the doors are open to the auditor at the Savannah River Site. I don't know any of the details. I just know we were involved in some discussions on that subject.

MR. GRIFFON: Well, I -- I think we -- I think we need to get this on the -- the scope of our discussions somewhere, especially why Tom is here, maybe, because my understanding at a previous meeting was that there would be no problems as far as access for the --

MR. ROLLOW: Absolutely.

MR. GRIFFON: -- for the auditor coming directly --

MR. ROLLOW: Our MOU, which is signed by the Deputy Secretary of HHS and the Deputy Secretary of DOE, provides for full and open access to

NIOSH and anybody that's supporting NIOSH. And so my -- you know, our courtesy or whatever you want to call it goes to Larry Elliott and to his organization. How he turns around and -- and extends that to contractors that support the Board or that support him is up to him. We just sent a letter out to the field -- to all field offices and copied Mr. Elliott on that letter, that reflected the letter I think that you folks actually sent to the Secretary of Energy and -- and reiterated that to our field offices, and said if you have any question on that subject to call Larry Elliott, because NIOSH has to actually open the door with their key, and if there's any DOE problems, to call somebody in my office.

DR. ZIEMER: I might insert that this Board sent a letter to the Secretary of HHS, who in turn made contact with the Secretary of DOE and -- and based on that letter, which Tom provided to his field contacts very recently to underline the need for access, specifically by the Board's contractor, so --

MR. GRIFFON: I guess I'm -- I'm getting back to the point where I believe -- I don't want to put words in Tony's mouth, but I think he raised

this at one meeting that a question at the site level of an unfunded mandate sort of, that they get these requests all the time from various researchers and everybody, and they want to know who do I bill to. And it is -- I was just wondering --

MR. ROLLOW: Well, I think we have to take those --

MR. GRIFFON: It's your impression that that's also --

MR. ROLLOW: Well, I can't --

MR. GRIFFON: -- access and -- and costs are covered.

MR. ROLLOW: Yeah, I right now fund the Department of Labor employment verifications, and I also fund NIOSH radiation dose -- requests for radiation dose information. I can fund a little bit of access to your contractor. But if it becomes a larger burden, that may be something that NIOSH and the Department of Labor may have to take up with us to work out some kind of solution. Generally overhead at the sites can accommodate some of this. It just depends on how much time it takes to service the request, and I just can't speak to that 'cause I'm not sure what

your contractor's doing.

DR. ZIEMER: Mike, and then Tony.

MR. GIBSON: You mentioned that your office funds the records search and all that.

MR. ROLLOW: Uh-huh.

MR. GIBSON: Does the local DOE office have the right, once the funding gets to that level, to do something else with it and take the monies out of the contractor's operating fund?

MR. ROLLOW: I don't know whether they have the right, but they haven't done it yet and we watch it pretty closely.

MR. GIBSON: Watch the Ohio sites --

MR. ROLLOW: We --

MR. GIBSON: -- (Inaudible) in particular?

MR. ROLLOW: Yes. The Ohio sites don't get a lot of money from us, but yes, we watch it very closely.

MR. GIBSON: And secondly, just as a comment --

MR. ROLLOW: If you know something I don't know, send me an e-mail tomorrow and let me know, 'cause we're always chasing down the dollars.

MR. GIBSON: And then secondly, there are some DOE contractors that are vigorously fighting

Workers Compensation claims to this day.

MR. ROLLOW: Okay.

MR. GIBSON: They are -- they are putting employees who get injured on the job under the sickness and accident plan and fight -- if they choose -- if the worker chooses to go Workers Comp, they're -- they're appealing it all the way to the top.

MR. ROLLOW: If they involve EEOICPA claims, which is -- I mean I hate to put blinders on, but of course my area is EEOICPA. But if they involve people who have positive determinations from the EEOICPA process, I'd be very interested in -- in the details of those and we'll go after them.

DR. ZIEMER: Thank you. Tony?

DR. ANDRADE: Yes, I just had a comment. I just wanted to remind the Board that during whatever meeting it was that I did mention that researchers or even our contractor going into DOE contractor's site would be considered an unfunded mandate. My statement was the basis for -- or was actually to be used as the basis for asking the Department of Energy to support that.

Now that the letter has gone out and I know

that it has certainly arrived at my site and I'm sure at all the other contractor sites -- active contractor sites -- the order is given, and in many cases overhead is used like for record centers to provide services and support the contractors. And then sometimes it's even programmatic funds that come out of say radiation protection programs to provide information directly to the subcontractor. And so it is a combination of dollars, but the contractors have been ordered to do, so therefore they will.

DR. ZIEMER: Thank you, Tony. Roy?

DR. DEHART: Tom, you alluded to the fact that there are some differences here on reimbursement. For the benefit of the Board, would you again give a little explanation to why the death of the claimant and the compensation thereof may be entirely different with the Worker Comp versus what we are seeing from cancer? I'm primarily talking about the siblings, the children.

MR. ROLLOW: Okay. Now are you talking the difference between Part B and Part D?

DR. DEHART: Yes.

MR. ROLLOW: Okay. Well, Part B obviously is

a -- is a set -- set amount, $150,000. For a survivor who has made an application to this program because say a parent may have succumbed to an illness caused by their work at the Department of Energy, if they have reached majority age -- in other words, over 21 or whatever majority age is in that state, and I'm not real well-versed on this, so there's probably people in this room that are a lot more knowledgeable on Workers Comp than I am. But if they've reached majority age say at the time that that person had expired, they were not dependent perhaps on the income from that worker, there would -- there may be very little compensation due to them, say other than maybe a burial payment or something of that sort. So in some states we might see an award -- several thousand dollars, basically just a burial payment to that -- to that person. In other cases, if the worker succumbed to an illness and died during their working career and it's a -- it's a widow that was dependent upon that worker, they're making an application to the program, there may be lost wages, there may be a large death benefit in the six figures. Is that the explanation you're

looking for?

DR. DEHART: One of the points is the minority issue of the children, which we don't have to deal with with the cancer --

MR. ROLLOW: Right.

DR. DEHART: -- issue. And if -- and we've all heard comments about the time criticality in dealing with the cancer issue. It's even more of a critical issue in dealing with the Worker Compensation.

MR. ROLLOW: It -- it can be, although generally most of our -- a large percentage of our applications are survivor applications, and -- and that person expired even before the program was passed into law, many cases.

DR. ZIEMER: Tom, could you address very briefly sort of the quality control issue on physicians? Now I recognize that, maybe with the exception of the physicians who are on this Board, there are some whose judgment may not be faultless. And how do you -- when you have a one-person decision point, how do you assure -- well, let me ask it this way. Do you go back and say is physician A always judging for the claimant or against the claimant; is there a

pattern that suggests other than objective evaluation? Or do you see the things -- do you send out an application, a duplicate one, to several and cross-calibrate them; or is there some kind of quality control on those judgments?

MR. ROLLOW: You're really putting me in the hot seat here. We do not score our physicians. We do not try to pre-judge or to judge, based on their performance, which way they're going to go. We do try to educate and communicate to them if we see them constantly leaning in one direction or the other. The single physician case is going to always be applicant-friendly, because if a single physician leans one way or another, the only way it can -- it can do -- the only thing it can do is help the applicant, because if they're always negative, there are two other physicians that also would have to -- well, one other physician would have to be -- have a negative on that same case, and that's why we retain the review from two or more physicians to get a negative. But we --

DR. ZIEMER: I'm more concerned about the luck of the draw for someone who's always positive.

MR. ROLLOW: Well, there may be some of those. What we do is we try to look for those. We do review every single case in detail, both by a panel of physicians that -- that were -- excuse me, not a panel, bad terminology -- by physicians that are under my employment, and I also have a medical director, Dr. Mike Mentopali*, and we review 100 percent of all the decisions. And if we see things skewed, we will go back and work with that physician to -- to clarify either policy in the program, to provide them additional technical information, medical information to help them make better judgments.

On the other hand, the process is set up by law for an arm's-length relationship between DOE and the physicians. And I have to be very, very respectful of that distance. And as a result there may be a program that we might want to run here that has more consistent results, but that won't end up with that consistency because of that arm's-length relationship.

DR. ZIEMER: Any further questions?

(No responses)

DR. ZIEMER: Thank you very much, Tom. We appreciate the update on that part of the

program.

It's now 12:15. We'll -- we'll shoot for -- let's say 1:30, if possible. I'm not sure how convenient lunch places are here. Do we have a list or anything of -- there's not much choice is what I'm hearing. Okay. Shoot for 1:30. Thank you. We're in recess.

(Whereupon, a luncheon recess was taken.)

DR. ZIEMER: Okay, we're going to go ahead and reconvene. Our regular Designated Federal Official is not present, and we have to have one, so the Acting Designated Federal Official is Jim Neton, and when Larry arrives they will play musical chairs and trade.

PRIVACY ACT AND FACA REQUIREMENTS

But anyway, we're going to begin the afternoon session. Liz Homoki-Titus is going to in a sense update us on Privacy Act issues and bring us up to speed on anything new in --

MS. HOMOKI-TITUS: Well, I think I am.

DR. ZIEMER: Yes, we think Liz is going to do that. So Liz?

MS. HOMOKI-TITUS: Okay. One piece of news that I want to share with you all, and you've probably noticed that David Naimon is no longer

with us. He has been promoted to the Associate Deputy General Counsel, so he'll no longer be attending Board meetings or working with this program, which has left me as the acting team lead, and at some point in the future you may see a new team lead who will be introduced to you, et cetera. But for right now, if you have any legal questions, any questions about the Privacy Act or anything else, you're still free to contact our office at the same number but you'll probably be dealing with me instead of David Naimon.

As I indicated to you at the last meeting, I wanted to go a little more in depth on the requirements of the Privacy Act. Now that you all are going to start reviewing individual dose reconstructions through your work groups and the subcommittee, and also as a committee, as well as beginning work on SEC petitions, this is once again very, very important for you to consider and remember.

What is the Privacy Act? It is Federal withholding statute, which means -- withholding means the Act prohibits the disclosure to any third party information about a person without that person's written permission. If you all

receive a request for a disclosure of a Privacy Act record, which is just basically anything that deals with an individual, please have that person contact OCAS, and please let OCAS know that you've received that request so that they can be aware of it and take care of it properly.

HHS also has their own Privacy Act policy, and it is the policy of the Department to protect Privacy Act information to the fullest extent possible. That means that we do allow the disclosure of records -- i.e., you all will be receiving full dose reconstruction reports -- for employees of the Department to do their jobs. But we do not disclose records to other people unless it's proper under Freedom of Information Act or we have received a proper Privacy Act release.

I do want to remind you that there are civil and criminal penalties that you will be held personally responsible for if you are found to have wilfully violated the Privacy Act. And please be aware that the criminal penalties can be up to $5,000, which you would be personally responsible to pay if you were found guilty.

There are some permitted disclosures with the

Privacy Act. These are disclosures that would be handled by the Department, not handled by you personally. If the government has a record that pertains to an individual, they have a stat-- they have the right to have that record. And then there's some other special interests that have access to records, especially at the Department of Health and Human Services where we have medical records.

And of course there are prohibited disclosures of the Privacy Act-protected materials. And basically you cannot disclose Privacy Act-protected materials to anyone unless the Department of Health and Human Services has received a written release for the release of that information to that particular person. For example, this includes dis-- precludes disclosures without written permission to family members, medical personnel and members of Congress, with certain exceptions that are statutorily set.

You've probably seen these before, but I'll run through them for you one more time. They're Privacy Act rules for special government employees, and I'll remind you again that each of

you is a special government employee who is an employee of the Department of Health and Human Services each time you're working on Board activities. So generally, avoid discussing or disclosing the merits of individual claims and SEC petitions. Stick to giving out public information. The public does view you as representatives of the Department of Health and Human Services because you are in the public eye. And you are allowed to share publicly-available information, but you can't share information specific to a person that you may have learned in their dose reconstruction report or in an SEC petition. When y'all are having dinner and stuff like that, avoid speculating about the identity of claimants, SEC petitioners or SEC class members. Avoid speculation about dose reconstruction and SEC issues that the Board may be considering, or that you may know that the Department is considering. Try to avoid predicting Department and Board future actions. You know that you're supposed to avoid assisting with the filing of individual claims, but you may be a fact witness, because we know that a lot of you have worked in this area and you may have

friends that -- or coworkers that you worked with for whom you can be a fact witness. And if you have any questions about that or you've been asked to be a fact witness, please feel free to contact OCAS or us to discuss what if any limitations that your Board role may have for you.

DR. MELIUS: These aren't all Privacy Act issues, though.

MR. GRIFFON: Right.

MS. HOMOKI-TITUS: No, some of them aren't.

DR. MELIUS: Most of them aren't. I think you need to be clearer about that.

MS. HOMOKI-TITUS: Well, the first one's a Privacy Act informa-- is Privacy Act.

DR. MELIUS: For SEC petitions?

MS. HOMOKI-TITUS: It can be because you've got three individual -- if you have three individual --

DR. MELIUS: (Inaudible) --

MS. HOMOKI-TITUS: -- petitioners.

DR. MELIUS: -- names, but --

MS. HOMOKI-TITUS: Right. Public information's not.

DR. MELIUS: Yeah, okay. I mean you don't

have to go through them all, I just --

MS. HOMOKI-TITUS: Okay. As I've mentioned throughout the presentation, there is no reason, as a member of the Advisory Board, that you should be disclosing Privacy Act-protected materials to anyone. You are not an appeals board, so therefore people will not know if you're reviewing their dose reconstruction, so therefore you shouldn't be discussing with anyone, including -- if you're talking to the person whose dose reconstruction you're reviewing -- their information with them.

SEC petitions that you all are reviewing should not be discussed outside of the Board meeting. And once again, if you get a request for a disclosure of any type of Privacy Act information, please direct them to OCAS and let OCAS know that you've received that request.

Now moving on to the role of the Advisory Board under the Federal Advisory Board Committee Act, which is FACA, you'll hear me refer to it. In 1972 Congress felt that it was important to regulate the role of advisory boards within the Executive Branch. And the law has special emphasis on open meetings, chartering, public

involvement and reporting.

Congress there was a need to share information that advisory boards were giving to the Executive Branch with Congress and with the public. They also determined that the role of an advisory board should be advisory only.

Under the advisory functions of the advisory board, unless there's a Presidential directive or your statute specifically provides for you to do so, then the role of the board is only advisory. For this specific Board, Congress nor the President gave you authority to make determinations on the behalf of the Department of Health and Human Services. You advise the Secretary, and that's your only function.

FACA also required there be a charter filed, and it needs to be filed with the head of the agency with whom -- to whom you report, which is the Secretary of Health and Human Services. You all do have a current charter, and you also now have a charter for your subcommittee, which will be important in a few minutes.

The law also requires that you have a Designated Federal Official at all of your meetings, so therefore for the Board to have a

meeting, Larry Elliott needs to be present. This will be very important when we get to talking about public open meetings, because the Board -- if six of you get together and start discussing Board issues, you have a majority and you're having a Board meeting, so you need to be careful about that if you're having dinner together and you start discussing Board issues. And also now that you have a subcommittee, which all of you are a member of the subcommittee on that roster and you have five members that sit that committee, if three of you get together and start discussing subcommittee issues, you once again have a majority. And so therefore you need to be conscientious of discussing Board issues and subcommittee issues in small groups outside of the public forum.

Closed meetings are going to be very important for you. Closed meetings have to be announced in the Federal Register, which committee management handles on your behalf. And the Department is the one who makes the determination as to whether or not a meeting should be closed. Now you all will be having a number of closed meetings because protection

under the Privacy Act is a reason to have a closed meeting, and you all will be reviewing a great deal of Privacy Act information.

As I mentioned before, the Government in the Sunshine Act is referred to by FACA and it requires open meetings. And this is once again where it weighs in that a majority of your members -- if you're meeting outside of the board room, three of you, six of you, and discussing issues specific to the subcommittee or specific to the Board, you are having a meeting that is not in the public, and it's illegal under these statutes. So please be aware of what you're discussing when you meet outside of the board room.

Once again, closed meetings (Inaudible). GSA has also put forth FACA regulations. They're interpretive guidelines for the management and control of FACA committees, which you all are a FACA committee, and HHS and this Advisory Board follows those regulations. We can provide you copies of them if you're interested in reviewing them. I assure you that we have a great committee management and they do keep us all in line, but I want you to be aware that you're

bound by those, and if you're interested in seeing any of them, we can share them with you.

As you know, EEOICPA established -- directed the establishment of the Advisory Board with certain duties, and the President established the Advisory Board through Executive Order 13179. And just a quick review of your duties under EEOICPA and the Executive Order, EEOICPA required for the dose reconstruction methods be reviewed, as well as what you are about to undertake, which is a -- to verify a reasonable sample of the dose -- doses estimated, as well as reviewing and advising on the scientific validity and quality of dose estimation. So just a review of what y'all are doing, and then that was also reiterated by the President in his Executive Order.

And finally, the EEOICPA SEC duties is to advise the President whether there's a class of employees at a DOE facility who were likely exposed to radiation. And just as a reminder, the President reiterated that in his Executive Order, and also just a reminder that you all do report to the Secretary of Health and Human Services, you give advice to the Secretary of

Health and Human Services, not the President, in accordance with the Executive Order establishing the Board. And I will take any questions, and hopefully that was short enough to get us back on time track a little bit. And all the better if there are no questions.

DR. ZIEMER: Questions for Liz?

MS. HOMOKI-TITUS: I know you guys have seen this a few times, so I was trying to keep it quick and just give you a refresher.

DR. ZIEMER: Yes, Henry Anderson has a question.

DR. ANDERSON: Could you go back one?

MS. HOMOKI-TITUS: That might be beyond me. How do I go back?

(Pause)

MS. HOMOKI-TITUS: What's your question while I'm getting back to it?

DR. ANDERSON: Basically my question was about the appointment, and it says all of the duties were assigned to the HHS Secretary except the appointment of Board members.

MS. HOMOKI-TITUS: Right, the appointment of Board members --

DR. ANDERSON: And we have ac--

MS. HOMOKI-TITUS: -- and the Chairman.

DR. ANDERSON: We've actually gotten two appointments.

MS. HOMOKI-TITUS: You've gotten two appointments?

DR. ANDERSON: I mean we got a White House appointment letter and notice, and then we also got a Secretary appointment, and for some of us, this is our last meeting, so --

MS. HOMOKI-TITUS: The Secretary's appointment was -- or wasn't an appointment; it was a welcome to the Board. The -- your actual appointment comes from the White House. The White House makes these determinations. Larry may want to address that, as well.

MR. ELLIOTT: I would like to speak to this a little bit.

DR. ANDERSON: Yeah, if you can.

MR. ELLIOTT: The White House appoints the members to this Board. The President retained the authority and didn't transfer that or delegate that in the Executive Order. That comes from the statute. The appointment letter that you got from the Secretary just confirms -- reconfirms, I guess, that the White House has

appointed you and you're serving on this Board.

Now Dr. Anderson, you made a comment a moment ago that this may be the last meeting for some of you. That's not the case, until you hear from the President or from the White House that you have been relieved from service and somebody else is appointed to take your place. You serve at the pleasure of the White House until they appoint a new person or you decide you want to resign from the Board.

DR. ANDERSON: So will we get a new letter from the -- from HHS? 'Cause it said my appointment expires in -- in August.

MR. ELLIOTT: It said your appointment expires in August, but you're Presidentially appointed, and that supersedes the comment or the sentence in that HHS appointment letter. So until you are replaced by Presidential appointment, you continue to serve. Or unless you decide, as Sally Gadola had decided that she could no longer serve.

DR. ANDERSON: So will we get new appointment from the HHS for our four-year term?

MR. ELLIOTT: That's unknown until the White House determines what they're going to do about

the appointments that are up at this point in time. They could decide not to do anything at this point in time and just let that ride. They can let it ride into next year, and next year there'll be eight members of this Board that would be sitting at the table that were beyond their appointment, perhaps. You un-- see what -- understand?

DR. ZIEMER: Could I also comment, and I think this has been a point of confusion to all the members of the Board. Other advisory groups within HHS, most of which are appointed by the Secretary of HHS, have specific terms. It was my understanding that the Secretary of HHS had intended for that pattern to be the case for this Board, as well. But as Larry's indicated, the overriding determination is -- lies with the White House. So maybe Larry is reluctant to say this, but regardless of what the Secretary of HHS would like to do, it gets overridden by what the White House actually does.

MS. HOMOKI-TITUS: That's exactly right.

DR. ZIEMER: I think that's the case. So in a certain sense, the letter from the Secretary of Health and Human Services assigning you a term

has very little meaning if the White House ignores it.

DR. ANDERSON: The only difficulty is, in order for me to attend -- as a State employee -- I have to show that I have a legitimate appointment here and to share -- the letter I got from HHS, which I then shared with the Wisconsin administration, says I end in August.

DR. ZIEMER: Wisconsin doesn't recognize the President's appointment as being legitimate? Is that what...

DR. ANDERSON: Well, I mean the --

DR. ZIEMER: Just kidding, just kidding.

MR. ELLIOTT: We can work with that.

DR. ANDERSON: I need to have some kind of an indication that in fact what the letter said --

MR. ELLIOTT: Well, we'll let --

DR. ANDERSON: -- that term doesn't end.

MR. ELLIOTT: Right. We can work with that and get committee management office to give you, for the State, a reading that will say that the White House takes precedence over what the Secretary's appointment letter says.

DR. ANDERSON: That would be helpful.

MR. ELLIOTT: They use standard language in

the Secretary's appointment letter for all HHS FACA appointments, and that's what caused this -- this confusion. The way I think this will happen, the White House is considering now what it's doing -- going to do, is my understanding, with regard to the first four members whose appointments expire this month. I don't know when they're going to make a decision on that. They work at their own pace. So --

DR. ZIEMER: But the absence of a decision --

MR. ELLIOTT: The absence of a decision means you're serving at the pleasure of the White House and you continue to serve until you hear otherwise.

DR. ANDERSON: Yeah, I guess I just need some written confirmation of that because they log it in.

MR. ELLIOTT: I understand.

DR. ANDERSON: It's just like with a grant, your grant expires, and if you don't tell them you got a new grant year, they close it out and the staff get notices, everything goes.

MR. ELLIOTT: I understand. We'll -- we'll --

DR. ANDERSON: You know, just some --

MR. ELLIOTT: We'll work with committee management on that and get you what you need.

DR. ANDERSON: Some -- just something brief.

DR. ZIEMER: Jim Melius.

DR. MELIUS: Back to Privacy Act issues, it seems to me that -- I'm trying to understand how this affects us procedurally, 'cause there's a balance between us functioning open to the public and -- and transparency to our process at the same time we have to deal with in-- you know, individual claims records that, for example, we'll be reviewing as part of our review of the dose reconstruction activities of -- of NIOSH. So --

MS. HOMOKI-TITUS: I believe a lot of that will be addressed when the subcommittee makes their presentation on the procedures that they have agreed to and are asking the Board to approve. We did have a discussion about that yesterday during the subcommittee meeting. So if you can hold your question until that point, we can come back and readdress it if you're still concerned.

DR. MELIUS: Okay, that's fine.

DR. ZIEMER: Insofar as individual cases are

being dealt with and you have that issue. If you're talking about a broad report, the statistical numbers and so on with no individual cases being dealt with, then it'll be a different story.

DR. MELIUS: No, no, I --

DR. ZIEMER: We're prepared to make some recommendations.

DR. MELIUS: Okay, that's -- my understanding -- I was just saying that there's a balance there and we've got to --

DR. ZIEMER: Right.

DR. MELIUS: -- understand how Privacy Act works.

DR. ZIEMER: Okay. Other questions? Comments?

(No responses)

DR. ZIEMER: Thank you, Liz.

MS. HOMOKI-TITUS: Thank you.

CONFLICT OF INTEREST, QUALITY ASSURANCE PLAN, ACCESS ISSUES

DR. ZIEMER: Now we actually have three presentations from the Board's contractor, SC&A. John Mauro's going to kick this off, and then Joe Fitzgerald will follow. Is Steve here, also?

DR. OSTROW: Yeah, I'm here.

DR. ZIEMER: Oh, there he is. Okay, so we have -- we have three presentations, and John I believe is going to kick it off and then he'll pass it on. Or are you going to kick it off?

DR. MAURO: Joe will start off.

DR. ZIEMER: Joe is going to kick it off, okay. Very good, okay. Thank you.

MR. FITZGERALD: Well, thank you. I know you have a tight schedule so we wanted to try to make this as efficient as possible, and I appreciate the opportunity.

We last spoke to the Board in April about an issue we felt some concern over, which was the question of information or data access. And you know, we now have a few months of experience. We have three out of I think four site profile reviews that we've been working on that are near completion. And we felt it would be a good opportunity to come back and mostly give you the on-the-ground perspective and experience, and also I think raise some issues that we would certainly want the Board to be aware of and to perhaps address in order to expedite these reviews.

This just comes from our background documentation, the task order, the procedures. I won't go through this in detail, except to note that, you know, the charter that we're operating under -- and we discussed this before -- certainly was to look comprehensively at the completeness of the records. But more -- maybe more importantly, to probe in a vertical sort of way, talking to workers, talking to site experts and looking at secondary documentation to provide the kind of validation which I think would be value added to the site profiles and the work that's been done by NIOSH.

And I'd like to report, after several months of doing this work, even though we're yet to deliver a report and we expect to do that soon, I think the charter is very sound. I think the insights that we're gaining, the feedback we're getting and the -- I think the documentation that we're reviewing is going to be particularly valuable in providing the Board I think with the kind of feedback, and NIOSH with the kind of feedback, that's going to I think be a asset to the process. So I think this is something that -- you know, in designing this I know there was

some thought put into it in terms of our procedures. You know, there was certainly some forethought of how this would work. But you never really know, I think, until you actually get in and start implementing. I think it's proven to be a very sound approach. I just want to make that clear before we go into some of the speed bumps that, not surprisingly, we're trying to grapple with and for which we certainly would like your guidance and -- and wisdom on.

Not surprisingly, access continues to be an issue that we're grappling with. It's -- it has slowed us down -- hasn't stopped us, but I think it continues to be a challenge that -- that keeps us from going as fast as we'd like and keeps us from perhaps probing as much as we'd like to probe in terms of some of these verticals that we're talking about. And again, we -- we did brief up on this general issue back in April. I think the Board agreed to ask that a letter be drafted for the Secretary at HHS and that has since gone over to DOE in July. And I think the real purpose of the letter certainly was to alert DOE that this is sort of a new group, new category, new activity that had started and that

certainly we would need to have access and clearances and what-not. And it's useful to have Tom here as a facilitator. It certainly helps us, as well.

The other -- certainly the other issue -- and we're picking this up certainly from the DOE sites, like Savannah River is -- they have spent a considerable amount of time and effort and resources to generate records in response to NIOSH's request. And before we can actually get any additional records or documentation, they certainly -- and rightfully so -- want to ascertain that we have cross-referenced our request against what's been already sent over. And so one thing that we've been pushing for for a couple -- two, three months, is to certainly have ready access to the NIOSH recovered database -- recovered file database. And as of last week we've been pretty much read into it and can navigate the search engine for those files. And that's going to certainly make it possible for us to do that and to then, you know, determine what records we don't have. So that's been, I think, a major milestone.

And certainly we've been looking at some of

these specific sites like Savannah River, and one issue that's coming up very quickly is we certainly need to make use of the process laid out by the MOU, make sure that we can ask for these records and ask for the interactions at the sites and have that supported by the resources that have been set aside for the MOU. Very clearly, and not surprisingly, but we're hearing back from points of contact is that, you know, want to cooperate, but someone has to pay the contractors for the time that they're going to spend with us. And I think (Inaudible) you raised this issue a couple of meetings ago, that's very real. I think in the DOE land that the margins are such that the contracts do not permit interaction without certainly exercising the MOU. So certainly talking to Tom, his office is ready to facilitate. I know, based on our conversations with Larry and NIOSH and the MOU's in place, so there's a mechanism for that.

A key issue I want to raise, though, is certainly the Q clearance is going to be a very real, on-the-ground issue. We have three sites -- Y-12, Rocky Flats and the Nevada Test Site -- for which Q clearance is almost a must in order

to be able to access and really go through the records, if not even get on site. I know for a fact, having been to Y-12 in my past lives, that certainly that's going to be a requirement to really be able to look at much there. And of course that's on the schedule that the Board has given us in terms of these reviews. So I just want to alert -- you know, the -- I just went through the DOD clearance process last week. NIOSH has set -- you know, put this thing in motion. It's moving ahead. Okay? We went through and certainly went through the clearance process with DOD. I think the top secret clearances are forthcoming. But that's a prerequisite to going to the Q. And as Tom has reminded me, since I've been out of DOE for a few years, that takes some time. That may take six to 12 months. So I think certainly a factor in our ability to do some of the secure sites, either that gets facilitated, walked through -- 'cause based on our experience, you can do these things in terms of Q clearances faster or you can do them in sort of routine time. There's a big difference between routine time and expedited. So -- but unless something happens in terms of

relieving that, we're going to have some difficulty in being able to accomplish reviews at this time -- at those two or three locations, anyway. So that's sort of the practicality.

It's moving probably as fast as it can, but it won't move fast enough I think to get to those sites in the near term, so we -- you know, there may be some consideration of, you know, how we schedule or pace those things to reflect that reality. And I heard that a little earlier, that we're not the only ones that have to deal with the national security questions. So it's not really an uncommon issue, but a real -- real issue for us.

So the real -- I think the bottom line question is the team is up and running. Analyses I think have been very fruitful. The discussions, interviews and documents that we've looked at have been very useful and valuable and I think they'll prove useful and valuable to NIOSH, as well, and to this Board. But we do have some impediments that will probably delay the schedule that we've been talking about.

We will be able to deliver two or three essential reviews. Savannah River is nearing

completion. We have somebody on site this week conducting final interviews. Bethlehem Steel and Mallinckrodt both -- being AWEs, of course, there isn't as much in the way of site access issues; there's no sites -- and the interviews I think are more straightforward, so there really isn't as much of a barrier there. Hanford may be somewhat of an issue. And certainly the balance of the sites, the ones I mentioned, will have some security questions that may prove to be a problem.

In terms of status -- this is a couple of weeks old. Actually whenever Cori requested these things to be sent in, and as I was saying earlier, we now have free and unencumbered access to the electronic database that NIOSH maintains, and that's going to make it much easier I think to look at some of the reference documents that are in site profiles. However, we still have the DOE access issues, and we'll certainly want to work with NIOSH and DOE and Tom's office to make sure that we can actually get any additional documents and site access.

Finally, this is the last slide, what it sort of comes down to is that we have in fact gotten

access to recovered data files. I think we're in fairly solid position to wrap up the three site profile reviews that we're doing now. However, the clearance issue's going to be a problem for at least three of the next four or five sites that we're looking at in terms of the Q clearance.

The other issue is that there may be some -- not may be, there will be some issue as far as being able to touch all the bases as far as the scope that's been laid out for the reviews in terms of, you know, what information we can get to without clearances and what's readily available to us. And I don't think the answer is certainly to limit what's been planned in terms of the scope for the reviews. The reviews certainly are working out where they in fact are very sound and the approach is one that certainly we think is a strong approach.

However, this question of deliverables, what we in fact can give this Board, is very specific. We can give this Board a final review, quote/unquote, and we're interpreting that as pretty much a key, one-time deliverable. And if we come up, you know, ten percent short, 20

percent short, whatever is the impediment because of the data access issue or security issue, the conundrum that we have and one that we want to kind of ventilate with you is how do we handle that in terms of providing you the analyses that you've requested, but not having what I would call the final assessment, the final review, something that, you know, we will still need some additional work -- maybe awaiting clearances. You know, maybe it'll take four or five months before we have the clearances. So we want to certainly tee that issue up and say we are right now obliged to give you a final review with the full spectrum of interviews, vertical assessments and everything else that's called for. If that cannot be accomplished to the full extent because of these constraints, where does that leave us in terms of your intent and how this should be handled -- 'cause right now we're sort of looking at a couple places where yeah, we might have a good portion of the analyses, but not all the analyses. And we don't want to presume to give you half a loaf or hold something back indefinitely without certainly making you aware of that issue. And I guess this says it all here

in terms of timeliness and resource issues. We're looking at the efficiencies. We've talked to NIOSH about the cost efficiencies. And we want to really control what right now is sort of uncontrollable, because I think that's going to be a factor in increasing the cost and time and certainly that needs to be addressed. So -- and that's pretty much it.

What we would like, frankly, is maybe a deliberation on the snapshot of today in terms of the actual experience that we now have on this issue and to sort of solicit a collective, you know, what -- what path would make sense in terms of preserving the feedback you need, but recognizing the practicalities of -- of just dealing with the information issue, as well as security issue. Thank you.

DR. ZIEMER: Thank you, Joe. Let's open the floor now for questions. It looks like Tony is ready to ask something, then Jim.

DR. ANDRADE: Okay, a few points here may be helpful -- hope they're helpful. You mentioned something about going back and looking at items called incidents. Okay. Let's be very specific. I'm not sure if you're familiar with the DOE

parlance, if you will, but incidents have a very specific meaning versus reportable(recordable)* occurrences.

MR. FITZGERALD: Right.

DR. ANDRADE: Okay. And occurrences -- and occurrence reports you should have access to once they're closed out to -- it's public information.

MR. FITZGERALD: Right.

DR. ANDRADE: However, if you ask for incident reports, some people in some of the DOE contractor sites will be much more sensitive to that and they'll say okay, these are sub-- occurrence reporting type incidents and we hold these for our own use in developing lessons learned, perhaps, and -- or trying to correct -- self-correct issues.

MR. FITZGERALD: Right.

DR. ANDRADE: Okay? They could become (Inaudible) self-reportables or that sort of thing. So when you ask about incidents, you might expect that sort of push back. And that's just a word to the wise. Okay?

MR. FITZGERALD: Okay.

DR. ANDRADE: Clearances. If you go the classical DOE route, right now it's taking DOE 75

days to turn a request and the final adjudication back to the contractor -- 75 days. That is on top of an OPM* or even FBI investigation that might take a year. Okay? So we're looking at two years, practically speaking.

Now, you mentioned that you had DOD sponsors that you might actually get secret or top secret --

MR. FITZGERALD: Top secret.

DR. ANDRADE: -- clearances from? Okay. I'm not suggesting this as a way around, but if you can provide a compelling reason to a DOD sponsoring agency that you need access to special caveat of information, the way it's held in the DOD circles, called CNWDI -- Critical Nuclear Weapons Design Information. Okay? That is the equivalent to having access to DOE -- a DOE Q clearance with access to signals(signas)* one through ten type information. That includes design information.

So if you can get access to CNWDI, or have your sponsor give you the CNWDI caveat, once you're -- you can actually transfer your badge from your DOD sponsor to a DOE contractor site and it will be recognized as you having access to

Q information. Okay?

So a little complicated there, but nevertheless, it's -- it's the way we work with all branches of the services, the Office of the Secretary of Defense, et cetera. Okay? So it may be a little bit easier than you think, if you have that DOD sponsorship and that compelling reason for the caveats of CNWDI.

MR. FITZGERALD: Yeah, I would have to defer on the -- sort of the protocol and processes. I'm -- I'm unfamiliar outside the DOE side as --

DR. ZIEMER: It'll be easier if you can figure out what he's talking about. Otherwise --

MR. FITZGERALD: If it works, I'm for it.

MR. ELLIOTT: I need to provide a point of clarification here. I'm not sure, Joe, where you're coming in with a DOD sponsor. You've got a DHHS sponsor to get you the top secret, so you may have mis-spoken that earlier.

MR. FITZGERALD: Yeah, it's D-- you said DOD sponsor. Actually it's -- the DOD is the one that responds to the HHS sponsorship to get the top secret. They're just the mechanism by which the investigation's handled. It's just -- the sponsorship comes from --

MR. ELLIOTT: DHHS.

MR. FITZGERALD: Yes.

MR. ELLIOTT: I don't think DOD is involved anywhere in this process.

MR. FITZGERALD: Well, they are in terms of actually conducting the investigation itself, but --

DR. ZIEMER: On your behalf, though, so --

MR. FITZGERALD: On your behalf.

MR. ELLIOTT: That's news to me 'cause we've been dealing with OPM/FBI.

MR. FITZGERALD: Right.

MR. ELLIOTT: DOD has never entered into the HHS realm. I need to check on this.

MR. FITZGERALD: 'Cause DSS, the Defense Security Service, actually handles a lot of domestic investigations, so --

MR. FITZGERALD: With the new Department -- with Homeland Security we're seeing a whole watershed change here in process, so this is news I need to follow up on.

DR. ANDRADE: If you -- if you could -- you know, like I said, this is a potential mechanism to be able to access -- at least get some information from the Q-cleared regime*.

DR. ZIEMER: Well, we can follow up on that.

DR. ANDRADE: Yeah, if you would. I think that -- that would be really good --

MR. FITZGERALD: I guess before we leave the topic, since you have first-hand experience at Los Alamos, would you agree, though, that even for a place like Los Alamos, lack of a Q or equivalent would pretty much handcuff you in terms of your ability to even move around, let alone get information?

DR. ANDRADE: Right.

MR. FITZGERALD: Yeah. You'd be a prisoner.

MR. PRESLEY: (Off microphone) Do you have any form of a clearance?

MR. ELLIOTT: Speak in the mike, please.

MR. PRESLEY: Do y'all have any form of a clearance now?

MR. FITZGERALD: No, we do not, and this process that NIOSH instigated with HHS sponsorship actually will lead to a top secret clearance probably within days, which is quite an accomplishment in itself, but will fall short -- which I think is what Antonio was saying -- fall short of what's required for the DOE complex at the weapons facilities. They require a Q and

nothing less than a Q, and that's -- that's the issue we probably have to resolve if we're going to do Y-12, Los Alamos and some of these other locations.

DR. ZIEMER: Jim, you have a question?

DR. MELIUS: Yeah, it's not on security, so if that's -- we're done with that, yeah, I have a couple of questions. And one is I guess for Larry. In terms of this issue of what's a report, how should the subcontr-- or the contractor report their findings and what if they sort of -- I guess you're sort of asking, Joe, should you -- because of access or other issues, cannot complete a review, would there be possibility for an interim report being part of the process. Is it possible like to modify their task orders or something to include that? I'm just trying to think within the contractual...

MR. ELLIOTT: Certainly. Certainly, that -- that -- you know, what -- you know, I think that it is certainly appropriate to effect a modification on a task order for a due cause, just reason. And I think the Board has to come to grips with -- with all of that and make some decisions on how to manage this audit process and

-- and conserve the resources at hand.

DR. ZIEMER: The question of what constitutes a final report is not a well-defined thing. I think SC&A, for example, may say we -- we don't consider it final until we've reached some level of comfort in what we've been able to look at. And we haven't spelled out exactly what that is. We've spelled it out in very general terms, but it doesn't say that you have to have a certain number of site interviews or this or that. It's a kind of a fuzzy end point, which is somewhat dependent on Joe's group and others saying yes, we have completed that and now we bring it to the Board. Or if we have to do it without certain components, we don't feel it's complete.

MR. FITZGERALD: Yeah, and my -- my --

DR. ZIEMER: And so that -- that's kind of part of the issue, what's complete. And you can go to extremes on this. You know, I had a faculty member once who we kept urging him to publish more. The papers were never complete. Why not? Well, they were -- he was never quite satisfied that he had achieved perfection. But somewhere between that and doing a really sloppy job, there may -- there may have to be some point

at which you say I'm done with this; I can't do any more. Within whatever the constraints are, whether they're time constraints, resource constraints, access constraints, there may be some point where you have to say that's as good as it's going to get, folks, within some reason. And you know --

MR. FITZGERALD: Yeah, the other reality, too, is site profiles are living documents and --

DR. ZIEMER: They're changing.

MR. FITZGERALD: -- sort of begs the question at some point -- for example, the construction workers are added as a component, you might want to at least come back with any assessment of that component. But this -- this issue is -- what we're looking at is going forward and seeing a certain unevenness. You know, a certain -- you know, we take the list that you gave us very seriously as far as the agenda of site profiles that -- reviews that are expected. Certain ones clearly, because of the clearance issue, are questionable in the near term. So those will be ones that we probably can't give you much at all. There were others that -- like Hanford, where that won't be as major an issue, but will be a

issue. So we may be able to do let's say 70 percent of what we think would be an adequate job of providing that feedback.

My question -- and then there's others like Mallinckrodt and Bethlehem Steel I feel pretty comfortable that we're -- we'll be prepared to give you something before your next meeting. So it's that sort of in-between situation where, you know, we're not able to do what we have looked at in terms of our procedures and your charter as being that, you know, full analysis. And you know, we're sitting here thinking well, on one hand we've expended resources to produce this -- this much work, but we can't share it if it isn't the analysis we think it should be. But you know, what do we do with it in the meantime? Do we wait until we get access or do we give you the best we can? Certainly we don't want to do damage to the scope that's been laid out. I think, as we said earlier, the scope has proven to be I think a valuable scope, and certainly we want to be able to give you as much as we can. But you know, the reality is that -- I guess it wasn't foreseen in the beginning that the access is not going to be uniform and comprehensive.

It's going to be uneven and it's going to be time-based. We'll probably be okay next year, maybe even sooner than that. But you know, I think as Antonio was saying, the vagaries of being able to get the unencumbered access to a high secure site -- anyone's guess. And I -- you know, the stakes may have gone up.

DR. MELIUS: Yeah, but -- but it seems to me that -- certainly I'm personally more comfortable with some of the review not being done because of a security clearance issue. That's a relatively straightforward --

MR. FITZGERALD: Right.

DR. MELIUS: I think when it becomes an issue of the resources necessary to pay the contractor for the time of their personnel and so forth involved, if that becomes an issue I think it -- I guess I would have more concerns about that. And it certainly I think puts NIOSH in a very difficult position because in some sense, if the resources aren't being made available for our contractor to do their work, it would certainly -- raises the -- you know, the appearance that NIOSH is, you know, holding back and somehow impeding our review of the NIOSH dose

reconstruction process. And I think that is -- puts NIOSH and puts us in a very uncomfortable and very difficult position. So if -- if we're going to be cutting back on what's being done in terms of them having appropriate access to the site and appropriate resources necessary for that access in context of the MOU and the other procedures worked out, then I think we -- we have to be very careful about that. I think the Q clearance issue is much more clear-cut and -- you know, we get at some point and say well, you know, 70 percent of this site profile review can be done, but 30 percent we can't because without the Q clearance access we just can't really review certain parts of the site profile or certain parts of the site. Then I think, you know, modifying the task order in a way that would allow an interim report and then, you know, a final report at some point when the -- you know, the Q clearance issue has been addressed, I think that makes -- it's pretty straightforward to do.

I also would say that -- I mean there's no doubt once some of these are -- for example, the site profile reviews are done, that we may want

to look at see what overall our procedures are and then -- and learn from that experience. I'd rather learn from maybe having done a little bit too much than cutting back, then, you know, being in a position of not having had, you know, complete access and not doing all that you originally thought should be -- should be -- should be done for that.

I also have a concern that -- in terms of scheduling. And if I understood you right now, your slides are -- what's been updated, it's Mallinckrodt you now have access to the documents and so forth? That's been...

MR. FITZGERALD: No, we -- we are still waiting for additional documents from NIOSH on Mallinckrodt.

DR. MELIUS: Uh-huh.

MR. FITZGERALD: We don't have everything that we need to finish Mallinckrodt. We have done quite a bit on Mallinckrodt and feel confident we can wrap things up probably within weeks, but we're still looking for some documents.

DR. MELIUS: Uh-huh, but -- 'cause I think one of the -- I mean we're going to talk about

this more tomorrow is this SEC petition review. And if we're in the -- I mean I would hate us to be in the position of having a site profile review pending from Mallinckrodt at the same time being in which we haven't got a report from our contractor on the original site profile, and NIOSH be in the position of reviewing a petition based on the site profile, and us reviewing the NIOSH SEC petition review. And maybe they'll not be connected at all, but may be they will and it would be, you know...

DR. ZIEMER: Larry, did you have a comment on the Mallinckrodt? Or...

DR. NETON: (Off microphone) (Inaudible) we're not aware of any documents that we owe you at this point in time.

MR. FITZGERALD: Well, I mean -- again, things are breaking pretty fast and to be fair, Jim, we have -- actually now that we have access to the NIOSH database as of last Thursday, we have done searches against it on Mallinckrodt just to see what reference documents in the site profile we had -- you know, actually had access to and which ones we didn't, and there are some documents that we want to look at that aren't in

the database apparently. I think actually John has the list.

But you know, again, this is breaking -- I mean what's today, Tuesday? We -- we did the search this Friday and, you know --

DR. NETON: (Off microphone) It sounded like you were awaiting documents that we -- you had asked us for and I just wanted --

MR. FITZGERALD: No, no, the question --

DR. NETON: -- to make sure --

MR. FITZGERALD: -- was were we all set with Mallinckrodt, and my answer was no, we actually needed some additional documents. But again, in terms of timing, we just got access to --

DR. ZIEMER: It's just a matter of finding out exactly where they are.

MR. FITZGERALD: -- the NIOSH database and finding out what was in there, and then compare it up against the site profile. And of course what we established where there was a delta. There were some documents referenced that were not in the database, and certainly two days later we're now prepared to ask NIOSH if we could certainly have access to those documents. So you know, again, a lot of this is just --

DR. ZIEMER: Just in real time it's just --

MR. FITZGERALD: -- mostly real time we've gotten the ability to know what NIOSH actually has in its database, so...

DR. ZIEMER: Let's see --

DR. MELIUS: I have another --

DR. ZIEMER: -- Mark? Oh, you have one more, Jim.

DR. MELIUS: -- one more question, final question. Is -- and this may be more for Larry, but Tom Rollow's -- I think referred this to you this morning, but could you explain to us this issue regarding access to the sites and this Memorandum of Understanding and the payment mechanisms and so forth, 'cause I'm just trying to understand if there's an issue or if there's not an issue now or if it's a short-term issue, long-term, what -- what's going on?

MR. ELLIOTT: There is no issue that has been brought to my attention at this point in time. We have been as cooperative and collaborative as I think we can be in trying to respond to requests. I'm a little bit disconcerted here that this was -- that, Joe, you just portrayed that you had -- awaiting documents from us that

you haven't even requested of us yet, but there are -- you know, I -- the arrangement that we have with DOE under our MOU is that we will facilitate access. If we hear that there is a push-back because of funding, a need to support the access request, we'll work that out with DOE. But to date we have not heard any of that, or no instances have been brought to my attention. And I don't believe to Tom's attention at this point in time, 'cause if they were, I'm sure he would have talked to me about them.

DR. ZIEMER: Tom seemed to indicate that the -- that the field was prepared to assist in our effort here, so --

MR. FITZGERALD: Well, with one caveat. I mean -- make it very clear that understandably the DOE field operations want to be assured that we have cross-referenced our document requests with the NIOSH database, which we were unable to do until last Thursday or Friday. And it will now be possible to give them that assurance and actually send a request through and know that it hasn't been already requested and recovered. So yeah, with that caveat, I think we're in a position to do so. But without being able to

provide that assurance, understandably the field office -- or field operations were unwilling to --

DR. ZIEMER: Well --

MR. FITZGERALD: -- to respond.

DR. ZIEMER: -- they didn't want to do double work.

MR. FITZGERALD: No, no, and that's understandable. I don't disagree with that.

DR. ZIEMER: Henry?

DR. ANDERSON: Yeah, I just wanted -- more for the Board, it would seem to me that a interim report -- what we want to do is be sure that you don't expend the resource, that you don't put extra effort into what you can do on a site --

MR. FITZGERALD: Right.

DR. ANDERSON: -- and then say well, we can't do the rest of this, and then if --

MR. FITZGERALD: Right.

DR. ANDERSON: -- subsequently access becomes available, you then turn around --

MR. FITZGERALD: Right.

DR. ANDERSON: -- and say well, we need more resources. I'd rather say let's reserve the resources and when the clearances -- which

ultimately they will come through -- then you would complete that, but we would just --

MR. FITZGERALD: Right.

DR. ANDERSON: -- kind of hold your -- your contract resources, but we would perhaps want to know what you had to date. Now we'll have the first ones coming up so we'll get a sense of, you know, how -- you know, where -- where was the confirmation strongest --

MR. FITZGERALD: Right.

DR. ANDERSON: -- if it was on the interviews or whatever. And you may say gee, you know, on the basis of the three we've done or two you've done, that seems to be a very important component of the assessment and when we talked to people on site, that --

MR. FITZGERALD: Right.

DR. ANDERSON: -- you know, the blinders came off and it was very obvious as to what was going on, so --

MR. FITZGERALD: Yeah.

DR. ANDERSON: So that's -- I wouldn't -- I wouldn't want you to --

MR. FITZGERALD: Right.

DR. ANDERSON: -- redeploy resources to do

your site, you know, profile assessments, put more effort onto this, and then -- because you can't do it here.

MR. FITZGERALD: Well, we -- we -- we do -- you know, we have a challenge, and I think that challenge has been re-emphasized by NIOSH that, you know, we have a explicit budget that we have to operate within, and so essentially it's a zero sum game --

DR. ANDERSON: Yeah.

MR. FITZGERALD: -- that we have to find a way to conduct these reviews within that set budget. And if we expend those resources, those resources are not available to review other sites or to do a broader scope. So you know, that -- I don't disagree. I think it's going to have to be managed very carefully or otherwise it's going to truncate the entire process.

DR. ZIEMER: Robert, then Mark.

MR. PRESLEY: You had two or three more down here before me.

DR. ZIEMER: Yeah. Oh, okay. Mark, (Inaudible)?

MR. GRIFFON: Well, I just wonder -- I guess the funding question has been answered here, but

I -- I'm looking at the first bullet up hereon your considerations, and the last phrase there concerns me a little bit that there seems to be some questioning of the comprehensive scope of the reviews. Is that -- I mean are there issues about what kinds of -- of data or the extent of data that you're looking to access as compared to the scope within the task order, or is that becoming an issue? Because we -- we as a Board haven't been put in -- that issue hasn't been raised to us and I'm just wondering how -- if there is that issue, how does that get resolved? It seems --

MR. FITZGERALD: Well --

MR. GRIFFON: -- seems there like you're referring to you -- you've had these conversations with NIOSH staff -- I don't know, I'm...

MR. FITZGERALD: -- NIOSH is the contracting organization, and what we have to look at is the expenditures and the burn rate and certainly one issue is to sort of compare scope in terms of what's being addressed and the depth as it's being addressed. Obviously this could be -- each profile review could be, you know, months and

months and months, you know, so you have to draw a line. And so the discussion's been pretty much to assure that there isn't -- I think the term of art is a scope creep where you're not necessarily beginning to move out of what is a defined scope for the review itself. And so those discussions have been involved in terms of, you know, what is in fact this scope that we're trying to accomplish.

Now the scope that we're operating against is the scope that's been laid out I think very clearly in the original task order and in the site profile procedures which this Board approved. But you know, again, they have not been tested in the field, so to some extent this is the sort of proof in the pudding of, you know, how this actually is going to be implemented. We're finding of course some things take more resources than originally envisioned. Interacting with site experts not surprisingly takes resources. And so we're gaining this feedback and passing that feedback to NIOSH, making sure they're aware of, you know, how this is going along. So there's been some I think discussion on scope, but certainly that's one

issue that clearly the Board should be aware of and certainly that's going to be something that will come up in the reviews that you'll be seeing over the next month or two in terms of what should be the model, as far as how deep you go in these verticals and what kind of analyses is appropriate for these audits. But...

DR. ZIEMER: And let me add to that, also, Mark. I think at the front end of the process, this Board or those who were acting in our behalf in terms of the original cost estimates, did an estimate that for a certain number of dollars you could do a certain number of reviews. And likewise, I think the contractor bid sort of in -- I don't want to say in the dark, but at least without all the information available as to what that would entail. Now as we get into the real issues and what it takes to do it, we may find out that the resources available are only sufficient to do -- let's say ten instead of 12, or something like that.

MR. FITZGERALD: Well, certainly --

DR. ZIEMER: We're sort of learning as we go, both of us, the Board and the contractor, as to what it takes in time and effort and resources to

do these reviews.

MR. GRIFFON: I guess part of what I'm -- what I'm inquiring is what's the decision-making process? 'Cause I don't think the Board's learning very much about that process. I mean I -- you know, we -- we've seen maybe that there's some questions on the complexity or the depth of the scope, you know. What -- what in particular and who -- who makes those -- I understand there's budget constraints and that NIOSH has the --

DR. ZIEMER: No, I think --

MR. GRIFFON: -- is the contracting officer --

DR. ZIEMER: -- the Board has to make --

MR. GRIFFON: -- but we've been very clear on this Board that we -- we --

DR. ZIEMER: The Board has to determine --

MR. GRIFFON: -- have the say on the scope.

DR. ZIEMER: -- if the tasks go -- is to change, and I think --

MR. GRIFFON: Right, so we can't --

DR. ZIEMER: -- Joe's giving us kind of a heads-up that -- what issues are emerging and --

MR. GRIFFON: But I don't know if we can wait

for final reviews to come out and then -- I mean maybe that goes back to that question of interim reports, but I -- I mean I think if there's issues on scope creep -- is that the -- you know, potent-- word you use, you know, if those issues are there now, I think we need to maybe resolve them or clarify what -- you know...

MR. FITZGERALD: Well, I think the considerations really touch upon I think some of the factors, one of which is the zero sum on resources, that we have to plan within those resources. That's -- that's one issue. The other issue is -- you know, again, we're -- we're establishing on the ground this issue of, you know, what the scope should be. It's defined certainly in the procedures, but in practice, how far do you go and all that? And certainly this question of what do you do as a contingency if in the interim you can't touch those bases? And certainly -- I think Jim was mentioning, you know, certainly some approaches to -- but there's many -- probably many more. That's why it sort of left it as considerations, but those are all -- those three or four factors are all key factors that I think constrain what that solution would -

- would be. And I -- we just didn't want to go so far and -- and presume what the Board would want to give us as guidance on this. You know, right now we're at the juncture where it would be very helpful to understand what -- what would make sense.

DR. ZIEMER: Robert?

MR. PRESLEY: Joe, you might think about changing your clearance from a Q to an L. In my estimation --

MR. FITZGERALD: I haven't got the Q yet.

MR. PRESLEY: If you -- if you've got a Q, then you're fine.

MR. FITZGERALD: Right.

MR. PRESLEY: But the people that are there really don't have a need to know for design data.

MR. FITZGERALD: Right.

MR. PRESLEY: Most of the documents are accessible at a lower level. It takes a whole lot less time to get a L than it does a Q.

MR. FITZGERALD: I guess I would defer to those who have crossed that line and had -- my experience with -- I had a Q for two decades, and my experience is certain places in the complex, even with a Q, without a need to know, I would

sit out in the waiting room for hours. And so can you imagine not having a Q? I suspect you couldn't get past the gate, particularly these days. I'm just saying from practical experience, for certain sites like Y-12 and what-not, it's going to be very difficult to accomplish our mission without Q clearance, and I think that's all I can say about that. Other sites, not so.

MR. GRIFFON: My experience is similar. I mean I had the L and then had to wait for an upgrade to the Q. The problem I ran -- a lot of the records that I had to review didn't need more than an L clearance. The problem is that they were in file cabinets or --

MR. FITZGERALD: Right.

MR. GRIFFON: -- placed in with Q-cleared -- right -- so you couldn't have access to those areas, you know.

DR. MELIUS: Nobody told them when they set up the filing system.

DR. ZIEMER: Jim, did you have another comment?

DR. MELIUS: Yeah, I have two -- two comments. One is a contracting one and somebody from NIOSH can correct me, but if we did modify

the task orders for -- allow for an interim report, I would foresee -- and let's use the Q clearance issue 'cause I think it's the most straightforward -- that our contractor could make the case that when they originally bid on this, they assumed they could do this all in one visit or two visits or whatever it is, that there would be extra costs involved if they had to spread these out over -- over time. So I think we have to, you know -- you know, laying the burden on them is to show that that was their intent in how they made their original bid, but I think we'd have to be ready to allow for some modification in the -- the cost of the contract, should these get split up into -- especially if it gets split up in more than one interim report, if there's -- some of this comes across piecemeal in some way or whatever.

The other issue I'd like to get at is sort of the schedule for when we will be, you know, seeing some of the reports from the contractor, because I think some of these issues are going to be easier for us to deal with going forward once everyone's seen a report and we've had some time to discuss it. So you know, can we assume that

for our next -- our October meeting that Bethlehem Steel and Mallinckrodt will be complete? How about Savannah River?

MR. FITZGERALD: We are on site this week. I think that's a possibility, although -- you know, again, you know, the review process through -- we're going to send the report through NIOSH and then to the Board. That takes time and that process itself may, you know, take weeks, so that part of it I can't account for. I think we'll certainly have the drafts that can be transmitted to NIOSH for review by then.

DR. MELIUS: Are we going to talk about the review process tomorrow when we're talking about -- okay. Then I'll -- I'm just trying to figure this out in terms of -- 'cause I think once we have, you know, one big site like Savannah River, and then the two smaller sites, I think we may have a better handle and better able to talk about some of these issues going forward and so forth.

MR. FITZGERALD: Small sites like the AWEs are much different than the larger, more secure sites -- DOE sites.

DR. MELIUS: Yeah.

MR. FITZGERALD: I mean just by nature, we -- we have much more ready access on the AWE information.

DR. MELIUS: Yeah. And -- but Savannah River I think would be a good -- if that's the first one done, we can work from there.

DR. ZIEMER: Other comments or questions?

(No responses)

DR. ZIEMER: Thank you very much, Joe. We appreciate that and Steve -- well, we're flexible here and Steve --

DR. MELIUS: You have 30 seconds.

DR. ZIEMER: -- Steve's going to do both the organizational conflict of interest plan and the quality assurance plan. Right, Steve?

DR. OSTROW: (Off microphone) Yeah, (Inaudible).

DR. ZIEMER: Right.

(Pause)

DR. OSTROW: Okay, first of all, I'm not John Mauro. I'm Steve Ostrow and I work with John, and I'm going to speak first of our conflict of interest plan.

(Pause)

All right, we have a conflict of interest

plan. It's a little bit misnomered. It's not just an organizational conflict of interest. It's also personal conflict of interest. And the -- it's basically a formal plan to assure that everything is done aboveboard and we don't have any conflict of interest with the organizations involved, SC&A and subcontractors and individual people involved in the project.

The basic mandate for the conflict of interest goes back to the government FAR regulations, and we translated it then into a procedure that we can follow. And the purpose is to basically assure that we can render impartial judgment and impartial advice to the advisory committee.

And we have -- the organization responsibilities, we have -- the plan's fairly long, but it boils down to a few things, that -- we committed that we're not going to bid on or perform any work for NIOSH or ORAU or any of their contractors. We won't accept any work from DOE or DOE contractor that has to do with radiological issues. And that we will -- if any gray areas, we'll consult with the Board for guidance to resolve them.

The individuals -- as part of our procedure, everybody on the project -- we have 36 total member -- individual members on the project. Not everybody's working and giving time, but potentially we have 36 people who could work on the project. Everyone was given a copy of the OCI plan. They have to acknowledge that they received it and they understand it. And they sent to the plan administer a questionnaire that they filled out about their past activities related to things like what sites they worked on and what projects they worked on. The administrator then makes a determination of whether they can have basically unlimited clearance to work on anything in the project or whether there's any restrictions on what they can work on.

These are just copies of the -- on the left of the acknowledgement form that the person fills out to acknowledge they read the plan and understand it. On the right-hand side are the five questions that people have to answer, and it's probably easiest to read this in the handout than on the screen. It's a little bit difficult. But basically any "no" responses -- or any "yes"

responses have to elaborate with attachments.

And some of the criteria that we have that individuals -- if they have served as an expert witness on any Worker Compensation cases, radiation-related, on behalf of DOE or DOE contractors, they're precluded. If they're currently working for NIOSH, ORAU or contractors under that, they're also precluded from working on the project. If they have worked for NIOSH, ORAU or companies teamed with ORAU on dose reconstruction in the past, we look at it carefully. If they worked for DOE or DOE contractors in the past, or have worked on DOE sites or contractor sites, we have to look at it carefully at what they were actually doing.

The -- we document this pretty well. We maintain -- after we make a determination, we maintain in our files in the SC&A headquarters -- we have a secure file -- all sorts of information about the plan, the individual responses, the findings on the individuals, what sites they cleared for or not cleared for. And the idea is to have it sort of a transparent process, that if there -- anyone wants to -- authorized wants to look at it, we have all the information available

for audit.

In addition to the individual, we also have corporate conflict of interest certifications that the different -- SC&A and its subcontractors, that they're not engaging in any outside -- different contracts or work which may conflict with the work we're doing on this particular contract.

And we maintain two summary lists that are available to the Board -- or will be, if... The first one is just a summary of the yes and no responses to the five questions that we ask for each individual. We have it by individual, and I'll show -- one of the last slides shows this and their yes and no to the five questions -- and the certification review results -- restricted, unrestricted or precluded from a particular site. And the other list is restricted site list, so all -- so it's the same information, but in a different format -- for each of the 36 individuals, where they may -- the sites where they may not serve as the lead reviewer.

Just a little statistics that -- these are the five questions, and I just will summarize them -- the questions are longer, but the first

one, has a person worked -- or working now or have worked on the dose reconstruction contract, and two people had worked on it in the past.

Second one, anybody an expert witness in Worker Comp, and zero, which is the way it should be 'cause that person wouldn't be able to participate in anything if they did do that.

Third, working for a DOE, DOE contractor, AWE, et cetera. Not surprisingly, a lot of the -- 27 out of 36 have, because pretty much anybody in the nuclear industry who would work on the project had in the past some experience with contractors or DOE, otherwise they wouldn't be qualified now to work on the project.

And same thing number four, working a DOE or AWE site, and in the past a good fraction of work -- done some work on the site.

And finally, five, current or past contracts or financial relationships resulting in actual or perceived COI. That's also zero because you wouldn't be able to work on the project if you said yes to this one.

Also in statistics, this has been -- this is two weeks old -- so right now, out of the 36, we have 21 unrestricted and they can work on

basically any -- anything; 15 restricted, zero precluded, and nobody's pending review.

The plan also has sort of a general provision it has to be somewhat self-policing because you can't anticipate, when you're filling out this form ahead of time, exactly what you're going to be reviewing in the future, so people have to use -- and task leaders have to use a little bit of judgment. Obviously you can't review any work that you have personal knowledge of, that you had worked on, you know, in one of your past assignments, so you have to be sort of self-policing, the people on the project (Inaudible). We stress that if there's any doubt, they have to consult with the COI officer and then if that can't be resolved, then we'd take it to the Board for a determination. But people have to be vigilant on this.

This is a first summary list, just a quick look where we have the five ques-- all the people in the project, organizations they're from, yes and no to the five questions, date of the reviews and whether it's any restrictions on their participation in any aspects of it. This is like a quick list you can go down.

There's always backup information of course in the files. If you pick a particular person, he has a folder in our files that has all the backup that exp-- you know, goes into the details on this. That's the second page of it.

This is the second list. This is also by person and lists the particular projects where people -- or sites where people may not have access to serve as a lead reviewer. So you can see, for example, one person is precluded from working on Fermilab and Los Alamos, for example, because that person had past experience at that laboratory. The person can still be a subject expert. You know, it's a valuable resource to have somebody who actually worked at one of these sites, but that person cannot be a lead reviewer, responsible for the review. This is the second page of the same list.

And finally, this is also going to the list, this is just the different site acronyms that we use and the organizations involved. So that was -- that's a quick overview of the conflict of interest draft plan that we've been operating with.

Before I go into the QA portion, this is a

good point to ask for some questions now on the conflict of interest stuff.

DR. ZIEMER: Yeah, let me point out to the Board that the conflict of interest plan is a deliverable, and requires our acceptance and approval. The slides are not the plan. The slides are a summary of the plan. The plan was e-mailed to you earlier. I don't know if you've brought copies with you or -- and if you -- what we need to do -- we'll have questions and so on, but we'll need a motion to accept or approve the conflict of interest plan. But let's open the floor for questions first.

DR. OSTROW: I was going to make a comment. In addition to the comments of the Board, we personally would like to make a couple of modifications, mainly of the housekeeping things. We read it and looked it and there's a couple of things --

DR. ZIEMER: On the actual document itself.

DR. OSTROW: Yeah, it's mainly in the editorial --

DR. ZIEMER: We'll need to know what those --

DR. OSTROW: Of course.

DR. ZIEMER: -- changes are, of course, but -

-

DR. MAURO: (Off microphone) (Inaudible) I believe --

DR. ZIEMER: John, you'll --

MR. ELLIOTT: Use the microphone --

DR. ZIEMER: -- need to use the mike for our recorder here. Or use one of those mikes there. Just grab one there.

DR. MAURO: I just wanted to make a point that I believe eventually material that we've been summarizing here by way of conflict of interest will be going up on a web site. (Inaudible) I believe there's conflict of interest information regarding your -- regarding NIOSH's contractors. There's certain information that's on the web site as full disclosure.

DR. ZIEMER: Right.

DR. MAURO: We will be doing the same thing once we reach the point where it's appropriate.

DR. ZIEMER: Right.

DR. MAURO: So for example, the lists --

DR. ZIEMER: Well, I think once the Board accepts it as the plan, then it's -- would certainly be appropriate at that point. Yeah, thank you.

Are there questions at this point? Henry?

DR. ANDERSON: I'm assuming that NIOSH has looked at it. I don't -- I mean -- I would be interested to know if you have any comments about it.

MR. ELLIOTT: We've read it --

DR. ANDERSON: You've got a lot of experience.

MR. ELLIOTT: We've read it, but it's your decision --

DR. ANDERSON: Yeah.

MR. ELLIOTT: -- it's not ours. We have no input to this.

DR. ZIEMER: Thank you.

DR. OSTROW: Well, could I just make one little statement? We -- the plan itself basically is very similar to what we put in our proposal. We made a few modifications to it, it's basi-- it's 95 percent the same, just maybe better English, hopefully. And the...

DR. ZIEMER: Wanda?

MS. MUNN: I'm assuming we will have hard copies of the plan and whatever changes have been --

DR. ZIEMER: Cori --

MS. MUNN: -- undertaken.

DR. ZIEMER: -- just went to check to see if there's hard copy available for you now in case you didn't bring your e-mailed copy.

MS. MUNN: No, I downloaded it, but I didn't even print it.

DR. ZIEMER: We can defer action on the plan until the work session tomorrow and (Inaudible) sure that we have hard copy by then.

MS. MUNN: I would prefer that.

UNIDENTIFIED: I have a hard copy.

DR. ZIEMER: You have a hard copy there that --

UNIDENTIFIED: It's got some mark-ups on it.

DR. ZIEMER: -- could be made -- but let's -- let's -- is it agreeable, we'll just defer the action to the -- tomorrow's working session so that we make sure everybody has a hard copy and then we'll get the what, editorial or minor modifications?

DR. OSTROW: I haven't actually made the editorial comments yet. I thought we would do it the other way around and see if the Board had any comments, then the final product of the editorial stuff. I thought I'd do it the other way around.

MR. ELLIOTT: Tony, is yours clean?
DR. ANDRADE: Yes.
DR. MELIUS: I have a clean one, too, if you...
MR. GIBSON: Both this and the QA plan, as well.
DR. ZIEMER: Okay, let's -- nonetheless, let's defer action at least till we make sure everybody has a hard copy and then we can mark in -- who has your changes then on this one?
DR. OSTROW: No one has, I didn't make them yet.
DR. ZIEMER: Oh, you haven't made them yet.
DR. OSTROW: I mean I have in the mind something I want to do, but I thought I'd do it the other way around and get the Board's comments --
DR. MELIUS: Yeah, but we really need to approve what we approve and what's --
DR. ZIEMER: Right.
DR. MELIUS: -- final, and --
DR. ZIEMER: Right.
DR. MELIUS: -- either -- you know.
DR. ZIEMER: Well, we'll get -- we'll get this copied. You'll tell us what changes you

want to make before we approve it then.

DR. OSTROW: Okay.

DR. ZIEMER: Okay. So we'll defer the actual action till either later this afternoon or tomorrow then, if that's agreeable.

DR. OSTROW: Fine.

DR. ZIEMER: Thank you. You want to proceed then with the other -- quality assurance information then?

DR. OSTROW: Sure. Okay. This is the second presentation on quality assurance on the project. And this basically is nothing new or novel, that all the work we do and I'm sure the work other people do in organizations is governed by a quality assurance plan. You have to have a -- we wrote a project-specific plan that is -- basically governs how the process is done and it reflects the job requirements, in addition to the regulatory requirements that are on the project. And basically it controls and documents all aspects of the project.

The goal is to do everything consistently, according to the contract requirements and regulatory requirements, and also to provide a record of what's been done so that in the future

if somebody asks well, why did you do this and this or how did you do this and this or what did you actually do, the record is there. You can go back and take a look and the process is clear and transparent. And it also provides an order trail for our work to do, so that's the basic purpose of a quality assurance project plan.

The -- I'm not going to go into all the details, but as part of the plan we have -- (Inaudible) applies to everything on the project and -- and it includes -- we were talking before about confidentiality and security provisions, as part of the quality plan also mentions that -- what we have to do to comply with the -- with any security or confidentiality provisions. It also outlines the organization, who does what. And in the SC&A organization, further down, which person does what, what -- what the different functions are so you work together. This is like project management 101 a little bit, but who's responsible for different things.

The -- it ensures also that all work's done to -- according to approved procedures, and we're talking about approving procedures and that the right people have the right procedures, and that

they acknowledge they have the procedures and they're up to date with the latest procedures.

And these are the -- altogether right now we have five procedures listed on this page. We were talking earlier -- Joe -- something about the site profile review procedure, that's one of them, so all work is done according to the approved procedure that we wrote and the Board approved. In part of the QA process we make sure that if Joe has ten people on his staff doing site reviews that all of them have the procedure and they acknowledge receipt and understanding of it, and they have the latest copy of the procedure.

It also outlines the management process about how we manage the project. This is the task order process, how we receive task orders from the Board and we respond with task order proposals and manage the -- you know, the budget, the -- the time and the work product.

I mentioned the training and documentation. Everyone has to basically sign off on the QA plan in the project. And the final -- we have a QA file also at our headquarters in the same NIOSH file room. It's a secure file. And that's

available for inspection -- proper inspection also at any -- any time the Board would choose to do so. Thank you.

DR. ZIEMER: Thank you very much. The quality assurance plan also is a deliverable to this Board and will require a similar action. This is not the plan. This is a summary of the plan, so we have the same issue on hard copy here. And are there -- do you anticipate any modifications to the actual plan before we take action?

DR. OSTROW: No, I -- I didn't have anything other than there's a typo here or there, maybe, but I -- which I don't think there is, though.

DR. ZIEMER: No, okay. Let's open the floor for questions. Tony?

DR. ANDRADE: Steve, your last bullet said that you had a section in there on problem resolution.

DR. OSTROW: Yes.

DR. ANDRADE: I read -- I read the QA plan a few days ago, but I must admit it's getting a little hazy now. Does that include a section on -- on problems that could exist between the Board and SC&A? For example, the one that was

described at the very beginning, you know, that we may have to change tasks or change the scopes of tasks as -- as time goes on.

DR. OSTROW: It deals with problems between the Board and SC&A, but I'd have to reread that myself in more detail to see exactly what the extent is of the -- how much detail we went into in the plan --

DR. ANDRADE: Okay.

DR. OSTROW: -- to see if it covers a situation like that.

DR. ZIEMER: Other questions at this point?

(No responses)

DR. ZIEMER: Okay. Again, we'll defer action on this for -- temporarily till we are sure that everybody has a hard copy and we have that before us for action, which probably is going to be tomorrow's work session, based on where we are on our agenda right now. Thank you very much.

DR. OSTROW: Thank you.

DR. ZIEMER: Can we take a very quick break? Let's take ten minutes and then we'll hear from Jim, which will be the last item on our agenda for today.

(Whereupon, a recess was taken.)

SITE PROFILE STATUS AND DATABASE USE

DR. ZIEMER: We're set for the last presentation, and that will be a report on the site profile status and database use, by Jim Neton. Jim, you're set to go?

DR. NETON: (Off microphone) Yes.

UNIDENTIFIED: Too much going on. Too much going on.

(Pause)

DR. NETON: (Off microphone) Thank you. (Inaudible)?

DR. ZIEMER: I think you may have to click the button, Jim.

DR. NETON: Got to be a little closer -- there we go. Is that better? Okay, thank you. Let me have a chance to catch my breath here. I was trying to juggle several tasks at the same time, which seems to coincide with my new position.

DR. MELIUS: We need more water here.

DR. NETON: I'm here to present what's sort of become a standard presentation as of late, which is to talk about the site profile status, where we are and where we're going with those documents. As well as -- there usually seems to

be a little twist on that, there's a little extra kicker that goes along with the presentation. And today I'd like to address what the Board asked about last time, which is a little description of the database; more specifically, the site research database. And concomitant, what goes along with that, is I'd like to touch on a fairly exciting area that we're delving into, both feet first, which is the coworker database and the analysis of claims using coworker data.

Okay. As far as the site profiles go, if the Board remembers, we had 16 profiles that were targeted for priority treatment for DOE facilities. The idea behind that was, we picked -- ORAU and us -- ORAU and OCAS together picked the sites that had the highest number of cases. And once we completed those 16 site profiles, we would have data available to begin processing approximately 80 percent of the claimant population base at -- at that time. And that's been holding fairly steady, even since -- for the last year.

I'm pleased to report that we have nine complete site profiles at this point, which

represent almost 10,000 cases. That would -- that comprises roughly 60 percent of our claimant population base. The two asterisks that you see on this slide indicate the two profiles that have been completed since the last Board meeting. That would be the Oak Ridge X-10 facility, which has 1,126 claims, and the INEEL facility with 669 claims in our possession.

I would remind the Board and the public that a site profile is, in most cases, a compendium of six chapters. Each chapter represents a specific aspect of the site, ranging from the site description to internal dosimetry, external, medical, those types of topics. So when we say a profile is completed, we mean that all six of those chapters have been reviewed and signed off by our office.

I will also remind the Board, though, that for expediency purposes we issue some chapters with sections that are labeled reserved or where information is missing, the idea being that if it is substantially complete we will approve it so that we can start processing claims that only require that portion of the data that we have at hand.

The next slide I men-- there were nine on that page. There are seven here listed. These are the seven remaining profiles out of the 16 that we targeted for completion. And this slide actually shows the individual chapters and where -- what the status is of those chapters, a green box meaning it's green, good to go, it's been signed off by OCAS and is in field use. The blue boxes are those that are in comment resolution. All chapters have at least one draft completed. There -- as I mentioned previously, there is a fair amount of give and take between us and ORAU in the completion of these chapters. And in fact I think since I put this in my presentation, Paducah section four is now complete, so the occupational environmental dose section has been signed off by OCAS, so there actually remains 16 out of -- out of 72 chapters, if you will, that are -- that would need to be completed. Which indicates that we've completed about 70 percent -- 77 percent, almost 80 percent of the individual chapters of those 16 site profiles that we had targeted.

One might wonder what's the holdup with these that are marked blue. A number of reasons. I

think you'll notice fairly readily that K-25, Paducah and Portsmouth are gaseous diffusion plants that are SEC sites by definition. Those are problematic sites. They were granted SEC status because of some issues of transuranic contaminations, among other things. We are taking our time and being very careful to turn over as many stones as we can so that we have a fairly accurate portrayal of those sites.

In addition to that, most of the cancers that we'll be getting from those sites are skin cancers and prostate. Skin cancer reconstruction -- skin dose reconstruction can be problematic at some of these facilities. We want to make sure we have certain factors like the geometry and those sort of things nailed down.

The other remaining sites that are not SEC sites -- Mound tends to be a compendium of the periodic table of isotopes. If any of you are familiar with Mound, they did a lot of plutonium work, but there's also a large number of legacy isotopes out there that require -- required to be fleshed out.

And then you've got some national security sites -- Los Alamos, Pantex possibly -- where

we're -- we're still digging for documents and making sure that we've got a fairly accurate portrayal given that some of the information there is -- is classified.

Okay. AWE site profiles -- a slightly different story. Did I skip a slide or two? No?

DR. ZIEMER: This is the next one in the book.

DR. NETON: Okay. These are additional DOE sites that are under development -- nine extra sites that we're working on. These are outside the original 16 we had targeted. I think I reported on these. They are in development. The two that are added to the list that had not yet been listed as under development since the last Board meeting are the two Argonne facilities, the one in -- near Chicago and the one -- actually Argonne West here in Idaho.

AWE site profiles, there's been no movement in approved site profiles. We've issued four -- Bethlehem Steel, Blockson, AWE complex-wide and TVA Muscle Shoals. The Bethlehem Steel profile we have used to complete the overwhelming majority of the cases that were in our possession. They moved through the process

nicely. Sanford Cohen & Associates is, as you heard earlier today, is well under way of assessment or an audit of that profile, and we look forward to hearing the results of their findings within -- well, certainly it sounds like before the next Board meeting.

I'd like to say a little bit about the AWE complex-wide. We've done a fair number of cases with this profile. Just to remind the Board what this is, we have developed some generic -- generic's probably not a good choice of words -- some overestimates, what we believe to be overestimates for certain processes at AWEs that used uranium. And in particular they're overestimates for organs that don't concentrate uranium, what we call non-metabolic organs, so cancers of the pancreas, of the bladder or the prostate, those type cancers. And we're fairly confident that with these overestimating doses we assign that we have covered the range of exposures at those facilities. And these -- this has been fairly successful in freeing up a number of claims, particularly at those AWEs where we don't have any profile completed.

These are additional AWE profiles under

development. There's 20 additional sites listed here. We talked a little bit last time about the point of diminishing returns with development of site profiles. I believe -- I'm fairly confident in saying that it's unlikely that we're going to add many more individual site profile documents to this list. I think if you go through the list of cases that we have in our possession, we're down to 40 or below. Once you get below that target line, it's our opinion that it's really not worth going down and writing a specific document. We prefer to either modify an existing document to accommodate the unique nature of that AWE, or simply write a larger dose reconstruction report that includes all the relevant information. And the fact of the matter is that's why we have site profiles, so we don't have to publish 80-page dose reconstruction reports. I mean the profile can be referenced and people can get it on the web site. But for these smaller -- what I call mom and pop AWEs -- I mean we have five or six claims that were little machine shops out in the hinterlands. We'll probably adopt that kind of approach just to include the entire explanation in the dose

reconstruction report. Might make the report a little less readable, but it would probably be more time-efficient for our purposes.

I'd like to talk a little bit about the worker outreach meetings. That's been, I think, a pretty good success story. Bill Murray, some of you may know, heads that up for us in ORAU's organization, but we work very closely with him. In fact we've had a NIOSH representative at each of these meetings. We feel it's important to have our staff and our position covered there.

We've had 13 meetings since we had the original one in Savannah River in 2003. And you'll notice that we've had multiple meetings -- there seems to be a pattern emerging where we're going back to some sites. This has principally been at the request of either the work force or just -- we had a feeling at these meetings that there was some information that we didn't capture. So we've actually had three meetings at Hanford, two at Portsmouth and, you know, we're considering wherever it's possible -- INEEL may end up having an additional meeting.

It depends, but when you go to the site, you work with the union reps, construction trade

folks, oftentimes you'll hear much more from them than you can capture in an individual setting. And particularly in the way the meeting is formatted, which is almost sort of a town hall -- mini town hall format. When we go back we've adopted sort of a workshop format where we'll sit around a round table and try to elicit from the folks any additional concerns they might have.

I would remind folks that we do take meetings of all of these minutes -- or minutes of all these meetings, excuse me. And as they are approved, we send them to the attendees to make sure that they're factually accurate. Once those have been vetted, they will appear or do appear on our web site.

All right, let me get into the site research database a little bit. This was brought up at the last Board meeting that -- you know, what is this site research database. And I think in particular it was -- it was brought up more in the context of where are these incident files that you guys have been talking about. So I'd like to just take a step backwards and talk about the site research database first, what it's intended to be. And you heard -- I believe it

was Joe Fitzgerald just mention that I think they had a training session within the last few days on this. This is the database that we are providing access to Sanford Cohen & Associates. This is our entire database of all the records that we have captured from the inception of this project.

It doesn't mean all the records that may be out there because some of the records that are in the public domain we just haven't bothered to put on there, and we can do that and we will do that. But these are the data capture efforts where we'll go out to a site and we'll bring them in, scan them and put them into this database. This contains images and data files for -- it's intended to contain images and data files for all covered facilities. I don't know that we actually have a populated image for each of the 215 facilities or whatever we have claims for. But wherever we have captured them, if they fit into one of these 215 pigeonholes, that's where they go.

So it's organized by facility, so if one wants to look at all the records we've captured for Hanford, you can do that. This is a SQL

server database that is linked in the whole NOCTS scheme of things, and it has -- it's recently developed a very nice front end -- what we call front end or an application interfa-- user interface so that it has keyword searches available, all kinds of nifty things that people who do this type of work like to have to be able to expedite their work. Frankly, when it was originated it was on our network drive. It was the O drive and it was just a bunch of files listed by facility. Now it's much more user-friendly and -- and, you know, more efficient for us to be able to do work.

What happens is when data capture efforts go out, there is -- there is a standard form. It's a yellow form, two-sided, that are -- is required to be filled out for each file that is captured out in the field. These files are indexed by keywords. They are indexed and reviewed by someone somewhat knowledgeable about the operations of facilities, and a little mini-abstract is prepared that kind of tells you what the content of that file relates to, and also the time frame and -- sort of the key parameters that you might want to know about this file rather

than waste your time having to read through the whole contents.

There's almost 10,000 references out there -- reference documents, as they call them -- that represent almost 45,000 files. I tried to get a page count because I know -- I relate more to page counts, and it wasn't easy for them to give me that, but I think anybody who does anything with computers will recognize that 65 gigabytes of data is a fair -- fairly large database. It's fairly robust.

Of course the larger sites have more files. If you go out there and look at the Savannah River Site, I think you'll find 380 files out there or something like that, and it varies from there.

Just one thing I'd like to point out is this was originally intended to be the research database that was used, and it was used, for site profile development. But it has also since morphed, if I can use that term, into a database that contains key links to capture coworker data. It kind of takes me into my next phase of presentation.

In capturing these data files -- in the

beginning they were just raw captured and put into these bins because, you know, we're just trying to collect these informa-- then it became fairly obvious that many of these files had information that could be used for coworkers -- bioassay monitoring data, TLD results, air sample -- you know, whatever type of information there was. The database now is being linked so that when information is available that could be used in dose reconstructions, there is a link established -- and in fact if there is unique data for a claimant, there is a link established to that claimant to alert the dose reconstructor that there is information in the site research database that could be used to process that dose reconstruction.

That effort is nowhere near complete, but it's ongoing and they're fairly -- they're well into it, but it's not -- it's not as complete as we'd like it.

Since I broached the subject of coworker data, I'll delve into it. Coworker data exists in the database here, which is the captured images that we've -- we've got in our data capture efforts at the various facilities. But

there also is claimant data that can be used as coworker data. That data is also being keyed in to the database -- the worker profile database, if you will -- so you have a combination of captured data that may be the universe of monitored people at a facility, but -- or pieces of that facility. Then you also have keyed in information. The 16,000 responses we've received from DOE that has external monitoring data is actually keyed in at the Richland office of Dade Moeller. So that information then is also become -- becomes available to reconstruct coworker -- coworker data.

We've spent a lot of time in the beginning of this project -- and frankly, most of the first 4,000 claims that we reconstructed relied predominantly on individual monitoring data -- external badge results, urine samples. People who were -- I don't want to necessarily characterize it well-monitored, but were monitored and characterized some way in their work environment using personal samples. The site profiles speak to that almost exclusively. There is some coworker data in some of the site profiles, but by and large the site profiles that

exist today speak very directly to interpretation of individual monitoring data and the exposure conditions at the facility.

We are now at the point where coworker data -- we've done a lot of the claims -- I don't want to say we're done with that, but we're working through those and now we are poised to develop the coworker database for people who were not monitored at all, or very poorly monitored and we need to supplement their data files.

So we're going to use the data from the capture efforts that we took out there at these sites, and the individual monitoring data from the workers, and there's a couple other sources of information here that I'll talk about. The Oak Ridge Associated Universities Center for Epidemiologic Research database; there have been a large number of epidemiologic studies done in the past evaluating workers at these facilities. These epi studies have catalogued a large portion of the available records. I'm not saying they're perfect, but we need to take -- I think we should look at them. We are looking at them to make sure that we take full advantage of those efforts.

In addition to that, we also have -- I mentioned the claimant data -- the Health-related Energy Research Branch within NIOSH also has conducted a number of epi studies, and there is coworker data for them. To some extent that overlaps with what the Center for Epidemiologic Research holdings have, but there are some unique facilities that the HERB database has. INEEL happens to be one of those.

And then lastly there is the CEDR database, the Comprehensive Epidemiologic Data Resource is actually a DOE-funded activity where all -- not all -- epidemiologic studies, as they are published, the de-identified data, the stripped data of personal identifier information, is put out onto a facility -- by and large accessible to the public, with some minor restrictions -- for use in further analysis and epi studies. And there may be some use that we can put to that dataset.

So this is the compendium of information that we intend to be looking at or ORAU is looking at to develop these coworker datasets.

Y-12 facility is actually our first completed profile for external dose using coworker data for

the '51 to '65 time frame. Actually it's complete. We haven't -- OCAS has not signed off on it yet as of yesterday, I don't think, but -- but we're that close. I mean we've gone round and round and I expect that that will be issued within the next few days.

So what are we going to do with all this data? We've got these datasets out there of monitoring information. They're going to take these sets and develop external -- for external dosimetry we're going to develop dose distributions for time periods for work-- when workers were not monitored, or even for when workers were monitored, workers that were not monitored. We can develop these distributions.

We're going to pay attention, though, to job categories as they are available. I mean clearly the best coworker data would be a perfect match for a chemical operator who worked in 1956 in plant two with a chemical operator side-by-side, that would be idea. That's unlikely to happen in very many cases, so we have to come up with some sort of a distribution that describes what is the reasonable characteristic exposure of these folks, and then put some uncertainty bounds about

them to allow for the fact that we really are not 100 percent certain what their exposures were. By and large these will end up -- those of you who are statistically oriented -- lognormal distributions. Most occupational exposure data tends to be that. We'll be evaluating these as we go.

Internal bioassay data is a sort of a unique set. We have a lot of -- as I'll show you later, some of the volume of data that's out there -- internal bioassay, that is urine samples, are not directly informative of what the exposure was because those are unique to the person and time and place of where they worked and how long they were exposed. But what they can tell us is give us an estimate of what the effective air concentration was in those work areas. So if we have a whole population of workers, let's say we have 5,000 air samp-- 5,000 bioassay samples for a work force over a three-month period. We should be able, using that data, to establish at least let's say the maximum conditions of exposure that existed in that facility, because we have a lot of urine data. And where we don't know process information -- solubility type,

particle size -- if we make some fairly claimant-favorable assumptions, then we'll at least be able to put some bracketing conditions about those exposure scenarios. That's the plan.

This is -- this is actually a fairly exciting area of investigation. I'm not aware of anybody that's actually kind of done this before at this level of magnitude.

I have one additional point here, though. As with dose reconstructions, a standard hierarchy of datasets is employed. That is, you know, personnel monitoring data would be our -- not a gold standard, but our best indication of the workplace exposure, followed by area monitors -- you know, TLDs that are hung about the buildings -- followed by the air samples, that sort of hierarchical approach that we use for dose reconstructions.

This just -- I'm just going to go through a few slides here to give the Board a sense of the magnitude of the data that may be out there. And this is above and beyond the 16,000 sets of data that we have from the claimant population that we've received from the Department of Energy. Of course there may be some overlaps here, as well.

These are the holdings that the Center for Epidemiologic Research at Oak Ridge Associated Universities has. I've got two slides here. I just did a rough addition. We -- there's over 4,000,000 records of bioassay monitoring results in the possession of Oak Ridge Associated Universities. So for example at the Y-12 facility, external dose -- that's TLD, film badge measurements, there is -- this is all computerized already. This is not going back and pulling stuff out of files. There are 834,000 TLD film badge results. There's a million urine samples from the X-10 facility in ORAU's possession on a computer database right now. Again, I can go through the litany, but you know -- external dosimetry, 330,000 -- 329,000 at K-25; 671,000 urine samples. There's whole body counting information, which if we can -- we can determine to be an accurate estimate of course is a very good indication of what the workers actually were accumulating over the long haul. Insoluble material over a long work period tends to accumulate in the lungs, so if we have, you know, 100,000 whole body counts at Y-12 -- is that right? Yeah -- we should be able to come up

with some sort of estimate of the upper limits of exposure.

And by the way, these values go back to the earliest days of operation of the facilities -- 1950's, 1945, that sort of thing.

Here again is the last four sites that we have computerized information at ORAU. Savannah River Site, almost 30,000. Mallinckrodt's sort of an interesting mix of information. Much of this was already discussed in our site profile, but some stuff that people might not be too familiar with, there's almost 2,400 breath radon samples. Breath radon analysis was an interesting technique -- not sure it's used too much anymore, but if you breathe in radium, radium eventually decays to radon gas, and so you will be -- if you have a significant body burden of radium, you will constantly be breathing out radon gas. So it's an indirect measurement. If you breathe how much radon gas is in a person's breath, you can infer how much radium is in their body. So given the pitchblende ore that was at Mallinckrodt, there was some concern at that time of what the radium burdens were, so we have breath analyses for that facility -- 5,000 radon

air sample measurements. So a lot of good data out there, already in computerized form.

Of course all this data -- these data need to be vetted and validated to make sure that the monitoring technique used gives the -- we have to give the values some sort of credibility. We just can't blindly use these datapoints. That's understood and recognized by us.

This is the CEDR resource holdings I mentioned. That's the DOE-funded cite that's out there for the public to use. And not quite as many, not quite as rich a dataset, but they are out there. There is some overlap. A couple of interesting ones that weren't there -- LANL-Zia, maybe, and -- this is the United States transuranic registry where people can -- workers can donate their body to science at the end of their lives and they can either do a whole body donation or a tissue. There are tissue analyses stored here that can be used to evaluate exposures.

Now I mentioned that when we -- when ORAU, for the most part, goes out and does data capture efforts, they do find individual monitoring data from various sites. And this is just a listing

of the individual data sheets that were collected from data capture efforts, and this happens to be facilities where we've retrieved film badge or TLD measurements, estimates of external dose. These range from fairly large holdings all the way down to small numbers of measurements at some of these smaller facilities. By and large, a lot of the smaller facilities -- early on these -- these film badge measurements were done by the Health and Safety Laboratory of the Department of Energy as part of the AEC back then. And we have some pretty good records, including the original calibration measurements that were done. So these, again, are another source of information for coworker data.

These are sites where there were actually bioassay data that were captured in these files, so we do have some. Again, these tend -- a lot of these tend to be AWE type uranium facilities -- Chapman Valve, Hooker Chemical, Ajax Magnathermic -- a lot of these just AWEs. Mound facility is interesting. There's a fair amount of polonium data hanging out there.

Okay. That's all of what I (Inaudible) wanted to cover on the coworker data. If there's

any questions or comments, I'd be more than happy to talk about them.

DR. ZIEMER: Dr. Melius.

DR. MELIUS: Yeah, I have a few questions. The -- I think I was the one that originally brought some of these issues up regarding this -- this database, and so refresh my memory 'cause I -- was a few meetings ago and so forth, but my understanding was that the site profile documents don't necessarily reference everything that you have in the database. Is that -- and...

DR. NETON: That's true. That's true.

DR. MELIUS: Yeah. So would an individual dose reconstruction that was -- would -- I assume it would reference the database -- it would reference the site profile -- you know, worker X someplace -- and then would also -- if one of these documents were used in their dose reconstruction, would it reference it in the dose reconstruction?

DR. NETON: Yeah. Yeah, that's a good point. The Y-12 criticality incident is a very good example of that. We have a Y-12 document. It may mention the criticality accident, but it's not going to go into any elaborate detail because

there's an entire report. And the six or so that we've done, we have referenced the individual report. That's a good example. I can't think of other instances, but...

DR. MELIUS: Would it be helpful in terms of the transparency of the program and maybe dealing with some of these issues regarding questions people have about their individual dose reconstructions to have some sort of public access to a listing of what documents are available, or maybe the short abstract of that -- along with that short abstract of that document available to --

DR. NETON: Yeah, I think that's a very good suggestion. We'd talked about that before, I think even.

DR. MELIUS: I just seemed to me with some of the issues that Pete Turcic brought up this morning and --

DR. NETON: Well --

DR. MELIUS: -- the questions people have are well, did you look at everything or --

DR. NETON: -- I think abstracting 10,000 documents would be difficult, but publishing a list of the documents that are contained on the

web site certainly would --

DR. MELIUS: I thought you already had a brief abstract --

DR. NETON: Well, you're right, there are --

DR. MELIUS: -- from your description. I'm not asking you to do extra work. I was just thinking of would it be helpful --

MR. ELLIOTT: I don't see it as extra work. The dose reconstruction report provides the reference. If the individual claimant or claimants want to see that reference in its entirety, they're entitled to it. We provide it --

DR. MELIUS: Uh-huh.

MR. ELLIOTT: -- upon request. If they want to see the abstract, we'd provide the abstract. If they want to see the whole document, we provide the document. They can do that either by, you know, requesting it of us through the closeout interview process, by e-mail, by a telephone call, or if they want to come into the offices we have a public reading room that they can view those things from.

DR. NETON: I agree with that. I don't think putting out a listing of what's on the web site

would be that -- that large of a challenge. And frankly, we -- I talk to claimants a fair amount, and some of the con-- people call up and say are you aware of this document -- it may be easier if they could access the web just to see that we had it and we've already covered it.

DR. MELIUS: Yeah.

DR. NETON: A lot of these documents that people think are super-relevant may or may not be, it depends on --

DR. MELIUS: No, and there's a danger it could sort of lead to extra work. People think a document should have been used and it isn't. But one would presume that you would have already -- you know, when you do the dose reconstruction, that would have -- you know, if somebody (Inaudible) bit knowledgeable about that, so I just think it would help --

DR. NETON: Sure.

DR. MELIUS: -- sort of people understand all the work that you're doing on the program.

Second question I had was -- I think at the last meeting or the meeting before you brought up that you were working on the construction worker aspect of the site profiles. Where does that

stand and how is it affecting the processing of those claims?

DR. NETON: We continue to work on the construction worker profile, although admittedly much more slowly than we'd like. We are having a meeting in August at the Savannah River Site that has been organized by some folks -- Knut Ringen is involved in that -- where we're going to meet with construction workers. One of the issues we're having is just trying to get access to some construction workers to work with us a little bit on these issues so that we really do capture the unique exposure characteristics. And it's slower getting us together than we'd like. We have not made a lot of progress. And the reality of that is that that is delaying completion of construction worker claims -- not all construction worker claims. We feel in some cases with construction workers with certain circumstances that we may be able to complete them using either some maximizing assumptions -- if they were in facilities where we feel comfortable with the exposure characteristics, we'll do that.

DR. MELIUS: Yeah, it's just that -- I mean

it's just very hard to evaluate that until you've looked at the other, and what's going to be in this site -- construction worker site profile.

DR. NETON: Right. I think I fleshed out the last Board meeting that general topics are going to be covered, but reality is we have not gone very far.

DR. MELIUS: Third is more of a technical question. It may be something for a future presentation, but to me, with this issue with the coworker data is -- a lot of the issue is sort of what uncertainty do you assign to that extrapolation or the use of that thing. And if I recall right, I think it was in Rocky Flats we had some testimony about -- at least in some of the processes there, I think it was some of the plutonium exposures, where coworker data wasn't a very good predictor or -- of -- you know, two people doing similar processes standing side by side or close to each other, it was not, so --

DR. NETON: That's a good point. I think very rarely would we use side-by-side exposures. We would tend to use a distribution.

DR. MELIUS: Right.

DR. NETON: And I'm going to talk a little

bit about that tomorrow, how we're assigning uncertainty to some of these things. You know, we try to craft the distribution and it'd be nice to match job categories, job titles. Reality is that we don't have that for many of the claimants. Then we end up developing these larger distributions where we put in a fair amount of uncertainty to accom-- we believe, to accommodate the lack of knowledge -- our lack of knowledge.

DR. MELIUS: My final question's on the site meetings that you're holding. Have you thought about holding any of these meetings earlier on in the process?

DR. NETON: Yes.

DR. MELIUS: I guess I think -- particularly the Linde site, where there was a fair amount of comment up at the Buffalo meeting that --

DR. NETON: Yes, that's a good point. We actually end up sort of tailoring when we visit the site based on the individual needs. Some sites want us to come later in the process. They'd like to have a document that they've reviewed and they can comment on it. It's easier to form comments if you've got something to read.

Some sites would rather have us come in at the very front, and Linde I think is probably a good example of that, that would like us to come there and capture their story before we go too far down the line. So it really varies depending on the site.

DR. ZIEMER: Thank you. Roy?

DR. DEHART: Perhaps you could remind us about how you take the recommendations, the concerns from the various sites and incorporate into the site profile. For example, while we were at Hanford there was considerable discussion, and this was followed by a letter -- a multi-page letter from one of the union activities. How do you use those concerns expressed in that letter in looking over the site profile, adapting it if necessary?

DR. NETON: Several ways we do that. In the cases where organized labor folks would provide us a fairly detailed document, that is passed over directly to the site profile team for evaluation and possible use in modification of the profile itself. Again, these are living documents, we like to say, where the book is never closed. If there's something there that

really casts doubt on what we've done and the generosity that we thought we put in there, we'll put it in.

So for instance, the Hanford site that you mentioned -- is it Ed Skolsky* I think, Dick -- help me out, Ed Skolsky is Hanford or no? Well, no, he's -- he's not -- we -- we fed that through the loop and they're actively -- there's been meetings held on these issues and we will get them back into the profile, and also feed back to the people that originated the document what -- what we found. When we post these minutes, we also want to get back to the workers -- you know, when we have verbal comments, even -- so we've constructed a database. There's a database that exists now of all the concerns that we've captured at all the meetings we've had. So it is out there. We can track and trend common themes, issues, that sort of thing. And we're working hard to address those things.

Is it going as fast as we'd like? Probably not, but we haven't forgotten. And I mean Bill Murray at the helm over in ORAU, I know he's a tiger on this. We meet very frequently to figure out how best to address these comments. I don't

know what else to say.

DR. ZIEMER: Mark?

MR. GRIFFON: Jim, I'm just curious, if -- along the line with the coworker data, I'm just curious, given our discussions with the case selection process and the variables that you have in the database for your individual claims -- I mean it doesn't seem to me that some of the key variables to linking workers are even being collected in your claims files. So -- so I'm curious how your --

DR. NETON: I'm not sure what you --

MR. GRIFFON: -- established cowork-- for example, job -- job category. Right now you don't have that as a -- a searchable field.

DR. NETON: Right. Yeah, when I was talking about the job categories and stuff, those are -- those are typically more present in the epidemiologic databases. I mean you'll -- you know, they go to a great extent in epi studies to -- you know, laborers, you know, administrative folks and that sort of -- that's what I was really referring to.

MR. GRIFFON: So you're going to go -- you're going to rely on those?

DR. NETON: We're going to rely on those. You're right, though. With the 16,000 that we've had in-house where we've keyed them, we don't have the linkages in place at this point to track those -- those datasets.

MR. GRIFFON: And I'm just wondering, even at the -- I mean I don't think you capture anything sort of at the sub-facility levels as far as where they worked within the -- just thinking of the way these things --

DR. NETON: Right, they're not -- they're not captured discretely, but you know, these are certainly searchable fields. As you know, doing this kind of work, though, you would have to envision up front some categorization that would work, and there are any number of ways to characterize a facility. Some people call it plant one, some people call it the green salt factory. You know, so to categorize that within our own database is actually more work than we've been willing to take on at this point. I think that's all I can say. Ideally, that would be the best way to go.

DR. ZIEMER: Okay. Further questions, comments?

(No responses)

DR. ZIEMER: Thank you, Jim. Appreciate that input. We're going to recess now for a bit and we'll reconvene this evening at 7:00 p.m. for our public comment session. Thank you very much.

(Whereupon, a recess was taken to 7:00 p.m.)

INTRODUCTION

DR. ZIEMER: Ladies and gentlemen, welcome to the evening session of the Advisory Board on Radiation and Worker Health. This is the public comment portion of today's meeting. We're pleased to have many members of the public here with us this evening.

My name is Paul Ziemer. I serve as Chairman of this Board. In a moment I'm going to introduce the other members. I would like to make a couple of announcements.

First of all, we ask that everyone in attendance today register your attendance with us in the registration book at the doorway. Many of you have already done that, but this includes everyone -- Board members, government staff people, members of the public. If you would please register your attendance, if you've not already done that.

Those of you who wish to speak this evening, to address the Board, we ask that you also sign up in the sign-up book. Some have already done this. But if you do wish to speak and haven't already signed in the book, please do that in the next minutes so we have some idea of how many individuals will be speaking this evening.

Before we actually open the floor for public comment, I thought it might be useful if I took a few moments to acquaint those of you here in Idaho, those members of the public who may not be as familiar with the operation of this Board, to tell you a little more about what we do so that you don't misunderstand what we are able to do and what we are not able to do. So with that, let me proceed.

This particular program that we're involved in actually involves a number of Federal agencies. These are listed here -- the Department of Labor, Department of Health and Human Services, Department of Energy, and of course the Secretaries of each of those are the key people that are -- as well as the Attorney General -- that oversee this particular program, the Energy Employees Occupational Illness

Program.

This Board, by statute, consists of up to 20 members. We actually do not have 20. The full Board is here before you. These individuals have all been appointed by the President of the United States. The statute calls for the membership of this Board to be made up of a variety of people with different backgrounds, as you see indicated here. These are the words from the statute, the representatives from these various groups: the affected workers or their representatives, and others from the scientific and medical communities.

Now in addition to my position as the Chair, let me introduce the others. Our Designated Federal Official is Larry Elliott -- and I'll ask each of these -- they have a placard, but if you wonder who's who, here they are, and their titles are indicated here for you to see; Dr. Henry Anderson, Antonio Andrade, Roy DeHart, Richard Espinosa, Michael Gibson, Mark Griffon, James Melius, Wanda Munn, Leon Owens -- Charles -- oh, Leon isn't here; I'm sorry, Charles Leon Owens, who goes by Leon -- Robert Presley and Gen Roessler. So these are the members of the

Advisory Board.

So what is it that this Board is responsible for? And here is the information, again pretty much quoting from the statutes. We're responsible for advising the Secretary of Health and Human Services, and we are an Advisory Board, and our advice goes to the Secretary of Health and Human Services. And that advice takes three parts, advising on the development of some guidelines -- and those guidelines have been developed. The one guideline has to do with what's called probability of causation, which is the idea of is it more likely than not that a cancer was related to the individual's radiation exposure.

And then advising on the guidelines for dose reconstruction. Those guidelines are in place and have been published in the Federal Register.

We have some responsibility on evaluating the validity of the dose reconstructions that are being done by NIOSH, and that is a sort of audit function which we have underway.

And then finally we are to be involved in the determination of whether or not there are individuals who should be added to what are

called -- or what is called the Special Exposure Cohort. There are guidelines on this that were recently published, and there are petitions now that are coming into the system, as it were, on the Special Exposure Cohort. The Board then will review those and have advice on those particular petitions.

So that is what the Board is responsible for. We do not do the dose reconstructions. We do not adjudicate the findings. We are not a board of appeals. We -- we do like to get feedback from people. We do like to learn of your experiences insofar as they help us understand how the system is working or not working. And I know many of you -- and our experience has been, as we've talked to groups around the country at various sites, people do have their stories to tell us. And as I say, we don't get involved -- the Board does not get involved in your case, but whatever you tell us may help us understand what may be working or not working in the system. So you're welcome to tell us your story -- or any other observations you wish to make.

We're not necessarily here to answer questions. We're here to listen. So we are here

just to hear what you have to say. If you have questions about your particular claim, if you have a claim, we do have an individual here -- Lynda Brandal is here this evening and she is the public health advisor for the program, and Linda is going to be back at the table back there at some point. And if you have specific questions on a claim, she will be the one to direct you to get what information you need.

Also, the Department of Labor has a table -- many of you saw it when you came in -- near the entrance that has other information about the program that you might find helpful.

PUBLIC COMMENT

So with that as background, we'll proceed to the public comment portion of the meeting. I'm going to return to my seat and get the list of those that have decided they would like to speak.

Now I should also tell you that there are a lot of folks that sort of want to speak, but they don't want to go first. But it's sort of like getting olives out of a jar. You know, the first one -- once you get it out, the rest come pretty easily. So we're going to get the first speaker going, and if you then change your mind, it's not

too late. I'll give you the opportunity to speak. Okay?

So let me get the list here and see who the first olive is. And I may have a little trouble reading the writing. It looks like Clinton -- is that right, Clinton Jensen -- Johnson -- Jason? Could you approach the mike, sir? And also for the record, indicate -- I believe it says Faith, Idaho or --

MR. JENSEN*: Firth.

DR. ZIEMER: Firth, Idaho. Thank you.

MR. JENSEN: Well -- well, to give you just a little bit of history about myself, I worked at the INEL and I worked at the SMC project, which is depleted uranium. That's all I'll say about that, other than the fact that I burnt -- I incinerated depleted uranium for two -- 18 months and during that period of time I became severely ill and I still suffer with the same symptoms. I had cancer spot removed. There's several different problems that I have. I take morphine and other medicines -- several of them a day -- just to get by.

DOE hired a doctor out of Bethesda, Maryland -- Dr. Melissa McDermott* -- to come out here and

kind of see what she could find out what was going on because I raised employees concerned about the safety and health and the radiation where -- and I'd like to read a couple of things that she found out. And this is -- this was the attitude that SMC had from 1985 till 2002. They -- they had a doctor in charge here in Idaho Falls that never stepped in the area from 1985 until after my court in 2002, and he was in charge of the IHs* there. And he never knew what was going on, but yet he was in charge of it. He never had a clearance. He couldn't talk about things -- supposedly. And he never stepped in the area.

Her observation of the SMC project, and this was in -- let me -- a date -- this is 2001, but this -- this went on from 1985 when the project started. (Reading) The lack of the on-site experience and industrial hygiene, the SMC IH had neither training nor the experience to carry fully (sic) responsibility for the program. A corporate CIH present for my visit was unable to answer basic questions about the major -- the majority -- major facility hazards and concerns to him. A cookbook mentality of the IH

management was observed where complacence with TLD was the only benchmark being used to gauge a potential haz-- health hazards. No truly competent person was identified by me who would have the working knowledge and experience to know, without looking at an MSD, which hazards to expect in a new operation or with the introduction of new things.

That's one of her comments on -- on the way that it was run. I had several things happen to me. I had a spill. Management at SMC tried to hide the facts. DOE went in and they found the log of the log book. DOE did a pretty -- pretty fair investigation of what they did investigate.

I had several -- different times during the periods of the years, I had spikes in the urinalysis. The urinalysis was not being ran right. That was one of my concerns, too, that urine samples were being lost. The day that I took this one sample supposedly that had spiked at 2.7, I had -- as you know, urinate in a quart jar and they take the jar and they do the samples. I had to cap it off, which probably took about an ounce during that sample in the quart jar. My urine -- or my internal

contamination was supposed to be 2.7. I believe that it was higher than that because if you put two ounces in a quart jar and it affects the whole thing or whatever to 2.7, it must be pretty high, in my opinion, from what little bit of chemistry I have that I don't know whether the saturation point or whatever, but it -- it takes quite a bit to raise it to that, as far as I know. And I was made sick at that time on 17th of December, 1998, and my life has been turned upside down.

I was called a traitor and everything else. I was pegged as a whistle-blower because of these safety things. They were incinerating this depleted uranium. They were -- only had a permit to construct. They never did pre-sampling. They never did sampling during the thing -- during the operation. These were never carried out. And so it was not an airtight unit. It was not a boughten* one. It was built on-site from -- from sheet metal and angle iron and plexiglas, and it was -- it was -- it was not a safe thing. And as soon as -- as soon as they could, they destroyed it. They got rid of it, so at least nobody else has to do that.

This is about all I have to say. If anybody wants to ask me any questions, I'll provide you with my medical record. I filed a claim with you guys. My number's like 10,065 or something. I was advised to wait till my court case was over with in order to file because I did win because I was right and I never lied, and usually the truth prevails. And what I say here is not a lie.

This lady, she did down -- down -- she did mark them down in -- in her visit on the way they -- they do business out there, and it wasn't safe, and this was still going on in 2001. So it's kind of like teach an old dog new tricks. They might -- you might think that they are learning, but it takes a long time after that before they ever do, so this is not something that -- that is ancient and stuff. I may have been sick for a long time and still am sick, but like I say, they might have changed now, but during the records and the past, this needed to be brought out that things were not quite kosher. And I can read here where management -- well, I already told you that management tried to cover it up.

They did everything they could to silence me.

They -- they forced doctors into keeping me off work. They wanted to get rid of me. They had a Army investigation. They tried to lock me up -- anything they possibly could to silence me. So I've taken this opportunity, I've taken others, to speak out for those that have been affected like this. I don't think it's right. I don't think it's right that the government can do this to people and get away legally, and managers and can sit there and lie and get out of it, and DOE backs them up by paying their bills and lawyers and everything else. And it's your taxpayers' money that's being wasted by them people frauding (sic) people. So I think that there's a lot of things that have went on that you people will never ever know about unless people like myself will get up and bare their souls to you and tell you some of the things they've been through.

So thank you very much for letting me have the time to express myself. Thank you.

DR. ZIEMER: Thank you very much. The next speaker will be David Fry. David Fry.

MR. FRY: Okay, I just have a couple of questions for the Board. On April 28th we had those site profile meetings here in Idaho Falls.

There was one at -- for the building trades people and there was one at PACE union hall, and I'm with PACE. And at that time we didn't have the internal dose report to review. And also at that time we had a lot of current and former employees that were in the room that made comments to the site profiles that we had. And I just wanted to -- and then we received the minutes from that meeting, and I just wanted to ask, will our comments be incorporated into the site profile? Will the site profile be redone or...

DR. ZIEMER: Let me ask one of the staff people -- Larry, or Jim Neton perhaps can respond to your specific inquiry.

DR. NETON: (Off microphone) Yes, when we receive comments --

UNIDENTIFIED: Use the mike.

DR. NETON: We receive the comments informally through the organized --

MR. FRY: Through the local?

DR. NETON: -- local that came there. We have passed them on to the profile team, and they are considering them, at which point if any of them may -- will come to make a difference in the

profile that's out there, it will be revised to reflect that information.

MR. FRY: Okay, thank you, 'cause the first profile -- there were some critical processes and buildings that we as employees and former employees felt like were missing. And also will there be another meeting in Idaho Falls, another site profile meeting when it's been revised and when the internal dose report's ready?

DR. NETON: The internal dose report is completed and it's on -- it's on our web site, available to be reviewed. We are certainly -- we don't have a meeting planned in the near future, but if one were necessary or you felt that you would like to have one, there was enough concern about the information that's out there on our web site, we would be more than happy to discuss -- to make arrangements to --

MR. FRY: I think the general --

DR. NETON: -- conduct a meeting.

MR. FRY: -- consensus that day was most people wanted a second meeting, but...

DR. NETON: Okay. And I think I mentioned earlier that there was some interest in a second meeting out there, but we just have not yet

planned to make that happen.

MR. FRY: Okay. That's all I have. Thanks.

DR. ZIEMER: Okay. Thank you, David. The next -- Knut Ringen is with the building trades.

MR. RINGEN: (Off microphone) Now if you have any other local people who want to speak, I'll be glad to forego my time.

Okay, I didn't think so. First of all, I want to thank the Board for holding these evening sessions. I think it was when you had your meeting in Las Vegas that I asked for these sessions, and you've done so since then and I think it's been very useful. And I'd like to make one more request of you today. That is to do a better job of advertising the meetings earlier. For instance, we didn't get notice really of this meeting until about two weeks ago, and didn't have time to notify our members in turn. And I think we -- a better job could be done of advertising them so that -- where we've had more time and been able to prepare -- for instance, for the meeting at Hanford, you know, we had a much, much larger participation, and we would very much encourage you to do that and we would like to help you also in doing that.

The main things I wanted to talk about here today are really fourfold. First of all, I think most of us think of this Board as being the conscience of this program, and it's very important that it's -- performs its functions effectively and with support from NIOSH. We have a problem, which I believe stems from a lack of credibility in the overall program, and which has led to a relatively small rate of applications for compensation. Here at Hanford -- no, here at INEL, only about 1,500 workers so far have filed claims out of an estimated, I would guess, roughly 20,000 workers who have been here and who had cancer since they have been here. So that's a very small rate of applications compared to the people who generally should be eligible for compensation. And I ascribe a lot of that lack of response -- and it's something that we see across the complex -- to the low level of credibility that the program has right now. And I don't see any group that can help fix that problem more than this Board can, so your function is very, very important.

The second issue I want to bring to your attention very briefly is how data are presented

at these meetings and by NIOSH in general. And I think it could be presented somewhat more effectively if you -- obviously you can slice and dice data all kinds of different ways, but if you were to do it in three different ways. First of all, by site, which you do on the web site. But when it's presented here, you don't see any of the data by -- by site, and if you'd known the data by site -- for instances, the data that were presented up through the first quarter of this year were heavily skewed by the results from the Bethlehem Steel facility, and then the last three months it's been heavily skewed by the results that have happened because a large portion of the dose reconstructions that have been done in the last three months have been for Savannah River. And if you just see the results more by site, I think that becomes more readily apparent.

The second way that I think it would be incredibly important to see these data -- at least from our point of view -- is by occupation. We would very much like to see a breakout by construction. I think there should also be a breakout by people in production, maintenance, administration and science and technical kind of

work. I realize that there are problems in trying to define things by occupation because people move from occupation to occupation. But if you were doing this as an epidemiological study, you'd have to find a way to define a person's principal occupation. There's no reason why you couldn't do it in this case, as well. And if you did present the results by occupation -- the reason it would be interesting to me would be to look at how many construction workers have you done dose reconstructions on so far, and what has the result been, given that there are many problems with the site profiles still when it comes to construction workers, and we have no way of judging that, if you're making lots of dose reconstructions for construction workers in the absence of adequate dose reconstruction materials. We'd like to know more about that.

And the third thing that I think would be useful -- and you can argue about this -- is if they could be presented more by probability of causation. And by that I mean there are roughly three groups of workers that we have out here file applications. There are those people -- those workers with obviously not enough radiation

exposures. Let's say those who have a probability of causation that's less than 20 percent. Then there's the group that's obviously compensable. Let's say the people with a probability of causation over 60 percent or whatever it is. And then you have the middle group, the people who cause NIOSH the most work and who lead to the most difficult decisions. It would be very good to see for these different groups how many claims are being filed in each of these categories and what the results are of them. I think that would give us a much better idea about -- is, for instance, the majority of the claims that you're putting through right now the easy claims, and are you leaving out the people in the middle category by and large, and this kind of thing.

Finally, I'd like to also say something about the site profiles, and Jim Neton today said that we're working on and we're trying to work together on doing a better job of developing site profiles for the construction workers. And the -- that's been a little cumbersome from everybody's point of view, but I think everybody's trying to work towards that end.

But I'd caution you to think about something. Jim referred to site profiles that were completed. And as far as I know, there isn't a single completed site profile. These are works in progress, even though they've been published on your site. And I think maybe saying that -- implying that they're complete suggests to me that you're never going to do anything more with them, while in reality you continue to change them periodically -- or may change them periodically, in the sense that you call them living documents. And I would be a little bit more careful with this. And I certainly don't think that you can say that any of them are complete when it comes to information on construction workers at this point in time, and maybe there should even be a caveat in them on that subject.

And let me just make finally one more request of you, also, and that has to do with SCA -- Sandy Cohen Associates -- review of these site profiles, 'cause they've started to ask if we could organize meetings with workers so that they can go out and interview workers and talk to them about it. And that's a time-consuming and very,

very important function, but it's very hard for us to organize a lot of these meetings with workers and provide them with the technical support they need and so on without some funding to pay for the time of these workers, because at least construction workers, if they come to a meeting, they're not going to get paid for that time. So if you will consider, as you look at the contract -- contractor that you have available to you and the scope of work that's in that contract, I would just ask you to consider making available some funding in the -- in the effort to assess the site profiles, or anything else that requires the involvement of the local workers, to provide some reimbursement for those -- for those costs. We don't expect NIOSH staff to work for free. We don't expect DOE staff to work for free. I don't think we should expect workers to do that, either, and I'd like you to take that into account. Thank you for your time.

DR. ZIEMER: Thank you for your comments. Now I go to page two, but there's only one page, so do we have a page two?

MS. HOMER: No.

DR. ZIEMER: There's no page two. Now's the

opportunity for anyone who's not signed up that still wishes to addresses the Board. Sir?

MR. HANSON: My name is Gaylan Hanson. I work at the INEL. I'm the PACE union health and safety rep. I work closely with retirees, and I have a retiree that, because of illness, was not able to attend tonight. But in a very short note, I'd like to read what he put here. It's a statement. I'll leave his name off. (Reading) Undocumented radiation exposure to worker. In the summer of 1957 I was working for Phillips Petroleum Company as a yardman. I was watering lawns at TRA. I was called to MTR reactor building and told there was a high radiation beam coming from the reactor through an experiment insertion hole. I've heard this many times from other workers of a beam that shot like two miles out toward the highway with a particular experiment they were doing there. They said they couldn't use their operators because they couldn't have them get burned out. I was to go into this sort of tunnel and lay lead brick shielding to stop the beam. I went in, laid two lead brick, came out. They said I had been there too long and was overexposed. I never found out

what the exposure was. Another time I was called in to decontaminate the manipulators in the hot cell. I got very contaminated and overexposed there, too. I had no dosimeter or film badge to record dosage levels.

And I think this is what a lot of former workers and workers is -- they do a pretty darned good job of documentation of what they have, but what about the unknowns in the area that wore the badges, et cetera? Is there anyone I can leave this letter with? Thank you.

DR. ZIEMER: Thank you.

MR. ELLIOTT: Thank you, Gaylan.

DR. ZIEMER: Yes, and again, have the opportunity for others who wish to comment?

UNIDENTIFIED: (Off microphone) You mean (Inaudible)?

DR. ZIEMER: Anyone from the public who wishes to comment -- yes, please --

UNIDENTIFIED: (Off microphone) (Inaudible)

DR. ZIEMER: You'll have to approach the mikes for our recorder to get the information.

UNIDENTIFIED: On that same line, there was --

DR. ZIEMER: Would you state -- state your

name, please, for the record? Thank you.

MR. EGBERT: I'm H. Doyle Egbert. I worked at CPP for 17 years as an operator. But for instance, we had to go into the west vent tunnel, which was a very contaminated area, to roll up lead shielding that covered up a 50-R field. Anybody that worked out at CPP knows what it was all about. It was a nightmare. Another time I had to go into a deep tank, retrieve a camera out of the WG waste tank, which is on the east site, very hot waste that would go to the (Inaudible), 50-R fields. They give you two weeks' dosage to go in and do it. You're in there maybe five minutes, but you still are in a 50-R field. And now they won't even think of over a 3-R field, I -- I think, out there now. I could be mistaken on that. They put robots in the cells for those things. But I just wanted to relate that experience that I had and -- and they weren't recorded. I passed out in the vent tunnel. They pulled me out of there, took my respirator off and then I come to on the -- outside the vent tunnel. It wasn't recorded. So just a insight. Thank you folks.

DR. ZIEMER: Thank you. Any others?

(Pause)

MS. CODDING: My name is Shirley Codding and I was really going to keep quiet till I got to --

DR. ZIEMER: Could you spell that for the recorder?

MS. CODDING: Oh, C-o-d-d-i-n-g -- and after hearing Knut(you)*, everything he said is absolutely true. The chem plant was known as the garbage dump of the world. It really was. It was dirty. It was a roped area from back of 601 just to even walk to an office in the early days. Now granted, everything is a whole lot better now. I think public concern has forced it. But we used to do things that the primary feeling of the chem plant in the sixties and seventies and eighties was do whatever it took to get the job done. And there were a lot of times -- I can tell you many times that my dosimetry badge was not on because we had to get the job done, just throw on the NICs* and get the heck in there and do it.

We had a blowout, blew out the bottom of the batch still, and I was one of the three operators that went into the cell. It was right at shift change. Not one of us had a dosimeter on. And

even if we did, the INEL did their own recording. They didn't send out for an unbiased opinion. It was unrecorded -- it was unrecorded by a independent. And I don't know of anybody out there that believes what's on their dose is a true reading. There -- I've talked to a lot of operators. I'm in operations, too. I've talked to HPs. And there's not one person that believes that INEL's been honest and true, and it's been that way -- and I've been out in operations 23 years, and I know for a fact that some of my dose in the rare gas plant is higher than what it shows -- sometimes for a whole yearly dose. So that's just my opinion. That's my say. Thank you.

DR. ZIEMER: Thank you very much. Anyone else? Sir?

MR. JENSEN: I guess I don't need to state my name again since you already know it, but one thing I'd like you to know is that SMC and everybody hides behind national security. I think that's just a big fraud, due to the fact is people's health is more important than a lot of things. And when you're putting people's health on the line, not telling them what they're being

involved in, working them without the proper protection, without knowing what they're working around, it's like sending you blindfolded into something. And then -- and then they have the gall to say it's national security; we can't tell you. That's denying me the -- the ability to get proper medical health care to try and help me. I don't -- if I -- if I had something -- I knew something that would you -- help you and I denied you of it, how would you feel? And I know other people feel the same way because they've been denied the truth about what they've been around, what the radiation count was. It's not been a pretty story for a lot of people. Thank you very much.

DR. ZIEMER: All right. Thank you again for those added comments. Yes, sir?

MR. QUINN: I'm John Quinn. I'm a retired worker at the site. I worked at the chemical processing plant for 27 years. The lady that spoke back there, I was there before -- I guess I was one of the original ones, I guess, that kind of started at the chem plant. I went there shortly after the SL-1 incident when they formed the decontamination facility to take care of

those who lost their lives in that reactor incident. I worked in that facility for seven years, with equipment that they originally put there. And they had lots of problems. And I got my dose reconstruction Saturday from NIOSH. I'm not totally convinced of their findings and the results and the dose that they had given me because, just like a lot of them, we went into these areas back in those days, in the early sixties, it was half-face respirators with just plain paper filters. And there was a time when they all -- money was an issue. To keep those operations going out there, when I first went to work there, we decontaminated in that facility the half-face respirators that the workers that went in the hot cells to do the jobs, and we was instructed to monitor those. If they read less than 60 min-- counts a minute, we would reuse them. We did that for two or three years, as I remember.

Then they come out with a charcoal filter, lot more money, and they said we got to use these, you know, in hot areas. Well, sometimes those hot areas, they was so hot that, you know, we just had to throw them away.

And I come up through the years in this to where we kind of got up to full-face respirators. Finally got into air lines, finally got into bubble suit. I've been through the whole works. But the first seven years in my work out there, I didn't see that.

We had ventilation problems. We had monitoring problems, and I -- just like the lady back there said, we went in to do the job. And I'm just wondering if the people who are estimating these NIOSH reconstruction, if they really know and saw the places that we had to work in, maybe they would -- we might get a different evaluation. That's all I got to say.

DR. ZIEMER: Okay. Thank you, sir. Again open the floor for anyone else that wishes to speak.

(Pause)

DR. ZIEMER: If not, we are going to adjourn. I feel like an auctioneer -- going once. Let me --

MR. GRIFFON: Paul --

DR. ZIEMER: Oh, there is? Okay.

MR. GRIFFON: No, no, we --

DR. ZIEMER: Comment or question?

MR. GRIFFON: I just wanted to say as a reminder, we're having another opportunity --

DR. ZIEMER: Oh, yes --

MR. GRIFFON: -- tomorrow afternoon. Is that --

DR. ZIEMER: -- thank you.

MR. GRIFFON: Yeah.

DR. ZIEMER: The Board meets tomorrow again all day. As you may know, our sessions are open. You're welcome to attend. Although we did not put it on the printed schedule, there is a public comment period tomorrow afternoon right after the lunch hour. I believe it's at 1:30. So if you or any of your colleagues do wish to make public comment tomorrow, you're welcome to do that. The Board will be here at that time and will welcome hearing from any of you that -- or others that may not have been able to attend tonight, if you know someone that wishes to comment, you might let them know that, as well.

Let me thank you again all for coming. We appreciate the input and will wish you goodnight and hope to see many of you again tomorrow.

(Whereupon, the proceedings were adjourned at approximately 7:45 p.m., to reconvene the next

day at 8:00 a.m.)

C E R T I F I C A T E

STATE OF GEORGIA)
)
COUNTY OF FULTON)

I, STEVEN RAY GREEN, being a Certified Merit Court Reporter in and for the State of Georgia, do hereby certify that the foregoing transcript was reduced to typewriting by me personally or under my direct supervision, and is a true, complete, and correct transcript of the aforesaid proceedings reported by me.

I further certify that I am not related to, employed by, counsel to, or attorney for any parties, attorneys, or counsel involved herein; nor am I financially interested in this matter.

WITNESS MY HAND AND OFFICIAL SEAL this _22nd_ day of September, 2004.

_____
STEVEN RAY GREEN, CVR-CM
GA CCR No. A-2102