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-SEVENTH MEETING

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

DAY THREE

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the DoubleTree Club Hotel, 720 Las Flores Road, Livermore, California, on December 15, 2004.

C O N T E N T S

December 15, 2004

TRANSCRIPT LEGEND

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

(By Group, in Alphabetical Order)

BOARD MEMBERS

CHAIR
ZIEMER, Paul L., Ph.D.
Professor Emeritus
School of Health Sciences
Purdue University
Lafayette, Indiana

EXECUTIVE SECRETARY
ELLIOTT, Larry J.
Director, Office of Compensation Analysis and Support
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention
Cincinnati, Ohio

EXECUTIVE SECRETARY (PRO-TEM)
WADE, Lewis, Ph.D.
Senior Science Advisor
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention
Washington, DC

MEMBERSHIP

ANDERSON, Henry A., M.D.
Chief Medical Officer
Occupational and Environmental Health
Wisconsin Division of Public Health
Madison, Wisconsin

ANDRADE, Antonio, Ph.D.
Group Leader
Radiation Protection Services Group
Los Alamos National Laboratory
Los Alamos, New Mexico

DeHART, Roy Lynch, M.D., M.P.H.
Director
The Vanderbilt Center for Occupational and Environmental Medicine
Professor of Medicine
Nashville, Tennessee

ESPINOSA, Richard Lee
Sheet Metal Workers Union Local #49
Johnson Controls
Los Alamos National Laboratory
Espanola, New Mexico

GIBSON, Michael H.
President
Paper, Allied-Industrial, Chemical, and Energy Union Local 5-4200
Miamisburg, Ohio

GRIFFON, Mark A.
President
Creative Pollution Solutions, Inc.
Salem, New Hampshire

MELIUS, James Malcom, M.D., Ph.D.
Director
New York State Laborers' Health and Safety Trust Fund
Albany, New York

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

OWENS, Charles Leon
President
Paper, Allied-Industrial, Chemical, and Energy Union Local 5-550
Paducah, Kentucky

PRESLEY, Robert W.
Special Projects Engineer
BWXT Y12 National Security Complex
Clinton, Tennessee

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

AGENDA SPEAKERS

(in order of appearance)

Mr. Ted Katz, NIOSH
Mr. Robert Presley, Member
Dr. Brant Ulsh, NIOSH

STAFF/VENDORS

CORI HOMER, Committee Management Specialist, NIOSH
STEVEN RAY GREEN, Certified Merit Court Reporter

AUDIENCE PARTICIPANTS

BEHLING, HANS, SC&A
BEHLING, KATHY, SC&A
BISHOP, STANLEY
BLAKE, PAUL K., DTRA
BLASZAK, MARK, WKBW TV
BLEWETT, BERYL, SUPPORT GROUP
BLOSSER, FRED, NIOSH
BRAND, ANSTICE, CDC
BRANDAL, LYNDA, NIOSH
BROOKS, JOYCE
BUMGARNER, ROBERT L., SAIC
CASE, DAVID R., SAIC
CHEW, MELTON, CHEW AND ASSOCIATES
CISNEROS, LEROY
ELLISON, CHRIS, NIOSH
FITZGERALD, JOE, SC&A
FULK, M.M.
GLENN, H. DAVID, LLNL
GUERRIERO, JUDIE, UNIV. OF CAL.
HALLMARK, SHELBY, LABOR
HEISTER, MELANIE, NCRP
HERBERT, NICHOLE, NIOSH
HINNEFELD, STUART, NIOSH
HOEY, STEPHANIE, WKBW TV
HOFFMAN, OWEN, SENES
HOMOKI-TITUS, LIZ, HHS
KATZ, TED, NIOSH
KOTSCH, JEFF, LABOR
MAIER, HILDA, NJPR
MAURO, JOHN, SC&A
MCDOUGALL, VERNON, ATL
MCGOLERICK, ROB, HHS
MILLER, RICHARD, GAP
MORAN, FRANCINE A., LLNL
NEELY, KRIS, CA RESOURCE CENTER
NESVET, JEFF, LABOR
NETON, JIM, NIOSH
NUGENT, MARIAN, U.S. GOV'T ACCOUNTABILITY OFFICE
OLSON, INGA, TRI-VALLEY
PORTER, DIANE, NIOSH

RICHARDS, JOE, IGUA LOCAL 3 OAK RIDGE
RINGEN, KNUT, CPWR/BCTD
ROBERTSON-DEMERS, KATHY, SC&A
SCHAEFFER, D. MICHAEL, DTRA
SCHAUER, DAVID, NCRP
SWEENEY, THERESA, BSAG
TOOHEY, R.E., ORAU
TURCIC, PETE, DOL
TYLER, SHARON, DOL
ULSH, BRANT, NIOSH
WALKER, ED AND JOYCE, BSAG
WOOSTER, BEVERLY

P R O C E E D I N G S

(9:00 a.m.)

REGISTRATION AND WELCOME

DR. ZIEMER: Good morning, everyone. We'll call the meeting back to order. I'd like to remind you to be sure to register again your attendance. In fact, now that I have done that, I realize that I didn't register my attendance yet, but you can join me at the registration table at your convenience and we'll make sure you're registered.

Again, if -- just remind you, and particularly for those who haven't -- were not here on Monday or Tuesday, there are a variety of documents on the back table, including the agenda and other handout materials. Please avail yourselves of those.

SEC PETITION PROCESS PROCEDURES

We begin our session this morning with a presentation on the Special Exposure Cohort petition process procedures, and that presentation is going to be made by Ted Katz from NIOSH. Ted, welcome to the podium.

MR. KATZ: Good morning, Mr. Chairman and members of the Board. Thank you for having me

again.
Is this working? Yes, it is? Okay.
And I'm going to summarize the internal procedures for evaluating Special Exposure Cohort petitions.
(Pause)
So these procedures are sort of the initial nuts and bolts for how we're going to implement the SEC regulations which we promulgated last summer and which you had a large role in reviewing.
Just to make a point, these are -- these are our, you know, beginning point for how we go about this, but we are surely going to learn quite a deal as to what's practical and how we can efficiently process these petitions as we go, as you have experienced with us serving you in this process and -- and as the Secretary of HHS has experienced our work here. And we'll be apprising the Board and the public in the *Federal Register* as we make changes to these procedures.
Now an initial point. This Board's been very vigilant about issues of conflict of interest with respect to NIOSH, and the procedures

include provisions addressing this. The primary reviewer for each petition, as the procedures lay out, will never have been employed at the facility for which the petition addresses. And the same goes for principal authors. For some of these larger petitions there are likely to be a number of people involved in producing the evaluation and the response, and that'll be our standard for -- for all of them.

Now there are two phases to the -- to the petition process, as you know. The first phase just involves NIOSH and the petitioners, and that's the petition qualification process. And the second phase is the evaluation process. And as you know, that's NIOSH and the petitioners, and the Board and the Secretary of HHS all have a role in that. So I'm going to start with the petition qualification process. It's so far been more time-consuming than we expected. We have several things to do in the qualification process. The first question is is the petitioner a member or representative of a member of the class. We have to answer that question and in effect, you know, for a

representative that might be, as you recall, a survivor or an empowered representative -- as we allow for under the rule -- or a union which represents or had represented that class.

Now the verification process. You know, wherever we can, when we have a petition that's come in on a person who's been a claimant we've already had experience with or are working with with respect to their dose reconstruction, you know, the verification that they're qualified to petition is, you know, going to be in our hands. But in cases where we have a petition from an individual who we haven't seen through the dose reconstruction process we're going to be relying on that well-oiled machine that DOL has to help us with the qualification process, and that's in these procedures. If it's a union, then it's -- that's an issue there we handle.

And as these procedures have -- we just need one qualified petitioner to proceed with the process of beginning the evaluation.

And just to note, as with everything else, you know, the petitioners are protected by the Privacy Act.

So the other part, qualifying petitioners is the first part of this. Qualifying the petition content is the second part of this enterprise for this first phase. And the question we're addressing is is the scope of the class, you know, legal and appropriate. Now legal is sort of shorthand for -- really, the main issue there is is the class from a single facility. As you know, it needs to be. And appropriate is a matter of whether -- whether the -- the justification for the petition suits the class that's -- that's proposed.

And the second part of this is is the basis for the petition adequate. And you'll probably recall from the SEC regulations, there's a variety of different evidence that serves as a sufficient basis for a petitioner to believe that a dose reconstruction may not be feasible, and they have to address that -- that evidentiary requirement.

And OCAS, when it comes to incidents that are claimed and are at the basis for the petition -- I mean OCAS has a -- has a sort of front-end role in confirming that the exposure incident

occurred, and that -- and that involves the petitioner where OCAS runs short on information to be able to confirm such an occurrence.

Another point to make is that OCAS will combine petitioners and petition content, you know, for overlapping petitions. And this, you know, has bearing -- bears on you, because when you see these petition evaluations, the petitioners from each of the petitions where we combine would then have the opportunity to address the Board concerning their petition.

Now I mean, as the procedures lay out in -- in some detail, there's a -- as we were speaking in the past couple of days about iterative processes, there's an iterative process for NIOSH to work with the petitioners to ensure that their petition addresses the requirements it must address. But at the end of that process, then the petitioners would receive a formal notification of whatever deficiencies may still stand, and have the opportunity to address those.

If the petitioner disputes a deficiency as being a deficiency, there's then the opportunity for the NIOSH director to run a

review, using independent HHS persons, of -- of that dispute and resolve it.

And at the end of having a petition that's fully qualified content, we'll date the petition accordingly. And this -- this is within -- having in mind the Congressional interest in timeliness, which is, you know, now -- and I'll get into this issue further with the EEOICPA amendments. It's -- it's been sort of formalized, and so this will be important that we sort of have a -- have a schedule that relates to when we have a proper petition.

So once we have a qualified petition, OCAS will prepare an evaluation plan. We'll provide a notice to the petitioners, to the Board and to the public of these qualified petitions -- the public through the *Federal Register* notice.

The Board has, as it already has had, will have an opportunity to evaluate our plan for -- for reviewing the petition, for doing the research on the petition and give us input on that, since we're serving the Board in this sense by preparing an evaluation that the Board -- so the Board can consider the petition.

And OCAS or NIOSH, as appropriate, will provide

notice of unqualified petitions to petitioners, and will publish summaries of these unqualified petitions on our web page, with explanation as to why they didn't qualify.

Now the second phase is the petition evaluation process, which involves the Board, as well as HHS.

You know, we're applying the standard dose reconstruction hierarchy to evaluate these petitions, starting with the most specific data -- personal monitoring data -- and going through the gamut as need be, area or group relevant monitoring data, and then general information on process and source.

And we'll begin this -- again, this is -- there are several -- you know, efficiency is very important and has been emphasized by Congress in these amendments, which I'll get to at the end of this presentation.

So we'll begin this process by mining our in-house data and our in-house dose reconstructions. And to the extent we can address petitions without going to DOE for data, we certainly will because time will be of the essence here.

The other efficiency issue that's addressed in the petition guidelines is that we'll address the petition according to the scope of the petition basis. So the depth of the petition basis as provided to us, the details, we'll address those fully, but -- but we're not going to go on a fishing expedition to evaluate issues, attempt to discover issues that -- that aren't raised. Obviously any of those that come to -- you know, come to light in our process of evaluating the petition, we will evaluate. But our point here is to address the petition -- petitioner's basis and to address the issue of whether, in -- in light of that basis and in light of the data we have, can dose reconstructions be done.

And through this process, as we learn -- if we learn -- that there are actually more than one class covered by a petition, we'll separate those classes, in effect, and evaluate them individually.

Now for classes that are found -- for which we find that we can't do dose reconstructions, we will then address the issue of health endangerment and we'll evaluate the sources and

circumstances of exposure to do that. And OCAS's business here is to determine, you know, whether exceptionally high level radiation exposures were likely or unlikely, based on the qualitative evidence. And I should probably, you know, more correctly say not likely, because it would require affirmative evidence of such exposures.

So as a result of this, we'll define one or more classes. We're going to define the class specifically as possible, of course. This will be important for DOL's role in adjudicating then claims as to whether they belong within the class. And we'll be working with DOL to address practical constraints there may be on identifying class members based on the records, you know, despite what might be the scientific evidence as to the scope of the class.

For classes defined with the 250-day employment criterion, you know, we'll also provide a provision, as is in the rule, allowing members to be defined by the sum of their SEC work history. So in other words, as you recall, if an individual worked in more than one class for portions of a 250-day period, they can sum

those portions together to be qualified to be a member of that class.

Now evaluating petitions under Section 83.14. You may recall things are handled somewhat differently in cases where NIOSH finds that it can't do a dose reconstruction, and that leads to a petition process. And we've charged ORAU with -- with beginning to look at its -- at our stock of dose reconstruction requests to identify likely pockets of classes, in other words, potential classes, individuals for whom we can't do dose reconstruction. Where we find that's the case, the feasibility issue's already determined for that class of employees and the procedures lays it out pretty clearly. There's no more to do in making a determination about feasibility. Our work is really to define the class and then address the health endangerment question.

And the second part of our work would be to determine, based on that evidence, whether it's -- it's possible that there are other classes that are in the same position, that -- for whom we can't do dose reconstruction. Because as you recall, we're making this initial

determination based on having attempted to do a dose reconstruction and all the evidence we collect in trying to do that. But that evidence may also indicate that the class is actually broader than can be supported by just that evidence. If it is, then we'll sort of initiate in parallel an evaluation of that broader question: Is that class bigger than that evidence specifically supports on its own. Now reporting evaluation findings, we'll transmit the petition evaluation report to petitioners, the Board, and summarize the findings for the public in the *Federal Register*. When a petition results in multiple evaluations -- in other words, concerning multiple classes -- the evaluations could be reported together or in separate evaluation reports, so you're probably going to see a bit of both of this in this. If we can quickly determine there's one class that should be added, for example, and there's more work to do to evaluate other classes covered by the petition, you know, we'll bring forward to you as soon as possible the evaluation of the class that we can already determine. And we won't

hold that hostage to our work addressing other elements that are, in effect, covered by the petition, are there other classes.

The petitioners, as you know, will have an opportunity to address the Board. This may not always be in person. It may also be by phone or writing, as circumstances require. You know, as you can imagine, as we get going in this process and build up a number of petitions that we're dealing with in parallel, we will not be able to, as a Board, be in multiple places at one time. And so if a petitioner can't make it to the Board meeting and wishes to, we'll have provisions for them to participate by phone and they'll have the option always, of course, to participate by written comment to the Board, as well.

And just, again, to reiterate, the Board and OCAS will protect the privacy of the petitioners and others whose information is covered by the petition evaluation process.

Then I'll -- the next step then after the Board -- and I haven't presumed to lay out the Board's nuts and bolts for their evaluation of the NIOSH report and work and deliberation, but

subsequent to that, NIOSH will propose decisions based on its evaluation and the Board's work. And again, we'll propose multiple decisions responding to a single petition if the petition were determined to cover more than one class.

And petitioners will be notified of the remaining steps of the process and their right to contest certain decisions. Now they can contest two elements sort of of the decision. That's -- we considered at first. They could contest proposed decisions obviously that deny adding a class. They could also contest the 250 work day health endangerment criterion that might be applicable to that class.

And their challenges must show that the contested decision relies upon a record of substantial procedural or factual errors. This is just sort of standard criteria for such challenges.

And these challenges, when we receive them, will be reviewed by a three-person panel by HHS, which will make its decisions on a majority-rule basis, and provides for -- if they should need it -- a minority report, as

well.
The final decisions, the Secretary of HHS or his designee will make these final decisions. They'll be summarized in the *Federal Register* and transmitted to petitioners. Affirmative decisions will be transmitted to Congress for its review. As you know, they previously had 180 days. That's changed, and I'll talk about that in a second. And NIOSH will work with DOL -- I said DOE, but that's really out of date now that the DOL is -- is in charge of the whole program of EEOICPA now -- to publicize the addition of classes to the Cohort.
Now let me just talk a little bit about the EEOICPA amendments 'cause they have -- in effect will change some of this I've just talked about. The amendments require that NIOSH submit to the Board recommendation on a petition within 180 days, so that 180-day clock will begin when we have a petition that meets all the requirements. And it also requires HHS to submit to Congress decisions within 30 days following the Board's recommendations to add a class. And it requires NIOSH to report to Congress concerning the status of petitions

that were filed before October 1st.
There's also another -- I think maybe Jim pointed to this -- also another provision in there, which is I'm sure of interest to the Board, which is for the same group of petitions, petitions filed before October 1st, there's a provision that -- that if NIOSH completes its evaluation report more than ten days before a scheduled Board meeting, then there's a provision for us to convene -- and it's titled I think an emergency meeting of the Board to address that petition.
The other important change that I just -- I hinted at earlier was that the amendments reduce that Congressional review period from 180 days to 30 days, which is, you know, great really, because it means the decision by the Secretary to add a class to the cohort will become effective much sooner.
Now as I noted, these changes to EEOICPA are going to require for us to make some changes to our procedures. They're also going to require us to make some changes to the rule. And just to give you a prime example, if -- as is now -- the Secretary has only 30 days upon your action

to -- to make a decision and inform Congress of that decision, we're not going to have time to have a process of NIOSH proposing a decision, doing the deliberation and proposing a decision on the basis of the Board, and then having the petitioner with an opportunity to contest that decision and then for the Secretary to go through the process of deliberating on that contest and making a final decision. So this is going to mean changing the rule, and we've already begun that work.

And I think that -- thank you. So I'll be happy to take questions now on this or --

DR. ZIEMER: Thank you, Ted, and let's open the floor for questions now on Ted's presentation. Yes, Jim.

DR. MELIUS: Yeah, I have multiple questions, so if you want to interrupt and move on at some point --

DR. ZIEMER: Well, others can get their --

DR. MELIUS: -- but -- but I mean I'll start --

DR. ZIEMER: -- get their tents put up here in the meantime. We'll intersperse them if they're there.

DR. MELIUS: Could you or someone speak to the

issue of how you deal with multiple petitions on -- that come in -- I won't say simultaneously, but close to simultaneously on a given site?

MR. KATZ: Yes.

DR. MELIUS: And I have some follow-up questions after --

MR. KATZ: Sure. So -- and we have that, actually, when we have that -- maybe not simultaneously, but within the same span. It really only matters that they come in during the period before we've finished with an evaluation report. And -- and where they cover the same class, as I noted, they'll in effect be merged. Providing that each petition, you know, is qualified in its own right as a petition, then it'll be merged in the sense that the petitioners will together be treated as, you know, one group of petitioners and the content of their petitions will be considered in its entirety in the evaluation process.

DR. MELIUS: But -- and if I recall right -- I may not recall correctly, but there was also a provision where you can turn down petitions if they're sort of duplicative of another petition

that had come in or had been dealt with, even to the point of being evaluated earlier.

MR. KATZ: The --

DR. MELIUS: And let me just give you -- what my concern is is that there may be a sort of weak petition that comes in that you've turned down, and then someone -- another group puts in a much stronger petition, essentially covering the same potential class of -- and so forth. I think it'd be a concern that you not be -- that the second, better petition, so-called, not get turned down simply as being duplicative of the earlier petition. Now when they come in at the same time, you can sort it through easier, but -- but some people have raised concerns about this -- this issue.

MR. KATZ: That's absolutely true. I mean we did provide for that -- very clearly for that scenario, which is a petition that comes in later that provides a better basis, that additional information is why it wouldn't be turned down on -- sort of presumptively, just because we turned down the previous petition. So that would be considered in its own right, and with that better basis, it would go

through.

DR. MELIUS: Okay. Second question's concerned conflict of interest.

MR. KATZ: Yes.

DR. MELIUS: Are we going to have a process -- a transparent process for this in the sense that everybody that works on a petition would be listed in some way so we'd all be informed, as well as the petitioners be informed, of people that contributed to the evaluation of that petition? And secondly, can you sort of give me a little better sense of who -- what do you mean by primary reviewers and primary authors as how those are going to be defined?

MR. KATZ: Well, I think -- I mean the -- you know, we're just getting started and things will develop as we go, but -- but at this point at least, when the petition comes in it'll be assigned to someone who has sort of management responsibility for the process of -- of considering the petition as to whether it's qualified and the evaluation process and so on. Authors, there may be -- there may be several experts that actually author the evaluation of that petition. All of them -- all of them --

would be held to the same standard of not having worked. As far as -- as information for the public about who's working on the petitions, I mean that's a detail -- I don't know, but I assume that -- that NIOSH will do as it does with dose reconstruction and make those identities known and their -- as well as -- so you'll be able to see transparently that they don't have that conflict, that they don't --

DR. ZIEMER: Maybe Larry --

MR. KATZ: -- have employment history at the site.

DR. ZIEMER: -- can add to that.

MR. ELLIOTT: Yeah, I think this is a good point and we need to work on this as we proceed. Certainly we envision that the authors will -- names will be presented on the evaluation report itself so that everybody can see who worked on it. But we need to look at and consider how we make that even more transparent as the -- as the report is being drafted. And maybe that's an entry on our web site, maybe it's -- maybe it's simply talking to the petitioners and revealing to the

petitions who's initially been assigned to work on their report and where -- what their backgrounds are. Again, these folks -- all their conflict of interest disclosure is on the web site, so we can direct them to that -- to ORAU's web site. But I think it is a good point you raise, Dr. Melius, and we will have to be looking at how we make this as transparent as possible.

DR. MELIUS: Okay. Again, it's -- again, trying to be sort of preventive in our approach so we don't have questions raised later.

In your slide on evaluating health endangerment you used the term -- let me quote -- OCAS will determine whether exceptionally high level radiation exposures were likely or unlikely -- you changed it to not likely -- based on the qualitative evidence.

Where does the exceptionally high radiation -- high level radiation exposures comes from?

MR. KATZ: I mean this --

DR. MELIUS: I don't remember that in the rule and --

MR. KATZ: Well, it is actually in the rule, and it -- and it relates to -- and there's the

example given in the rule of criticality incidents.

DR. MELIUS: Okay.

MR. KATZ: But these are occurrences where it's -- we're talking beyond sort of mediocrity or whatever you may have in terms of a safety program to really the failure of protections.

DR. ZIEMER: Well, are those the cases where the 250 days is also waived?

MR. KATZ: That -- exactly true. That's what this relates to.

DR. ZIEMER: Right.

DR. MELIUS: As I recall it -- well, but the slide doesn't relate to that necessarily, and I'm just asking for -- the -- the test -- you don't have a test for exceptionally high level radiation. I think you used an example --

MR. KATZ: No, there's no litmus test, exactly right.

DR. MELIUS: -- you used as an example, and that's just what I'm --

MR. KATZ: That's right.

DR. MELIUS: -- trying to clarify, that's still just an example and --

MR. KATZ: That is just an example.

DR. MELIUS: Okay. Thank you. This is -- may be an observation I'm not sure you can answer. Your next slide called defining the class or classes, we have this -- the 250-day rule and so forth. I don't believe we still have come to grips with -- though we talked about it many, many meetings ago -- this whole issue of the overlap. You have somebody that's got 240 days and then has -- as part of the -- of a class, and then has, you know, whatever, six months of -- or three months or something or six years where they are not part of a class but have radiation exposure, we still have to sort of come to grips with how to deal with those people in terms of how -- how you evaluate and qualify them. Say if they don't qualify under their, you know, five years of non-class exposure and don't qualify under their 240 days of SEC class exposure, reasonably one might expect them to -- to be -- I mean there's going to be a cutoff there someplace, but it's just an issue that may come up, I don't know.

MR. KATZ: I mean it -- I mean I understand exactly what you're saying about being an issue

that we will -- I mean these will go -- their claim will go to the Department of Labor. If their claim doesn't meet the parameters, the 250 days, it'll come to us for dose reconstruction, and then we'll have the enterprise of reconstructing the dose. And all of -- to the full extent we can. And as we -- you'll see in the procedures themselves, as opposed to this presentation, we're going to be very clear that because we add a class, it doesn't mean that there aren't doses within that class that we can reconstruct. And so for a given individual, though we may not be able to reconstruct the doses for everyone in a class, we may be able to reconstruct the doses within that class period for that individual, if that makes sense.

DR. MELIUS: Let me -- I've actually got some more, but if somebody else --

DR. ZIEMER: Let's go to Mark --

DR. MELIUS: -- wants to ask some questions, then come back to me --

DR. ZIEMER: Right.

MR. GRIFFON: I just -- on your slide on evaluating feasibility, I was just a little --

and I understand the logic behind this, but it says OCAS will match the scope of evaluation to the scope of the petition basis. You know, my -- I guess my concern there would be that -- and we'll obviously learn as you go forward with some of these petitions, but my concern would be that it seems like it's a burden going back on the petitioners. Oftentimes you're going to have -- probably going to have groups of people that have their own personal information, personal datasets, personal experiences from their -- from their jobs at the site, and together they've -- they've realized, you know, whatever, this area that we worked in, they can't, you know, possibly reconstruct this dose. But they don't have a lot of support documentation. They're unable to get that documentation. So I think obviously -- and I think this is your intent, too, but obviously NIOSH has to pull those threads, so you might have a fairly thin proposal that has good merit, and if the thread's not pulled, you know --

MR. KATZ: Absolutely, and --

MR. GRIFFON: I just wanted to draw attention

to that.

MR. KATZ: I mean the point in that is that -- is that the issues that are raised by their petition basis are the issues that we'll address, not the depth of evidence they have regarding to -- regarding that particular issue or issues.

DR. ZIEMER: Okay. Henry Anderson?

DR. ANDERSON: Just kind of responding to the new, you know, review and calling special meetings and things like that, I think it'd be real -- I'm assuming you will have this, but it would be nice to have a time line so that now that you have, you know, a couple of these in, what -- you know, you aren't going to have a firm date necessarily, but as we now look forward three months out scheduling Board meetings, if you anticipate that you'll have something done at a given period of time, if we can get some sense of that in advance so that we don't get caught of -- all of a sudden it comes out and we have a -- have to meet very quickly, I think that'd be -- be helpful so that, even if it's between meetings, if you're going to adjust a completion date to -- so we

have as much lead time as possible, I think would be very helpful.

MR. KATZ: Right. I agree. I mean it'll be hard for us to pinpoint exactly --

DR. ANDERSON: Yeah, you know, it is --

MR. KATZ: -- when we'll complete an evaluation, but the thing that ought to put your heart a little bit at rest, in terms of this, is that this -- this applies -- this provision applies to petitions that were filed before October 1st. It expire-- so this is not going to be a condition for all petitions for all time. We will certainly want the Board to meet in an expedient manner when we have a petition evaluation done anyhow, regardless of this Congressional requirement. But the specifics of when we're -- if we complete one, you know, more than ten days before a planned Board meeting convening an emergency mem-- meeting of the Board, that -- that sort of provision expires March 1st and applies only to petitions filed before October 1st.

DR. MELIUS: You can rest easy, Henry. It's December 15th. I think we at least are -- don't have to meet again till after Christmas.

DR. ANDERSON: That's what I don't want to hear -- this oops, oh, by the way, you know, between Christmas and New Year's we have to meet.

DR. ZIEMER: Talk a little more about that. So the drop-dead date on that has passed. It's October 15th?

MR. KATZ: October -- for -- it's for petitions that were filed before October 1st, and the -- and the legal provision --

DR. ZIEMER: Do we know how many that is then and which ones those are?

MR. KATZ: Yes.

DR. ZIEMER: Right, so --

MR. KATZ: And -- and in --

DR. ZIEMER: So we'll know when the clock starts on each one.

MR. KATZ: Yes, and then the provision expires March 1st -- I think it's March 1st.

DR. ZIEMER: While we're talking about that, let me insert -- I'm going to ask Leon, could -- could you address the time issue, too, that was a concern to you at this point? Or does that address it, actually?

MR. OWENS: I think the issue that I had, Ted, was in regard to the dose reconstructions and

also the timing of reviews for the SEC petitions. And -- and it gets back to what Henry had said earlier -- also Dr. Melius -- when you receive the SEC petitions, I'd like to think that there may be some type of notification mechanism to the Board so that we would also be aware that petitions had been received, and then some type of time frame for when the Board might be expected to consider those.

MR. KATZ: There -- there is provision for us to notify you as soon as -- as a petition is qualified, which makes more sense than us notifying you for petitions that you wouldn't see. But absolutely. The question as to how -- sort of estimating how soon you would receive the petition evaluation, you know, that -- that's probably going to be hard to do at that point, initial point. But this Board meets frequently enough that, you know, certainly I think you're going to get plenty of heads-up as to, you know, when it's likely you're going to see an evaluation report. And we can obviously do that by e-mail, as well. It doesn't have to be only when we meet with you.

DR. ZIEMER: Okay. And let's go to Wanda next.
MS. MUNN: Our Chair knows things that I don't know, and when he says we know how many there are --
DR. ZIEMER: Well, I --
MS. MUNN: -- and everybody nods their heads up and down --
DR. ZIEMER: This is -- this is a --
MS. MUNN: -- this "we" does not know how many there are.
DR. ZIEMER: This "we" doesn't include me. This is a kind of encompassing "we" -- all of us.
DR. ANDERSON: The royal NIOSH "we".
MS. MUNN: Oh, that "we".
DR. ZIEMER: Ye know. Ye know.
DR. MELIUS: It's not "we"; it's someone knows.
DR. ZIEMER: Someone knows.
UNIDENTIFIED: Larry knows.
DR. ZIEMER: The Chair knows less than anyone else here.
MS. MUNN: May -- I am aware of only two. Are there more than that which are involved in this up-to-October-1st issue?
MR. ELLIOTT: There are -- I don't know right

now off the top of my head. I'm sorry, I should know this, I guess. I don't know how many we're talking about. It is -- it's very dynamic, these numbers. I mean they change, as our dose reconstruction statistics change. I know some of those we received before October 1st have already -- we've qualified and you have their evaluation plans in your hands for two of them. And some of those have found to be not qualified and they're on our web site, and I think we did notice the Board about that. If we have not, we will. Our intention is to, by e-mail, let you know when a petition has qualified or not qualified and placed on our web site. We'll notice you on that. But I don't have those numbers right today with me.

MS. MUNN: Okay.

MR. ELLIOTT: I don't know what -- what they are off the top of my head. I can say this, that at the February meeting it's our full intent, our plan, to have a evaluation report for Mallinckrodt and for Iowa in your -- in your meeting in February for your evaluation. We are working very hard toward both of those sites.

The Iowa site we have Q-cleared folks going -- working with DOE security experts looking at information that we were not able to put into our site profile originally and so we're working with that aspect on Iowa to determine whether or not we can get our hands on the information in a timely fashion in a content that makes rational sense in whether we can do dose reconstruction or not, so we're working toward that end.

And for Mallinckrodt it's a different set of circumstances. As you know, we had a -- had a portion of the site profile that was reserved because of the early years when we couldn't find enough data, so we're looking at that very -- very critically right now. And so we're planning to bring those two before you in February.

MS. MUNN: Thank you.

DR. ZIEMER: Richard?

MR. ESPINOSA: Just a point of clarification. The only people that have received the SEC on the Army ammunitions and the Mallinckrodt was the working group, not the whole Board.

MR. ELLIOTT: The working group did receive a

copy of the evaluation plan and the petition submittal, yes. But the whole Board should have been notified, I think, by e-mail -- or noticed that we had qualified those two and put them on our web site.

DR. MELIUS: I think it came in a Chris Ellison --

MR. ELLIOTT: Yes, it came --

DR. MELIUS: -- the web site update e-mails.

MR. ELLIOTT: It's a web site update e-mail from Chris Ellison.

DR. MELIUS: Which I never open till the next day 'cause the web site isn't up-- she always -- I mean which is good she notifies -- she always notifies us in the morning saying it'll be ready, you know, later in the day or the next day, and so I always ignore them until, you know, a few days later, so...

DR. ZIEMER: Go ahead, Jim, you have another question.

DR. MELIUS: Okay. I have a few more questions. Under -- you had a slide called evaluating petitions under 83.14 and then you referred to the fact that ORAU was going -- these are the ones that you would generate the

evaluations or the classes by not being able to complete the individual dose reconstruction. You said ORAU was going through your claims now trying to identify potential classes -- I think that's the right term -- under this provision. Could you talk a little bit about what criteria they're using for making that evaluation?

MR. KATZ: Well, I -- I don't know what specific criteria they're using, but -- but their -- I have some knowledge of those claims for which they have little information and I think --

DR. MELIUS: Yeah, I'm not looking for names or places, I'm just trying to get -- sort of understand the process --

MR. ELLIOTT: Let me answer that question, if I may, and maybe Dr. Toohey will stand up and help me here. But you know, we've charged them with screening all the cases that we have in our hands that are not being worked on, trying to determine what information is necessary to complete a case.

DR. MELIUS: Uh-huh.

MR. ELLIOTT: And along with that effort, we've asked them to look very diligently and very

critically at whether or not a dose reconstruction can be done for a case.

DR. MELIUS: Uh-huh.

MR. ELLIOTT: And if it can't, let's get that on the table right away. So I don't know if Dick wants to add to that, but I think -- you know, he might be able to embellish my comment a little bit there.

DR. TOOHEY: Yes, we are actively working on that. In fact, it's worth some points in our six-month evaluation plan we have. It's been incentivized and we owe NIOSH the report by the end of December. And just to tell you what we area doing on it is just creating a matrix of all the sites, and the first thing we are reviewing is the information, the data we already have on hand for that site and is that adequate to support at least an exposure model, like -- like we generated for Bethlehem Steel. Second thing to look at is if we don't have data for that specific site, do we have enough process knowledge to use data from another site. For instance, Simonds Saw and Steel, Bethlehem, other rolling mills, like that. And then the third thing to look at is okay, in

our data capture efforts that we've done so far, even though we don't have all the data, we have some idea of the data that are out there, even if it's not in hand, and we'll cross-compare against that.

So the final product that we hope to have will be this matrix of what our best guess is, the data we have on hand, data availability, other ways to characterize exposure, and do we think we can in fact at least be able to put what is required for the SEC evaluation, an upper limit on exposure. So that will be the product and hopefully we will have that in.

DR. MELIUS: And I would presume the process would work the other way, too, that if we have identified -- approved a class and went through the whole process and so forth, you'd then be going back through and pulling the people already through the system and -- into -- into the class.

MR. ELLIOTT: Yes, we would, absolutely. As soon as a class is identified, we'd be looking at our case load, working with DOL to notify all people who fit into that class, so they're aware that they may have a status in the class.

DR. MELIUS: The other -- and this is a comment more than a question. You indicated that when you're evaluating a petition that would concern potentially multiple classes that you would -- might divide that petition up and do part of it first and then -- because the second part might need further evaluation that you would split it up. And I think that -- that's good, particularly if there's going to be a long time period before you're going to be ready with the second evaluation, though given the Congressional deadline, I'm not sure that there's a lot of time -- do that, and how often this will practically fit. I do just think early on in this process that there's some advantage to not splitting up too much and letting you work through the process, and also the Board, look at these in a broader sense at least that -- that we don't look at six different evaluations of Mallinckrodt, for example. And I don't remember what's in the petition. So that as we're -- as we're figuring out how to evaluate this, we're not sort of evaluating one class in one way and then suddenly saying well, gee, if we had

thought about that, maybe we need to think about another class in a different way. And in some sense we're setting precedent with these early ones, and I get worried that we -- if we try to divide it up too much we're going to --

MR. ELLIOTT: Yeah, I don't think that --

DR. ZIEMER: There are going to be some differences, though --

DR. MELIUS: Oh, yeah --

DR. ZIEMER: -- as well as some similarities.

DR. MELIUS: Yeah.

DR. ZIEMER: And are there any separate time clocks then that are established once the splitting is done? Well, I mean --

MR. KATZ: No, I'm -- that's a fair question. The 180 days -- I mean --

DR. ZIEMER: I mean I can see one subset that might take considerable effort to, in a sense, qualify -- or maybe it's qualified at the front end and then you split it, I'm --

MR. KATZ: It's really --

DR. ZIEMER: It seems like a practical question there.

MR. KATZ: It's really -- yeah, and it's really also a legal question as to how you would

interpret that 180-day requirement as to whether it is for addressing all classes covered by a petition or whatever we find are covered by a petition, or that we at least address one within the 180 days. That's a -- also a legal question.

DR. ZIEMER: Yeah. I'm sorry, go ahead.

DR. MELIUS: But -- but -- I guess maybe before you -- Liz -- I guess I would also see you coming to the Board with an evaluation for, you know, three sort of classes, say -- this group's -- and the Board saying okay, two of them -- this is fine. Three, it really would be helpful to have this kind of --

MR. KATZ: That's why I say --

DR. MELIUS: -- evaluation done or further information or something and -- and splitting off. And then I guess how we deal with 180 days in that and so forth...

MR. KATZ: But -- I mean I think -- and then I'm going to let Liz go, but in that term, in that case, where the Board sends us back to the drawing boards, in effect, I certainly think that the 180-day would have been fulfilled by coming to you.

DR. MELIUS: Yeah.
MR. KATZ: Because the Board is not under a time limit in terms of its work and its sending us back to the drawing boards is sort of a component of that.
DR. MELIUS: We -- however, we shouldn't take too long or I'm sure -- I have a feeling Congress might --
DR. ZIEMER: Liz might have some additional --
DR. MELIUS: -- tighten up the Board --
DR. ZIEMER: -- input on that.
MS. HOMOKI-TITUS: No, all I was going to say is that those type of issues will be addressed in the new rule, so you'll see HHS's interpretations coming out in the new rule on that, which I believe is going to go through public comment and all that kind of stuff.
DR. MELIUS: And if you could stand there, 'cause I think my final question is about the new rule. What -- are you going to do that as a draft rule for public comment? Have you decided where that stands? What's the plan?
MR. KATZ: That'll ha-- that -- we can't decide that on our own, so that ultimately will be an HHS sort of -- it needs a lot of legal advice,

the decision, but just at NIOSH we're assuming at this point that it -- that it might be an interim final rule because -- because we have these requirements and right now our rule is out of sync with them -- these statutory requirements. I'm sorry, Liz.

MS. HOMOKI-TITUS: I'm not sure I have an answer for that question right now 'cause it's just not a decision that HHS has made, and all I can go off of right now is what NIOSH is working on.

DR. MELIUS: Okay.

DR. ZIEMER: Yes --

DR. TOOHEY: May I make a comment?

DR. ZIEMER: -- Dr. Toohey, yes.

DR. TOOHEY: Regarding Dr. Melius's earlier question on conflict of interest, I just want to clarify one point on that. The same thing applies to dose reconstructions, site profiles and SEC petitions. You do not prepare, review or approve any of these if you worked at the site. But that does not preclude us, in the case of site profiles and SEC petition reviews, from having people who did work at the site serve as site experts and contribute their

knowledge and expertise to that preparation.

MS. MUNN: We need that.

DR. TOOHEY: And of course we can list that --

MS. MUNN: We really do need that.

DR. TOOHEY: -- on the report, which is what I think you really want to see. We would have author, contributors, site experts.

DR. MELIUS: And I would also hope to avoid that very awkward situation where we had -- where we were implementing new conflict of interest -- in the rules and in your contract that got hung up for a long, long time and --

DR. TOOHEY: Well, that -- the new policy is in place and, as you know, it's on the OCAS web page. You'll -- before too long you'll see it in slightly different format. We're entering it into our controlled document system as an ORAU team policy, but won't really change anything in there except maybe the ordering of the paragraphs. And that does apply across the board.

When we implemented that policy, you'll also recall we did grandfather in some of the site profiles that were already in preparation at the time, but I think all of those are due into

NIOSH by the end of this year. And on our second round of site profiles that we're currently doing, those COI requirements are in effect.

DR. MELIUS: Okay.

DR. TOOHEY: Thank you.

DR. ZIEMER: Okay. Gen Roessler.

DR. ROESSLER: Ted, you have a bullet in your slide on reporting evaluation findings that woke me up, and I think now that I've read it several times I understand it. But let me read the bullet and tell you what my first reaction was and then what I think it really means.

It says (reading) Petitioners will have an opportunity to address Board in person, by telephone or in writing, as circumstances require.

Well, I'm sure that "by telephone" part means that the telephone will be in the middle of our room, and my first reaction was the petitioners would have a list of the Board members with telephones, but I'm sure that means it'll take place in teleconference or during a meeting.

MR. KATZ: Yes.

DR. ROESSLER: Okay.

DR. MELIUS: I actually had --

DR. ZIEMER: Jim, go ahead.

DR. MELIUS: I had another comment. Thank you for reminding me. But I would just -- I think I've made this at other meetings, also. To the extent that it's feasible, and it may not always be feasible 'cause we may be reviewing multiple petitions, so forth -- I think to the extent that we can be holding our meetings when we're reviewing the evaluation in geographical proximity to the petition site, I think it would be helpful. There -- there is a role for the petitioners and we should try to provide them with access to the meeting in person rather than by phone or otherwise and -- now again, it may not always be practical, but I think it would be helpful and helpful for the credibility of the process.

DR. ZIEMER: Thank you.

MR. GRIFFON: Just --

DR. ZIEMER: Mark?

MR. GRIFFON: Just one last thing. Your last bullet, Ted, that 30-day statutory deadline may prevent HHS from providing petitioners with opportunity to contest decisions, is that sort

of an unintending consequence of the amendments, or...

MR. KATZ: Well, I don't know -- I don't know the intent.

MR. GRIFFON: Yeah, and the second thing -- I guess it's just for consideration. And the second thing is, is there any vehicle by which you can say if petitioners contest, then that clock stops or something like that? Is there a way to keep the ability for petitioners to contest in there 'cause I think --

MR. KATZ: There's sort of a -- I mean that's, again, in a sense a legal question.

MR. GRIFFON: I guess that might come out in the regulation --

MR. KATZ: It'll certainly be addressed --

MR. GRIFFON: Right.

MR. KATZ: -- you know, in the regulation.

DR. ZIEMER: If there were some way for the rule-making to abide by the intent of the legislation and still provide a mechanism for that to occur, it seems to me it would make sense. But we don't know -- or maybe we do know how rigid that -- it certainly seems rigid as it's defined in the law. Is that correct,

the 30-day?

MR. KATZ: It seems pretty clear, plainspoken --

DR. ZIEMER: Well, I mean 30 days is pretty --

MR. KATZ: No, I mean --

DR. ZIEMER: It's not 29.

MR. KATZ: No, I understand what you...

DR. ZIEMER: But is there any wiggle room --

MR. GRIFFON: Right.

DR. ZIEMER: -- because --

MR. GRIFFON: I guess that's what I'm asking.

DR. ZIEMER: -- we don't know the intent, but I think Mark has suggested that it might in fact be an unintentional -- what's the word we want -- unintentional consequence of -- unintended consequence, really.

MS. HOMOKI-TITUS: We're not in a position to answer that right now.

DR. ZIEMER: No, I know, we're speculating here, but just pointing out that that might be in fact something that wasn't realized at the time.

MR. KATZ: And you certainly understand it's not in our interests to -- I'm sorry.

MR. MILLER: I had some proximity to this

provision and --

DR. ZIEMER: Okay, Richard, we'll allow you to speak. We'll make an exception --

MR. MILLER: Very briefly, just on the 30-day question. All Congress is doing is rolling it back. Right? From 180 to 30 days? Merely what's called a notice and review provision, so when you have notice and review, it's only if they want to take legislative action to stop a Special Cohort petition, say through some suspension calendar bill. Am I wrong on that?

MS. HOMOKI-TITUS: (Off microphone) I think (unintelligible) talking about the 180 -- the provision that the Board makes a recommendation and then HHS has to --

MR. MILLER: Okay. I stand corrected.

DR. ZIEMER: Thank you. Okay, any further comments or questions on --

MR. GRIFFON: Just --

DR. ZIEMER: -- the procedures?

MR. GRIFFON: I just have one last one, but I think it rolls into our next working session, so it'll probably be a pre-break kind of comment. The -- you said Mallinckrodt and Iowa would be ready for -- likely ready for the next

meeting, or hopefully ready for the next meeting. The question I have is, you know, do -- do -- this brings up the contractor question. I'm -- I'm concerned that when we go to review these petitions that we may need technical assistance, and we don't have a task for the contractor. We have a provision in the task order contract, but we never created a task for SC&A to help us -- and specifically I can see situations where we run into this "sufficiently accurate" sort of dilemma, and I'm just wondering -- I don't think at this point we have time to get a task out and have it ready by the next Board meeting, but I'm just -- I think we might want to at least discuss that in our next -- next --

DR. ZIEMER: We can certainly do that, and perhaps having one of these that comes to us directly and we can make a determination to the extent that we think we need additional assistance on that effort. But we don't know a priori what we're going to be looking at and -- and the extent to which we might need, or not need, such assistance. Jim?

DR. MELIUS: Yeah, I would just say, if I

understand the deadlines in the process correctly, is that NIOSH could present its evaluation to us. We're then going to decide, you know, do we need assistance, and at least hypothetically I suppose we could try to do a task order to do that. I think the delay in there is probably too long and I think we're much more likely to be in the position of doing it for future evaluations. So I think having the -- the other test of this in some sense, we should -- I hope -- have the site profile review for Mallinckrodt by the next meeting, which would tie it -- and I think would be -- help us sort of inform us about how to -- how to handle future situations, as well as they hopefully would be helpful in evaluating the -- NIOSH's evaluation of the Mallinckrodt petition. Now for Iowa we're not going to have that same -- we're going to have to decide, but it may -- sort of have to wait and see.

DR. ZIEMER: Any other comments?

(No responses)

DR. ZIEMER: Okay. Then we're pretty close to being on schedule. We'll take our 15-minute break and then reconvene.

(Whereupon, a recess was taken from 10:00 a.m. to 10:20 a.m.)

SEC PETITION REVIEW PLAN WORK GROUP

DR. ZIEMER: We're ready to reconvene our session. The Board has had a work group called the SEC petition review plan work group which was chaired by Robert Presley, and that group has met by e-mail or telephone between -- between our last meeting and this meeting to review the SEC petition review plan. And Mr. Presley's going to tell us briefly what the work group did and what their recommendations are. And as he does that, let me remind the Board -- I think all of you received a copy -- or did they all receive a copy? Yes, of the -- of the petition review plan -- should be in your file -- in your book here somewhere.

MS. MUNN: It is. It is.

DR. ZIEMER: Yes, it's in the tab.

MR. PRESLEY: Our findings are in the book.

DR. ZIEMER: SEC petition review plan and work group report. Let's see, the work group report is there. I'm looking for the plan itself.

MR. PRESLEY: The plan itself is not in there, I don't think.

MR. ELLIOTT: No, it's not, it's only the report.
DR. ZIEMER: Was the plan -- the plan distributed to the --
MS. HOMER: What's in the binder is what I received.
DR. ZIEMER: Well, the plan itself, was that distributed to --
MR. PRESLEY: That was only --
DR. ZIEMER: Board members got the plan, either on the web site or --
MS. MUNN: I think it was on the web. The committee received it in hard copy, but I believe it's on the web.
MR. PRESLEY: I don't think the -- the Board didn't get it, just the committee. It went to -- just went to four members on the Board is who's addressed at the bottom of them.
MS. MUNN: It's very brief.
DR. ZIEMER: The evaluation plan is simply a two-page document.
MR. GRIFFON: Is it available here? I don't have a copy.
DR. ZIEMER: And I want to make sure that Board members are -- I have a copy.

DR. ROESSLER: We just have a letter.
MR. ELLIOTT: My apologies, I thought this -- the two-pager was going to be prepared for you, and we'll get it prepared and get it copied and submitted.
DR. ROESSLER: We have a memo.
DR. ZIEMER: You have a memo from Mr. Presley, which is -- which is the --
MR. PRESLEY: That's our findings.
DR. ZIEMER: The group evaluated NIOSH's plan as to how they would evaluate the petition. That plan is a two-page description of what they plan to do. This work group has reviewed that plan and has developed this set of recommendations.
But Robert, why don't you proceed and we'll make sure that the plan itself is in your hands here momentarily.
MR. PRESLEY: Okay. We are called the petition review working group. We had a conference call on November 23rd at 3:00 p.m. Eastern Standard Time. Those present were Wanda, Jim Melius, myself. Richard was unable to attend but did get back for a comment, and also Dave Sundin was our government official for the meetings.

The topics of discussion were use of available data. It was noted by Wanda that the Technical Basis Document from the Iowa Army Ammunition Plant referred to information on medical screening data collected and archived by the University of Iowa, College of Public Health, on IAAP workers, but that no summary or comment regarding that data was evident in the report.

Second, use of records and documented information from other production and assembly facilities, in addition to Pantex, PNNL -- Pacific Northwest -- may be used to complete the qualification process for SEC and the petition evaluation plan.

Third, the Advisory Board on Radiation and Worker Health experience and knowledge is critical to the evaluation of each petition for the SEC.

Those were our discussion points as noted by the people on the committee.

Recommendations and findings were we, the specified working group, have no major findings with regard to petition evaluation, SEC-00006. However, the working group does have recommendations that, number one, the Advisory

Board request NIOSH to be diligent in obtaining and documenting all available data on their worker population, particular including any statistical significant -- and there should be data seen at the University of Iowa research data -- or Iowa research data.

Number two, any records or documented information that may exist for similar production activities from other nuclear weapons production and assembly facilities throughout the United States be used in the review process.

Three, if classification or declassification of records becomes a hindrance, the Advisory Board urges -- the Advisory Board urge DOE to undertake, in a timely manner, whatever action is necessary to provide the required information in a usable format.

The conference call was conduc-- was concluded at 3:21 p.m.

DR. ZIEMER: Okay.

MR. PRESLEY: I will say that I think that every one of these items that we discussed in our discussion about the evaluation plan was discussed in the last three days, about NIOSH

coming up with -- talking to the outside people and gathering all the other information. Are there any questions before I make one last comment?

DR. ZIEMER: Appear to be none -- oh, yes. Yeah, Leon.

MR. OWENS: Bob, in regard to recommendation number three, is that the issue relative to clearances?

MR. PRESLEY: No, sir, that's not. That -- that problem arrived when -- we have -- NIOSH goes into a place to get records and they say you can't have those records, they're classified. Then we urge DOE to do whatever it takes to either redact those records or get them declassified in a timely manner so that NIOSH can use them. That's what that is. And they're -- they're having some problems --

DR. ZIEMER: It's not -- it's not the --

MR. PRESLEY: No, it has nothing to do --

DR. ZIEMER: -- individuals, it's the material.

MR. PRESLEY: Right, this is the material is what this -- what this represents.

DR. ZIEMER: Other questions? We'll act on this in a moment. You said you had an

additional comment, however.

MR. PRESLEY: I have -- I have one more comment. We've talked about this. We have the Mallinckrodt petition review in our hands. It came in last -- mine, I think I got it Saturday.

DR. ZIEMER: Review plan, not --

MR. PRESLEY: Review plan. I think this one came in Saturday before I left on Sunday. I read it on the way out here. I've gone over it one time. What we're doing is evaluating the plan that NIOSH uses to evaluate these things. My estimation, the plans are going to be almost all the same each time we do this. If you go through the two plans from Iowa Army Ordnance and the evaluation plan from Mallinckrodt, they're almost the same.

My recommendation would be that we right now say that the plans look good and we not meet as a committee on each one of these petitions -- petition plans, and that we let them do their work and we spend our time and effort when the plan comes back for the full Board for review. Now that's not to say that I won't be more than happy to do this, and I would like some

discussion on this, but I -- I see the plan as being almost identical for each one of these things. There may be a few things that would be different, but --

DR. ZIEMER: And that may ac-- that -- that will actually be a separate issue --

MR. PRESLEY: Yes --

DR. ZIEMER: -- from the recommendation --

MR. PRESLEY: -- right.

DR. ZIEMER: -- here, but Larry, did you have a comment on that? And then I don't believe there's a requirement that the Board do an evaluation on those plans, actually --

MR. PRESLEY: Right, there's not.

MR. ELLIOTT: That's right.

DR. ZIEMER: I believe NIOSH asked us to do that, at least on the first one, but I don't know that there's any requirement in either the regulation or the procedures that require that.

MR. ELLIOTT: That's correct, there is no requirement that the Board approve the plan. We felt that it was important to us to hear the Board's input and comment on these plans, seeing this is the first one. We do see these as -- the plan you have looked at and the rest

of the Board will soon have a copy of that plan, as well, I hope, this morning. These are generic in their structure. They're basically an outline of our approach to evaluating the petition and coming up with an evaluation report.

We agree and find your recommendations on this first review to be very important to us and we will address those. We have addressed those. Perhaps we didn't factor those into the outline as best we could to let you know that yes, we do have DOE's full support. We have our Q-cleared folks working through the data. We did not specify in the plan the type of documents that the University of Iowa holds, but we understand that's of interest to you.

We can do this however you wish. You know, if you say today that you don't want the working group to continue in evaluating the plans, we can still provide the evaluation plans for each petition to the full Board, just so that you can see what we're -- what we're doing and what we're approaching. And if you have any comments, you -- we still would love to have them. It's your choice.

DR. ZIEMER: Okay. Thank you. Jim and Wanda?

DR. MELIUS: Just to follow up on that, the evaluation plan -- not everybody has seen it -- it's very general. I'm not sure that at this point in the process that we could expect a more detailed evaluation plan. And some of the genesis of this group was trying to -- would our evaluation -- evaluation plan assist if we were going to be confronted with a full evaluation at this meeting. It turns out we're not.

I think we may, as a next step, want to come back and look at this issue after we've seen a couple of evaluation plans, and we may have some general recommendations at that point in time as to what should be the content of the evaluation plan. As well as NIOSH may -- as it gains experience doing these evaluations, you know, decide to organize them differently or -- or whatever, and --

DR. ZIEMER: So you concur with Bob's statement that probably the working group doesn't need to look at each of these evaluation plans as we go forward, at least for now?

DR. MELIUS: At least for now, correct, yeah.

DR. ZIEMER: Thank you. Wanda?

MS. MUNN: I guess I have a slightly different perspective. It appears to me that even though the general template may be the same for most of the reviews that we can anticipate, it's also very obvious to me that every petition is going to have some uniqueness to it. And until we have a few of them under our belt, it would seem wise to me that we have a working group that does in fact try to evaluate how large those differences in approach might need to be, given the unique nature of each of the petitions that we get. I think in the long term I probably will agree with Bob. But at this juncture, this is too fresh, too new, in my view, for us to make that step quite so completely.

DR. ZIEMER: Let me raise, though, in that connection, a practical matter. And maybe the working group can help us with this. Let's take, for example, the Mallinckrodt plan, which is the next one in line, and the work group has that plan. Now if you were -- if the work group were to meet and do what you did on this one and come back to the Board and the Board

have to approve that before NIOSH proceeds, it seems to me we have a very practical problem because we're looking toward having the Mallinckrodt evaluation at our next meeting. And unless this Board wishes to meet again, either by conference call or in person, to act on that individual item, then we have a practical issue as to what to do -- unless the Board wishes to authorize the working group to review it and to pass their comments along. Anyway -- yeah, so could you respond and --

MS. MUNN: Yes, that latter suggestion was what I had in mind, that the Board review -- report to all the members of the Board essentially the -- what we just saw, that that go to the Board as soon as possible after the working group has looked at it, just our -- our statement that we've looked at it and this is --

DR. ZIEMER: But the Board cannot act on that unless we formally meet. That's my point. Jim, you had a comment.

DR. MELIUS: Yeah, that was just what I was going to reiterate, also. And I guess I would see more utility to -- if I'm -- I'm sort of guessing at the number of evaluations we're

going to be seeing and how soon we're going to be meeting again, but that -- that we may again want to empower another working group, after we've seen a couple of evaluations, to sort of review what ought to be the content of the evaluations and make recommendations at that point in time, rather than -- I think that might be more useful than an ongoing process to review each evaluation plan.

DR. ZIEMER: Is there any reason, however, that the plan, such as this plan, the plan for the next -- the Mallinckrodt petition can be made available and Board members individually comment, or are you able to use that if they don't represent any kind of consensus? I'm not sure --

MR. ELLIOTT: No, first of all, we didn't give you this for approval. We're moving forward. Okay? And anything you give us is going to be considered in our effort to research and evaluate the petitions.

DR. ZIEMER: Yeah, but I'm asking -- you don't necessarily need consensus --

MR. ELLIOTT: No, no, I do not.

DR. ZIEMER: -- comments. You can utilize

individual comments.

MR. ELLIOTT: I can utilize -- we can -- OCAS can utilize individual comment on these evaluation plans if that's your pleasure.

DR. ZIEMER: Okay. We'll take that up in a moment then, in terms of what the Board wishes to do. Let's take action -- the recommendation from the working group represents, in itself, a motion. It doesn't require a second. It's those three recommendations that Bob enumerated. Is there any further discussion on the recommendations of the work group?

(No responses)

DR. ZIEMER: If there are not, are you ready to vote on accepting those recommendations? All in favor, say aye?

(Affirmative responses)

DR. ZIEMER: Are there any opposed?

(No responses)

DR. ZIEMER: Are there any abstentions?

(No responses)

DR. ZIEMER: Then those become our recommendations and we thank the work group for taking that issue and preparing this recommendation for us.

Now do you wish to discuss the issue any further on providing input on the Mallinckrodt -- Larry's already indicated that the -- the plan -- the review -- what's the proper name? The petition review -- petition evaluation plan for Mallinckrodt will be provided to all Board members. He has indicated that they will be glad to have individual comments. Does the Board wish to proceed in that fashion? It doesn't necessarily take a motion, but I'd like to get some feel -- if this is how you wish to proceed.

In the absence of any action to the contrary, that's basically what will happen, because you will get the document and you're welcome, of course, to provide individual comments. So unless we have a motion to act in some other manner on this next one, that's basically kind of the default position. Does that seem to be agreeable?

Well, one or -- one or two are agreeable, I --

MR. PRESLEY: Well, we'll go -- we'll go do them, but --

DR. ZIEMER: The rest are still numb. Okay, I think -- I think we're going to proceed on that

basis.

MR. PRESLEY: Thank you.

DR. ZIEMER: Thank you.

MR. ELLIOTT: So has the working group concluded its effort?

DR. ZIEMER: The working group has concluded -- and keep in mind, working groups, in a sense, are ad hoc. They have -- they have carried out the mission that --

DR. MELIUS: The working group has expired.

DR. ZIEMER: They have carried out the responsibilities that -- for which they were appointed. I think they can be reactivated later, but they -- they cease to exist, I believe.

MR. ELLIOTT: Yes. So I'll make sure that we get the other Board members who weren't on the working group a copy of what the working group got. And if you individually have comments, you can send those by e-mail or however you wish to us and we'll carefully consider those.

DR. ZIEMER: Okay. Thank you very much.

BOARD WORKING SESSION

I'd like to outline for the Board very quickly items that we have to address

during our working session -- or sessions -- so that we can kind of judge time and so on. And I believe -- Henry, you're leaving at noon?

DR. ANDERSON: Yeah.

DR. ZIEMER: So we need to select those issues that we want to address -- those things we want to do once Henry leaves.

DR. MELIUS: Form a new working group.

DR. ZIEMER: I have on my list the following items. I want to make sure that the charge to the new working group that's going to monitor the -- the final dose reconstruction report, that the charge to them is clear. I have it written out before me, based on our minutes -- or our comments yesterday and I want to make sure that's clear.

We need to address the handling of future site profile drafts. I believe that's the one that we wanted to address while Henry was still here, actually.

We need to talk about future meeting times and places.

I actually have on my notes that we still need to act -- take final action on SCA's quality

assurance and conflict of interest plans. You may recall at our last meeting there were some primarily editorial changes, but there were a large number of changes that SCA wished to make -- just some wording things, mainly. There were no substantive changes, but we deferred final action on those till we got the clean copy. That clean copy -- I'm not sure it's in the book. Maybe it is, I haven't looked, but I know it was distributed by e-mail earlier.

MR. ELLIOTT: It is in the book and you were -- it was submitted to each member by e-mail.

DR. ZIEMER: So we also need to take action on that. I don't anticipate that that will be long or prolonged, but just to outline those items that have to be taken care of, and then there may be some additional housekeeping issues that Cori wishes to take care of, as well.

DR. MELIUS: I have one --

DR. ZIEMER: Are there some other items that I've overlooked in terms of this working session?

DR. MELIUS: I have one, and I may have missed it 'cause I didn't attend the subcommittee

meeting the other day. But I believe that SC&A had raised some issues about access to -- site access about Q-clearance issues and about getting some information, I believe from NIOSH, I can't recall specifically --

DR. ZIEMER: Well, I don't think that was part of that session, but those -- those issues were raised, I think in some separate letters that --

DR. MELIUS: Right, and my question is that do they need to be discussed or have they been resolved or -- I guess I'd like some feedback on them and --

DR. ZIEMER: Yeah, let's --

DR. MELIUS: -- at some point that could be --

DR. ZIEMER: -- have that as an item, the status -- I'm just going to call that status of SCA access. That's -- I think basically has to do with -- it's more in the Q-clearance issues. I'm looking for John -- it's the Q -- the Q-clearance issues, is it not, John?

DR. MAURO: Yes.

DR. ZIEMER: So we'll put that on the agenda, as well. And -- other items? Mark, did --

MR. GRIFFON: Yeah, just -- I think we need

more discussion on the function of the dose reconstruction subcommittee.

DR. ZIEMER: Okay, yes.

MR. GRIFFON: We've done one item out of eight scope items, at this point. We're down to case selection is all we really have been doing --

DR. ZIEMER: Yes.

MR. GRIFFON: -- and I want -- you know, going forward, how --

DR. ZIEMER: Okay, thank you. Let's start with going forward on this site profile drafts issue. That's one that Henry wanted to be present for. Let me begin that discussion by outlining what I think are the issues, and then the rest of you can help clarify it.

Perhaps the overriding issue has to do with the status of the contractor's report to the Board in the interim period from when the report is completed to the time of the open meeting where the report is discussed. The report is identified -- at least has been identified, I believe from kind of a legal point of view and from the Department's point of view, as a work product that is subject to certain kinds of constraints. One of the issues, as I

understand from the discussion that arose, was the extent to which those legal aspects completely bind us to a certain kind of action, or is the Board in fact in a position -- if it wishes -- to allow the document to be viewed sort of in the open market prior to the Board's having discussed it or indicated any kind of position on it and that sort of thing. Is that -- that's the nature of the issue, I believe, is it not? Right.

DR. MELIUS: My understanding of the issue was that it is a HHS policy, and so I think the nature of any action we would take would be a recommendation I guess to the Secretary that that policy --

DR. ZIEMER: If we -- if we wished to somehow --

DR. MELIUS: -- if we wished to do -- yeah, there's a conditional -- maybe Liz can --

DR. ZIEMER: Liz, can you -- can you speak further to that maybe?

MS. HOMOKI-TITUS: No, actually I can't. That's what I was going to say is the Department doesn't have a policy on that right now.

DR. ZIEMER: Does not have a --
MS. HOMOKI-TITUS: There's a legal determination that has to be made and the Department's going to have to take it up -- well above NIOSH. But Dr. Melius is absolutely correct, if you all have a position on that and want to make a recommendation to the Secretary, you're welcome, but we can't give you guidance on that right now.
DR. ZIEMER: Okay. Do -- we don't know whether or not there is a policy or...
MS. HOMOKI-TITUS: I'm not sure that they have -- as far as these documents go, I'm not sure that they've established a policy. But I can assure you that we don't have a legal position on them yet.
DR. ZIEMER: Yeah, I understand then. Okay.
DR. MELIUS: But -- but you did take an action on these, so --
MS. HOMOKI-TITUS: We --
DR. MELIUS: Yeah.
MS. HOMOKI-TITUS: We did take an action on this first set of documents, but you know, this is a learning process for everyone and the Department now realizes that this is an issue

and it's something that we need to legally consider, as well as determine what our policy's going to be, and that hasn't been done yet. But you act as an advisory board and if you want to advise the Secretary on it, we would --

DR. ZIEMER: Sure.

MS. HOMOKI-TITUS: -- obviously welcome your input.

DR. ZIEMER: Right. Thank you. Okay. So that -- that's sort of the framework, and before maybe even getting a motion before us, maybe we can have some general discussion and kind of learn where people are coming from on this. Henry and then Jim.

DR. ANDERSON: I guess my issue was one of there were public comments, critiques, rebuttals by Department of Labor and NIOSH to a document that, you know, others had not seen so that you have basically a critique by -- a public critique without the public having an ability to review what are they actually critiqueing and are those critiques -- do they make sense. I think that -- to me, that was one of the issues. It's sort of like having a

medical journal write a negative editorial about a manuscript that hasn't been published yet. It isn't out there in the public yet. Now if the NIOSH comments and other comments were similarly not going to be anything but communication to the Board, then I see it a little differently, but it just seemed to me, on a fairness issue, it's very hard to judge the -- or assess the credibility of critiques if you haven't had an opportunity to see what's being critiqued.

DR. ZIEMER: Uh-huh, To-- no, let's see, we had Jim and then Tony, okay.

DR. MELIUS: And just in follow-up to that, I think there's that point. There's also -- I think Tony made the point yesterday that -- I think he used the term real world, I don't recall specifically, but that we were not in the real world, but we're -- part of the real world we're in is a Federal advisory committee that's supposed to operate in the public, that -- I think we've operated in the sense -- and NIOSH has -- that this -- given some of the past issues with DOE and this kind of a program that it was very important that we operate as

open as possible, that our processes and so forth be as transparent as possible, and that we try to maintain, you know, openness with the public and with the people affected by this -- this program. And having a document labeled as not being available to the public raises issues and I'd just like to pass to the Board -- I'm not sure everybody got a chance to see this, and I believe there are copies in the back for the public, also. I mean this issue on the Bethlehem report made the -- an editorial on the Buffalo news. I'm sure you've read it in Wisconsin or --

DR. ZIEMER: It's one of those papers we all read on a regular basis.

DR. MELIUS: -- you know, what's new in Buffalo, but -- but I mean they raised I think legitimate concerns, at least their perception was that this is an issue that people should be open about and so forth. We also had, you know, a group come from Buffalo by train all the way out here to listen to us review report and -- that they hadn't seen yet, they hadn't had an opportunity to see until they got to the -- the meeting. It's a long enough report that

it took many of us some time to struggle -- struggle through it. And I just think in the interest of the credibility of this program of being open that we should, you know, in the future let these reports be in the public domain. I think we probably should indicate that they are a draft report, indicate that the Board has not accepted them yet or endorsed them yet, however we want to view that process, but that we would have a process where we would make the reports available or -- through NIOSH. Again, there may be privacy concerns, so there could be a review for Privacy Act issues, make those available. And as NIOSH completes its review, that document would also be -- become available. And then at the next meeting, you know, we would discuss and take whatever action's appropriate. But I think it would improve the credibility of the process and make the public less concerned about -- that there's some secret information that we're withholding from them or that is not going to be allowed to be -- be available.

DR. ZIEMER: Tony?

DR. ANDRADE: I suppose I wouldn't be -- I

wouldn't be as concerned as I am currently about making predecisional drafts available to the public if -- if there was some sort of very, very strong communications process at our disposal that would ensure that everybody -- everybody, from the senators on down to the worker at any of these facilities, or claimant or whomever, public in general, knew darned well that anything that is written in these predecisional drafts is subject to being completely erased, completely voted out, that anything there is only the opinion of an assessor. Okay? I don't like the fact that we had to go into -- well, okay, that's a different issue, and that's the fact that, you know, we had to debate this -- at least the site profile stuff publicly because that turned into the sort of thing that you expect at a closeout meeting after any assessment. And so they even go -- even -- I think that even if they had had the information available, I think they would have walked out of here just as confused and frustrated as -- as perhaps some of us were.

So I still see that there is, without some sort

of proviso process -- okay? -- in place, the potential for misinterpretation and for misuse of data -- and frankly, I don't trust the senators and I'm -- or let's say politicians in general. I'm not going to point to anybody in particular. There -- there could be, quote, errors that have been pointed out in -- in a predecisional draft by an assessment team, which in-- which indeed turn out not to be errors, and they're really only indications that there need to be further clarifications made in the way approaches are taken by NIOSH in determining some aspects of a site profile. Some of those data that are -- are brought to light by the assessing team are norm-- are normally, the first time out, taken by newspapers and editorial and newspaper people who are not technically qualified, taken to be the final product and put out as though that is going to potentially be the policy that is adopted.

And then raw data and/or scientific -- new scientific methods for looking at data, these -- these really can be used to further the political agenda by allowing politicians to use

these to make statements that are derogatory to our work. And frankly, I am really, really hot under the collar to hear that we're supposedly an obstructive body -- okay? -- that we are not doing our -- last night it was made clear to us again that we're not doing our jobs -- not by the senators, but by a member of the public. In other words, the data is taken and twisted. And so, again, I am not against completely -- or completely against hiding this stuff, but there has got to be something that is put right on the front cover that if you take this then -- at face value and you think this is a final product, you are really stupid. I mean it's got to be just about that strong.

DR. ZIEMER: Okay. Leon?

MR. OWENS: Dr. Ziemer, I think everyone on this Board knows that the members serve at the pleasure of the President of the United States. And for that reason and that reason alone, this Board is political. I think that we hear the word transparency used just about every meeting, and I think it's incumbent upon the members of the Board to ensure that the public perception of this Board is maintained and --

and the credibility of the members of this Board is maintained.

If a document is stamped "draft" and is provided, each of us have no ability to change the perception of individuals who read that, but we are aware that it is a draft. And then once a document is stamped "final," I think that individuals are of the intelligence to recognize that that means it's a final product. So I'm hopeful that in the future documents of this nature can be provided to the public for their purview, along with the responsible members of the Congressional delegation who created and enacted this legislation that allows us to have these type of debates.

DR. ZIEMER: Thank you. Wanda?

MS. MUNN: If we lived in a perfect world or had no basis for making a judgment on issues of this sort, I would have no qualms with what we did with any predecisional document. We do not live in a perfect world, and we have more than adequate evidence of what happens when predecisional documents are made public. Given that background, it seems to me that the old adage that those who do not recognize history

are doomed to repeat it is one that applies in every respect to what we are deliberating here. A predecisional document is a predecisional document. Individuals who seek to identify any single statement in any document that will support a contention that they hold closely, whether it is factual or not, will use that information in every way that they can. Predecisional documents should be treated as predecisional documents and published at the time that they have been fully vetted by the organizations responsible to do so.

DR. ZIEMER: Okay. Thank you. Roy?

DR. DEHART: I don't think there's any other way to word the audit report other than saying it's quite negative to the NIOSH dose reconstruction process. That's the way the report is written and comes across, at least to me. It will probably be misinterpreted or interpreted as being a very negative slam to NIOSH, and to anybody who has had a dose reconstruction done, particularly if it is a dose reconstruction that does not reach the 50th.

We can argue that we can clarify that, that we

can take care of some misinterpretations, that we can bring intelligence and science to bear that will soften that. But once it's in the press, once it's in the mind of the worker that they are being had by an unfair dose reconstruction, you're not going to change that. And I would hate to see us go forward to publicly release that document until we've been able to resolve the issues as best we can and know exactly what that document is saying with regard to the dose reconstruction that NIOSH has been performing.

DR. ZIEMER: Okay. Thank you, Roy. I'm not sure who was next.

DR. MELIUS: Mike was next.

DR. ZIEMER: Mike?

MR. GIBSON: Thank you. It appears to me that based on most of the comments I hear from the general public and constituents around my area that they already think they're had. And I think the more that we keep documents that people know that may be in draft form and we keep them behind a closed door, so to speak, until we get them finished, I think that's going to further the case to make them feel

like that they're being had.
A second issue I have here is in this -- this report, and maybe it's just the way it was written by the reporter. In the fourth paragraph it says that NIOSH and the compensation board agree that until the draft has been reviewed by the Board as a whole, releasing any information would pose an unnecessary confusion.
"Compensation board," is that referring to us?
DR. ZIEMER: We're not a compensation board. I'm not sure who that's referring to. I don't know where that comes from. This Board never made such a statement, that I'm aware of.
MR. GIBSON: I would hope not 'cause I was never polled on anything like that.
DR. ZIEMER: No.
MR. GIBSON: But I am in support of -- of making our working documents and drafts available to the public. Again, I agree with Leon. This is nothing but a political environment and there's nothing we can do to help that.
DR. ZIEMER: Jim?
DR. MELIUS: Yeah, a couple of clarifications

on this issue. I think one is that the drafts we're talking about are not -- it's not like writing a series of drafts of a final report and releasing. We're talking about a report that -- it is a -- has not been reviewed officially by the Board, but that same report, once we get to a meeting, is released. I mean it -- so we're talking about from the time the report is completed, sent to -- sent to the Board and the next public meeting. The next public meeting, it's -- once we take it up as an action, it's released. So it's not like we're -- it's a series of drafts and we'd be releasing each draft or that we're taking action that actually changes what will be released to the public -- and do that.

And secondly, to Wanda's point of repeating past mistakes of history or not remembering what's happened to history, well, you've got to remember a large part of the history here has been a -- what many people view as a cover-up of information about their exposures and -- and about the potential harm from that exposure. So there's a high degree of suspicion out there that this Board and this whole program is just

continuing that cover-up. And while we all can -- may disagree with that, I think we have to recognize that that is a pretty strong perception. And again, I can't see the risk of harm -- I believe that the risk of harm from not releasing the report greatly outweighs the risk from any harm from -- from the report in terms of misperceptions and so forth. You know, providing that we release it in a way that clearly indicates that it is not a -- that it is -- the Board has not reviewed it, that it's something that's going to be discussed at the next Board meeting and we may very well take action that would reject or refute certain findings of the report.

DR. ZIEMER: Thank you. Gen?

DR. ROESSLER: I think we have no choi-- I don't like this microphone -- no choice but to release it, make it open and available to the public. But I think -- think there's a down side that, in view of what -- our experience with this one, is that once we do that, I think the discourse that scientists normally have to -- to discuss something and reach a consensus will become less forthright. It'll become less

detailed. It'll -- maybe fewer pertinent points to be discussed will come up. And this -- this might be because we understand that the public doesn't under-- really understand how scientists discuss things. It seems more like a debate rather than evaluating different points, and so I think we might lose some of that value that we would normally get.

DR. ZIEMER: We'll come back to Tony in a minute. We've heard a lot of items. If I might have permission from the group -- normally Chairs don't enter debate, but I'd like to weigh in myself, if -- with your permission.

At the front end of this process I felt that it was important that things not be released because of the possible misuse and things that have been described. I'm now pretty well convinced that any such misuse will occur regardless. The document is now released. And honestly, the Board does not have a defined or an ultimate position on the document that would be very useful in quelling any misuses. We can't say well, that's what the document said but here's what the Board thinks. Anyone who

is going to put that forth as the right answer to whatever issues they want to be addressing I believe will do that anyway. So that the issue of its being available a couple of weeks early -- it was a little longer period this time, but in general, we're talking about a few weeks earlier before either -- either the proper or the improper uses get underway. And therefore it seems to me that the -- the only thing that we would have to do, from a -- kind of almost like fiduciary point of view, being responsible, is to make sure that it's clear at the front end that this is not the Board's report at this point. This is the contractor's view that we are going to consider. In that sense, if people end up misusing it, which I would -- I'm pretty well convinced if someone's going to misuse it, they would do that anyway. They would say well, here's this document -- I mean regardless of what action the Board took later, and the misuse might occur.

But it seems to me, in light of some of the things we've heard and seen, if we can find a way to make it possible for the information to be out there, almost like -- almost like a

rule-making, which is out there and people can comment on it, and it may end up very different. If someone wishes to use earlier versions of things on down the line, they do that to their own peril. But the process may in fact be iterative. It is turning out to be iterative on this first document. So that it's not clear to me as I look at what's happened that it would have made much difference, honestly, if the thing had come out a couple of weeks ago because regardless of what happens -- say in New York and amongst the senators -- we would be saying well, that's not the Board's position yet. That's just a piece of information that we're going to consider.

As far as the proprietary stuff, if the contractor knew that it was going to be out there on the street right away, I'm sure they're not going to put any proprietary information -- they wouldn't, anyway. I don't believe there is any, so it doesn't seem to me that that's an issue.

So -- and I share all the concerns that have been raised by the folks, and you know, I sort of polled the Board early on when I got the

letter from Senator Clinton to -- and then realized I still couldn't respond to it, under our operating rules -- and we were honestly split. And I think there's valid concerns on both sides of this, the concerns for misuse and all of those, and yet the concerns for transparency. And if we can find a way to say look, we do want to get the document out there -- and to some extent, this puts an additional burden on the contractor because they don't want to end up looking stupid, either. That's not a good way to do it, but they don't want to look like they've completely missed the boat by putting out stuff that is not factual and is not well-thought-through. So they're going to -- they're going to be extra cautious, too. They had a little protection in this round 'cause the product's not going to come out till there's these iterations, kind of before it's out there in the real -- real world. But it seems to me that it puts an extra burden on the contractor to make sure that they've covered all the bases, too. And maybe that helps give a better product, also. I don't know. These are just -- they're kind of top of the head,

but I've been mulling this over for several weeks 'cause I've had all kinds of folks after this thing and, you know...

DR. ANDERSON: Going through your garbage, things like that?

DR. ZIEMER: Right. And you know, in a way, we can't accommodate everything, but we need to find the best way to do this that protects the integrity of the product and yet provides a level of transparency that we need so that we have credibility in the process. So -- now --

MR. PRESLEY: I agree with that.

DR. ZIEMER: -- I'll get back into my role as moderator. Tony?

DR. ANDRADE: Actually what I've heard from -- from Jim and from yourself, Paul, is something akin to what I was trying to bring forth in my first comment, and that is that if there is a strong enough cover page, set of provisos, what do you call those things that --

DR. ZIEMER: Yeah, the caveats that --

DR. ANDRADE: The caveats --

DR. ZIEMER: -- explain exactly what this is --

DR. ANDRADE: Exactly.

DR. ZIEMER: We could probably leave out the

statement about being stupid if you use it.

DR. ANDRADE: Exactly. I mean almost to that degree. I would not be against -- I think that we would all agree that we would -- I would not -- we would not be against releasing this to the public. And we know that there are shady characters out there that would use it to their own -- for their own purposes, and that's too bad. But at least the well-informed and the well-thinking citizen will probably act responsibly.

But just throwing it out there without any such caveat I think would be dangerous.

DR. ZIEMER: Robert?

MR. PRESLEY: I've held my comments. As somebody that's worked with audits and assessments for the Federal government for probably about the last 30 years, I do know that if you send things out prematurely that they will be used wrong. There's people out there that that's all they look for to tear groups and officials down. But I do think that there is a way that we can put these documents out with some type of caveat on them that this is a preliminary draft, preliminary, draft,

whatever you want to put on this thing, and get them out to the public.

I do think it's going to open up some discussion down the road, and we as a Board will probably have to defend some of the actions in that, that people are not making the right decisions and things like that. But as long as we do these with the right caveats, I have no problems with putting them out. But to just open them up to the public the day they come out, no.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah. I guess I'd like to get ready to offer a motion here if it's timely, but let me sort of describe the process to make sure that everyone's in agreement and that it covers certain issues, is that I would be ready to offer a motion that we do reco-- I guess recommend to the Secretary that we release the -- these draft reports to the public; that that be done in a manner that includes on the cover page a statement describing that this is a draft report that has not been reviewed nor accepted by the Board yet, nor -- and that NIOSH has not had -- yet had the opportunity to

comment on factual or other information that's in the report or -- in the report.

Then I think we have to modify our process for these reports so that rather than having -- us receiving them directly from the contractor, that when a report is ready to be transmitted to us, it would go to NIOSH; that there be an opportunity for review of that report for any Privacy Act or other proprietary information; that then at that point it be transmitted to the Board and at the same time that NIOSH make it available on the web site. And I believe the best place for that would be under the site profile documents where you have a space for -- where you -- for -- for public comments on the site profiles, where you sort of collect those. Now you may have to -- probably should label it some way, but I think that's the best place to put it and would also link back to the -- to the Board, Advisory Board part of the web site, also.

So that would make it publicly available, would have appropriate disclaimer on it, and I think would satisfy a need for Privacy Act and other -- other review. I guess I'm concerned that if

we receive a report from the -- our contractor and -- directly and then it goes to NIOSH and they find a Privacy Act issue, then we're going to have two versions of the report and that's just going to open ourselves to problems as to -- you know, somebody asks us for a copy, we give them the wrong copy or something like that.

DR. ZIEMER: Could I ask, Liz, is -- is that, the Privacy Act review issue, a -- is that a required step or can the contractor agree to have it waived?

MS. HOMOKI-TITUS: No, the contractor can't waive the Privacy Act. That would have to go through our privacy office to be cleared. They -- I don't know why they --

DR. ZIEMER: That's to make sure that they're not --

MS. HOMOKI-TITUS: Right, and they --

DR. ZIEMER: It's not their -- it's not business confidential issues, it's --

MS. HOMOKI-TITUS: Yeah, if they --

DR. ZIEMER: -- issues that can -- I'm with you now. Yeah, yeah, yeah. Yeah, Mark and then Roy.

MR. GRIFFON: Just one more before he makes the motion there. I -- I'm just reflecting a little on Gen's comment, too, and I think, you know, the really -- I -- I agree, by the way, that I think we need to release this, and -- and two or three weeks staggered is not going to make a difference and so forth, but I -- I think of the -- this iterative process and I think that Jim makes a good point that -- and I think we -- we see it spelled out in this Bethlehem Steel site profile process. The -- there was an iterative process before a report came from the contractor to the -- to the Board. In other words, NIOSH was involved in a factual accuracy review meeting with SCA, I believe --

DR. ZIEMER: That was separate, and I think factual accuracy --

MR. GRIFFON: Right, right --

DR. ZIEMER: -- would still occur --

MR. GRIFFON: -- no -- no -- yeah, but -- -- yeah, the only -- the only point I wanted to make was that there was no iterative process where the Board was purviewed (sic) to those discussions and I think maybe we -- sort of

like that iterative process that we just set up with the dose reconstruction case reviews, we might want to have some sort of Board role --

DR. ZIEMER: Actually, let me correct that. The instruction before was that the Chair of the Board would be informed of the issues, which I was, that were raised by NIOSH. And I was provided actually with that and a transcript by SCA of the meeting with NIOSH, so --

MR. GRIFFON: Oh, okay.

DR. ZIEMER: -- that information -- and that was on the instructions of this Board to -- that the Chair be informed of the exchange, so we had an independent paper trail of what -- what discussions went on between the contractor and NIOSH so they're not just working off here by themselves. So I was --

MR. GRIFFON: Okay, I guess --

DR. ZIEMER: -- provided with that.

MR. GRIFFON: I guess my -- my hope was that maybe in the -- going forward we can alter, strengthen that iterative process so that hopefully we can have, at that level, some -- some comment -- some resolution to -- to the

first publicly-released report, and that may go to -- what I'm trying to get at is Gen's question of some -- you know, real dialogue between -- over -- over differences in findings, and it might happen easier prior to two publicly-released positions that -- that differ greatly, so I'm thinking, you know, maybe there's a different iterative process that can go on, but I think it's critical that we have Board involvement in that somehow, but it couldn't be subcommittee or full Board because then it's a public meeting.

DR. ZIEMER: Right.

MR. GRIFFON: You know.

DR. ZIEMER: Right.

MR. GRIFFON: So the work group --

DR. ZIEMER: A comment from Jim here.

DR. NETON: I just wanted to comment on the -- the iterative process, which was really just a factual accuracy review. And under the ground rules laid out -- I think by the Board -- and adhered to by SC&A, we -- we had very limited opportunities. Factual accuracy was just that, and we were not requested to comment on any conclusions that were drawn or any assumptions

that were made in the document itself. So this was really just a -- a calculational data type review or a misinterpretation of the regulation, and we had a very limited time -- I believe it was five days or something like that. I think we met it in seven, but you know, to review an 80-page document in five or six days is not reasonable.

And I would also comment that the day that it's released as -- by the Board, I can guarantee NIOSH is going to be asked for their comment on a document that they have not had a chance to look at the final version, and it's going to put us in a very difficult position. But that's just my opinion.

DR. ZIEMER: And it's even pos-- the iterative process that you're talking about might include a step which allows NIOSH to develop comments so that they can be released together or something like that. That's also a possibility, which would -- which -- but does that occur before the Board sees it? Because at the point the Board sees it, we're talking about that's presumably the release date that we're talking about, the date that the document

comes to us.

DR. MELIUS: Can I just comment on that? Roy, if you don't -- I just think we -- we also have to remember we have to avoid a perception that NIOSH is somehow involved in censoring the report from SC&A and so forth. So I -- as much as we would like to get resolution, I don't think we can expect complete resolution without running into other dangers.

I would also think the factual -- there's a -- attached to this report was a memo describing the factual exchange and so forth, that when NIOSH does have its comments prepared on the document and it -- that those would also be posted on the web site, and those don't necessarily need to be a complete set of di-- and if you, you know, want to be split in parts in order to be more timely on certain issues or something that, you know, that NIOSH has prerogative to do, I don't see a problem with that. And I think if we keep them together that once -- you know, we -- again, depending on the timing of some of these issues, we may get them two weeks, you know, before the Board meeting, whatever, but at that point NIOSH

would -- they'd be there. They'd be in the same place on the web site. People would be able to read both of them.

DR. ZIEMER: Well, in fact the Board will be in the same position, in principle, because that's what happens. Reporters call and they -- they want to know what the Board's position is on this, you know, and I would have to say well, the Board has not reviewed this yet. And you would end up in the same position. I know, it's -- it's tougher for the Feds.

DR. NETON: Right, I got the distinct impression from the first round of this, though, that what's going to happen is when the Board receives the report they'll conduct a meeting and forward a copy to us for review and say please provide your comments. So I'm not sure whether it's -- at that time it's appropriate or just to pre-stage it and get your comments at the same time. It's sort of -- you know, if you get the copy and then forward it to us and we comment, does it really make a difference? I mean we're not editing the document, we're just commenting on it. We would not be allowed to do any revisions at

all, but just to prepare some comments so the Board could get them in a more timely manner.

DR. ZIEMER: Uh-huh. Okay. Roy?

DR. DEHART: A point of clarification. We keep referring to the SC&A audit of the Bethlehem site as a draft. Was it a draft? Wasn't that a final report to us?

DR. ZIEMER: I believe that was SCA's final report.

DR. DEHART: Yes, so I think that's important that we -- it's not a draft.

DR. ZIEMER: We're using it I think here in our discussion -- the word draft in the context that we're actually envisioning some kind of an iterative process. But in fact the contractor's report is the contractor's report. Under our task, that's the deliverable, and they deliver their report to us. And in fact, at some point -- we've gone through a process which we didn't envision at the front end, but down the road, perhaps at the next meeting after we have the exchanges that we've described in our motion, this Board is going to have to come to grips with specific items. We cannot just say you guys go off and work this

out and let us know what you decided. We will have NIOSH's view on those issues. We will have the contractor's view. We -- we will then have to say to the Secretary we agree with this or we don't agree with that, or we would like additional emphasis put on this or that. We will have to specifically take a position of some sort.

Now keep in mind that doesn't mandate that NIOSH necessarily do anything. It's a -- it's a recommendation to the Secretary. But we're not off the hook by saying you guys get together and work out these scientific issues. If there -- there can be very valid, good scientific disagreements. That's the nature of science, and I -- I always take a little exception to people who try to characterize those as adversarial things. It's the nature of science. It's a kind of collegial adversarial relationship where we argue our positions. I don't know who had said something like that, but the point is that I don't think we should expect that somehow all of these things are going to go away by the groups talking to each other. There are some valid

different points of view, which could very well remain. That's the nature of the process. Actually it's one of the reasons that the audits are done is to bring in another possible perspective that may or may not eventually change the final product. Preach it, Brother. Okay.

MR. GRIFFON: How about a motion?

DR. MELIUS: I'll make a mo-- okay. We're ready. I move that the Board recommend to the Secretary of Health and Human Services that the contractor -- our -- SC&A -- our contractor's reviews -- report on the review -- site profile reviews be released as a public document at the time that they are -- the final report is conveyed to the Board; that that public release include a statement advising the public that this is a report that's not been accepted by the Advisory Board and there's not been an opportunity for full review by NIOSH of the report; and that the Board will be reviewing the report and may have findings and recommendations relevant to the report at future public meetings; that the process for doing -- making the report public would also

include a Privacy Act and -- review of the report before it be made available to the -- to the public.

MR. GRIFFON: Is that it?

DR. MELIUS: That's it.

DR. ZIEMER: Is there a second?

MR. GRIFFON: Second.

DR. ZIEMER: Okay. Is there discussion? We've had a lot already that, in essence, pertains. Tony?

DR. ANDRADE: I'd like to offer an amendment. Rather than include all of the wording with -- that detailed what -- what the provisos might be, why don't we just say with appropriate caveats, and between now and say our working time this afternoon I'd be willing to work with anybody here or I could do it myself in developing a cover sheet that would have a list of caveats.

DR. ZIEMER: Are you offering that as a possible amendment right now?

DR. ANDRADE: The amendment would be to strike the specific wording on what would go on the cover sheet from -- from Jim's statement -- from Jim's motion.

DR. MELIUS: Can I offer --
DR. ZIEMER: Is that a friendly amendment, Jim, or --
DR. MELIUS: It's a friendly amendment, but I would just like a clarification. I was not trying to specify the wording of the cover sheet. I would expect it to be lengthier. I was trying to describe in general the wording, but not specify the wording, that it could very well be longer and I have no objection to --
DR. ZIEMER: Here's a -- here's a way you could include those, to include appropriate -- or have appropriate caveats, including -- 'cause you have two -- you at least want it to indicate that it hasn't been accepted by the Board, whatever words that takes, nor that it's been reviewed by NIOSH. There may -- and you're saying yes, and there may be some other caveats.
DR. ANDRADE: Exactly.
DR. ZIEMER: So perhaps I'll interpret the motion as -- as including the words "appropriate caveats, including" those two that you mentioned. Is that agreeable as a friendly --

DR. MELIUS: As a friendly amendment, yes.
DR. ANDRADE: That's agreeable.
DR. ZIEMER: So that we're sure that at least two topics are addressed in the list of caveats. And it would be understood that the exact wording of the appropriate caveats would be worked out and would not necessarily be part of the motion. Is that correct?
DR. MELIUS: Correct.
DR. ZIEMER: So the motion is that the Board recommend to the Secretary of Health and Human Services that future SCA site profile reviews -- review reports be released to the public at the same time as they are released to the Board, with appropriate caveats, including a statement indicating or advising that the report has not yet been accepted by the Advisory Board, nor has the report been reviewed by NIOSH. Prior to the release a Privacy Act review by NIOSH would also take place.
Is that the motion?
DR. MELIUS: Yes.
DR. ZIEMER: Okay. Further discussion? And this -- this, if it's passed, would become a

recommendation to the Secretary of Health and Human Services as a policy -- as a policy for the Board or for the agency, and it would -- basically we would be asking then that the policy allow this, and the Secretary could say yea or nay.

DR. MELIUS: Yeah.

DR. ZIEMER: That's understood then?

DR. MELIUS: And just another -- another clarification is that I'd leave it up to NIOSH to decide how to make it publicly available, where on the web site and so forth. I don't think we should specify that.

DR. ZIEMER: At this time.

DR. MELIUS: At this time. Let -- they may want to think about it.

DR. ZIEMER: That's a mechanical thing that can be -- and this doesn't address other process issues, such as the one that -- as this stands now, Jim, I think this says it's going to be out there before you have a chance to do anything about it.

Let me ask also this question. Is there now an acting person who could actually do something about this before -- is confirmation going to

come pretty fast? This is almost off the record. We don't know, but I guess confirmation will be coming pretty fast, from what I read in the papers on the new candidate for --

DR. MELIUS: But somebody is acting, so I think...

DR. ZIEMER: By the time this gets up and into the system --

DR. MELIUS: You may have trouble how to address your letter, because it could happen while it's --

DR. ZIEMER: To whom it may concern.

DR. MELIUS: Be careful, Paul.

DR. ANDERSON: Dear Secretary.

DR. ZIEMER: Well, I have a bit of a concern on the timing issue, although actually there won't be a big lag time before our next meeting and the other reports. This -- the chance of this being approved before our next meeting may be fairly slim. But I don't think there's a big time lag involved between when we would get it and when our meeting occurs. I mean we may -- we may need to operate under what we think the policy is now, unless it can -- unless we can

find out one way or the other, we don't know. We don't know.

Are you ready to vote on the motion then?

Okay, all who favor this motion signify by saying aye.

(Affirmative responses)

DR. ZIEMER: And those who oppose, say no.

(No responses)

DR. ZIEMER: And any abstentions? We have one abstention. The record will show that Wanda abstained. The Chair has voted yea.

Then I declare that the motion has carried.

Thank you very much.

Yeah, Larry.

MR. ELLIOTT: I think you do need to come up with whatever the cover sheet will say and give that to your contractor. I -- I don't know where they're at with regard to the last -- to the next three site profiles. My understanding was Mallinckrodt, Savannah River and Hanford were very close, should be at the next meeting -- is that right, February meeting, Dr. Mauro?

DR. MAURO: The only proviso is we are awaiting certain documents with respect to --

MR. ELLIOTT: You're not on there, sir.

DR. MAURO: The answer to your question is yes, regarding the three site profile reviews, with the exception of Savannah River, which might be delayed. We are currently awaiting certain documents that we requested in a letter that we submitted to you folks. As soon as those documents come in, we will move expeditiously, so it may be possible to have all three reports.

MR. ELLIOTT: But the point being is at least one or more are coming for the February meeting.

DR. MAURO: Yes.

MR. ELLIOTT: And in order to comply with the intent of your -- of your consensus here, you're going to need to provide that so that your contractor can put that on the cover to effect the transmittal to us.

Let me just explain -- my reaction to the Bethlehem Steel site profile, when I sent out my e-mail, was that it come as a final report, which it wasn't. It is final for the contractor, perhaps, but it's not final as a decisional document. That's why I sent you the e-mail. That's why it was labeled

predecisional, do not disclose. I remind the Board that this is -- you had a pilot process here. You agreed to a process, and I think we all can go back to the transcript and look and see where you talked about it being a pilot, a learning experience.

I have been dismayed by this process, actually. I think it has been disjointed and I look forward to working together with this Board to make it a more transparent process, a more informative process. But taking this motion now, we're going to have to go back and Liz and the general counsel team are going to have to look at what can be done and what cannot be done. And we're going to have to do that very quickly, because we're anticipating that in February you're going to want to deal with the next set of site profile reviews that come forward. And whether we can get anybody in the Secretary's Office to respond --

DR. ZIEMER: Well, that's why I asked --

MR. ELLIOTT: -- to your -- to your motion, I'm not sure --

DR. ZIEMER: -- the question because I'm not sure it will be in place in time for that

meeting, which means that we're under the present conditions.

MR. ELLIOTT: My intent here is -- I've heard you out, and we want to proceed as best we can here. So please come forward --

DR. ZIEMER: And we can go ahead and get the language that we'll --

MR. ELLIOTT: -- yeah, come forward with the language so that your contractor can put that on there, and that's going to I think go a long way toward putting a document out there that would be construed by the public as a decision of this Board. And that's what you want to avoid until you have your deliberation and you come to consensus, and that's what we're waiting on, your consensus.

DR. ZIEMER: Thank you. Jim and then Wanda.

DR. MELIUS: Yeah, two things. One is that I agree on the language and we should be ready to implement this. I'm not sure where the decision point is in the Department and whether -- you may very well be able to reach a decision at -- at some level while this is going on, and maybe by the time it comes back down from the Secretary it's -- the point may

be moot. It may have to go up through the Secretary and sit there. It's hard to tell -- and do that. And I think we have to recognize we're putting you in an awkward position of -- you know, if someone raises a fuss about the next report, you know, you're going to have the Board on record saying it -- it should be this way, so hopefully it could get resolved sooner rather than later, but I think we recognize the frustrations with that.

I think it's also we may look at this process, you know, a few site profiles down and maybe want to change it in some way. I think this is the best we can do at this point in time, and we'll have to continue to look at how to best work this -- this overall process.

DR. ZIEMER: Wanda?

MS. MUNN: In the interest of collegial discussion and suggestion, it would be awfully nice if the individuals who were very strong in their concern with respect to how we approach these things and worked to make sure that -- that the Buffalo News and various elected officials saw our deliberations as being inadequate, it would be very nice if those same

individuals now pointed out to them what efforts the Board had made to bring the light of day to the transparency that was so desirable, and that perhaps the same kinds of -- of effort could be shown in a positive light, now that what we have undertaken today is in fact complete.

DR. ZIEMER: Thank you very much for that comment.

Are there any other comments? After lunch, during our work session today, if we're able to we may be able to work on some wording. And Tony, if you want to do a straw man for us between now and then, that would be great.

DR. ANDRADE: Okay.

DR. ZIEMER: Then let's recess for lunch for -- until 1:00 o'clock.

DR. ROESSLER: Do you have Henry's travel schedule?

DR. ZIEMER: Oh --

DR. ROESSLER: He's going to leave.

DR. ZIEMER: Henry, we're -- yeah, you need to make sure Cori has your availability dates when we talk about...

(Whereupon, a lunch recess was taken from 11:45

a.m. to 1:05 p.m.)

ADMINISTRATIVE HOUSEKEEPING

DR. ZIEMER: We'll continue this working session for this Board meeting. We have some housekeeping items to take care of, the first of which will be scheduling of future meetings. I think many of you already know that, partially as the result of non-availability of room space in the Tampa area, we're not able to schedule our February meeting in Tampa, as originally anticipated.

Plan B I believe was St. Louis, and we need to re-examine calendars so that we give Cori some flexibility in trying to find some time there. We actually are thinking about looking a little later in the month for St. Louis, because if we go first week of February, we're only six weeks off, which really pushes some of the things that are in the chair -- pipeline for us that might not otherwise even be ready. But we're wondering how the calendars are the second and third week of February.

DR. ROESSLER: The third week is the Health Physics Society meeting in New --

DR. ZIEMER: I have it down for the second.

DR. ROESSLER: I have it down for the 13th through the 16th and 17th.
DR. ZIEMER: I do, too, is that the third week?
DR. ROESSLER: Well, I call it the third week.
DR. ZIEMER: Oh, okay. So when you said second week is a possibility, then --
MS. HOMER: I was meaning the 7th through the 11th.
DR. ZIEMER: Oh, 7th through the 11th. Well, let's check -- 7th through 11th, let me see who's got serious conflicts 7th through the 11th.
DR. MELIUS: I have them at the end of the week.
DR. ZIEMER: Early in the week is okay?
DR. MELIUS: Early in the week is okay.
MS. HOMER: 14th, 15th and 16th are okay?
DR. MELIUS: No, no --
MS. HOMER: I'm sorry, 7th, 8th and 9th are okay.
DR. MELIUS: 7th, 8th and --
DR. ZIEMER: Others have conflicts earlier in the week there? And you have Henry's calendar?
MS. HOMER: I do, but not in front of me, unfortunately.

MR. GRIFFON: He's no good for February.
DR. MELIUS: He's said February's bad.
DR. ZIEMER: Regardless, so we may have to go ahead without him.
DR. MELIUS: I mean I -- well, those following weeks are bad for me.
DR. DEHART: The following weeks I'm out of country.
DR. MELIUS: Yeah, country, and I mean I don't see what we gain by moving a week.
MS. HOMER: We gain a week.
DR. ZIEMER: We gain the ability to find a hotel. This just gives you some options. Right?
MS. HOMER: It gives me some options, yes, and it gives a little extra leeway for, you know, preparation and working through the holidays.
DR. MELIUS: I mean I don't mean to cause a hard time about this, but we all work our calendars around these dates. I've changed a whole bunch of things that would have been the week of the 31st in order to keep that week open for you, and now you change it and -- and you change it -- you know, you changed it two weeks ago it would have helped me a lot.

MS. MUNN: It is a problem.
DR. MELIUS: I mean I understand your problems. I don't want to minimize those. But...
MS. MUNN: Yeah, my -- my personal issues around changing this California meeting were just enormous, affected every member of my family.
DR. ZIEMER: Okay, you have the information.
MS. HOMER: I do.
DR. ZIEMER: We're not --
MS. HOMER: I do.
DR. ZIEMER: -- locking that date in, we're --
MS. HOMER: Okay.
DR. ZIEMER: -- simply trying to provide some options in terms of --
MS. HOMER: Did we --
DR. ZIEMER: -- flexibility.
MS. HOMER: -- want to look anywhere in the future?
MR. ELLIOTT: Cori, before we go there, though, can we just --
DR. MELIUS: Cori --
MR. ELLIOTT: I'm sorry, Jim. Go ahead.
DR. MELIUS: I just was going to speak to Henry Anderson. I know if we're going to keep it

that first week in February, 3rd and 4th are bad for him. He's got an IOM committee meeting that -- that week.

DR. ZIEMER: Right.

DR. MELIUS: Those two days. I thought he said he was bad -- be bad the rest of February I guess for...

MS. HOMER: Okay. So we might want to look at the 31st, 1st and 2nd?

DR. MELIUS: Uh-huh.

UNIDENTIFIED: That'll work.

DR. ZIEMER: And then those other --

MS. HOMER: I was trying to avoid a Monday start date for some -- I didn't think anybody cared to travel on Sunday, so...

DR. MELIUS: Are we doing a three-day meeting, a two-day meeting, subcommittee? I mean that's also --

MR. GRIFFON: To be determined.

MR. ELLIOTT: I think we also need to discuss thoughts on agenda items --

DR. ZIEMER: Agenda items.

MR. ELLIOTT: -- and let the agenda items kind of drive --

DR. MELIUS: Yeah.

MR. ELLIOTT: -- how we --
DR. ZIEMER: Yeah, we can identify --
MR. ELLIOTT: -- construct the days.
DR. ZIEMER: We can identify a number of those right away. We know that we have the first 20-case -- the next step of that first 20 cases to handle. We have -- I believe we'll have the --
MS. MUNN: The Mallinckrodt SEC.
DR. MELIUS: And Iowa.
DR. ZIEMER: -- Special Exposure Cohort --
MR. ELLIOTT: We hope to --
DR. ZIEMER: -- we may have --
MR. ELLIOTT: -- we hope to have two site petitions for you -- evaluation reports for you to review.
DR. ZIEMER: For evaluation. What else?
MR. GRIFFON: At this point I'm assuming that that 20-case process comes back to the full Board. You know, originally -- Originally it was a sort of a scope item for the subcommittee, but we haven't really --
DR. ZIEMER: Oh, you -- the first 20?
MR. GRIFFON: Yeah. I mean the -- if you look at the items on scope for the subcommittee, one of the intent was to avoid that the whole Board

had to be involved in rolling those -- those things together and presenting -- you know, it was to save -- so that everybody didn't have to travel three days --

DR. ZIEMER: We can still ask that that be the case.

MR. GRIFFON: Yeah.

DR. MELIUS: So if the subcommittee met on either Monday --

MS. HOMER: Uh-huh.

DR. MELIUS: -- and then have a two-day Board meeting.

DR. ZIEMER: We can still do that.

DR. MELIUS: Yeah.

MR. ELLIOTT: Is there enough work for the subcommittee to work all day or do they need a half a day? And we also need to determine whether or not the subcommittee and/or the full Board needs a closed session in those reviews or are we going to redact those reviews and you'd have an open session. You need to come to grips with that.

So I'm sorry to lay out so many question at one --

MR. GRIFFON: No, no, you're right.

DR. MELIUS: Since you've already redacted the original reports -- is that my understanding? Not -- not from when we looked at them, but there's a redacted version out there. Is that --

DR. ZIEMER: If you deal with the redacted version, you will --

MR. GRIFFON: Of the individual case reviews.

DR. ZIEMER: -- have much more limited information on individual cases. One of the issues will be --

MS. MUNN: You won't know what you're looking at.

DR. ZIEMER: -- at this point, having reviewed them individually and then looking -- looked at their kind of the first wrap-up, do you still need the individual cases or can you deal with the wrap-up plus having redacted information as reference material?

DR. MELIUS: Can I ask procedurally a -- whoever can answer this is -- I presume you could have a -- say a subcommittee meeting that would be partially open and reserve an hour or two closed again?

MR. ELLIOTT: Yes, we could do that. We could

-- we can do that, yes.

DR. MELIUS: So that you'd leave --

MR. ELLIOTT: You can have an open session, and then you have a closed session.

DR. MELIUS: So if there were issues from the summary reports that people felt it was necessary to refer to the individual case reports --

MR. GRIFFON: We could go into closed after and --

DR. MELIUS: Go into closed --

MR. GRIFFON: -- we could table them for the time and go into closed.

DR. MELIUS: Yeah.

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

MR. ELLIOTT: Yes, you could do that.

DR. MELIUS: And that would avoid the re-- having to redact everything -- prepare a redacted version.

MR. ELLIOTT: The only difficulty would be that when we go forward for a determination to close for a closed session, we have to put in when the time is, and we can't change that time --

DR. MELIUS: Yeah. No, you're --

MR. ELLIOTT: -- once we get the approval.

You're locked into that time. And if you don't need it, that's okay, you don't have to use it.

DR. MELIUS: Yeah.

DR. ZIEMER: Okay. I'm thinking half a day would be enough, but that's intuitive.

MR. GRIFFON: I -- I think we need a -- I -- I would say a full day and leave the aft-- leave like 2:00 to 4:00 for the closed session, but have the regular open meeting start in the morning, 9:00 o'clock or whatever.

DR. ZIEMER: You're thinking you would look at individual cases after you looked at the wrap-up?

MR. GRIFFON: No, I'm thinking that we can do it without looking at individual, but we leave that --

DR. ZIEMER: But if you're unable to --

MR. GRIFFON: We reserve that --

DR. ZIEMER: -- we'd go to closed?

MR. GRIFFON: -- yeah. I mean I guess you could --

DR. ZIEMER: But then you're -- then you can't really tie things up, can you? Unless you go closed/open -- open/closed -- closed -- open/closed/open.

MR. GRIFFON: I mean we have -- we have redacted versions of these reports anyway --
DR. ZIEMER: Right.
MR. GRIFFON: -- so I don't know why we can't just deal with that.
MS. HOMOKI-TITUS: If you guys are going to have a closed session, we have to know about it because it has to be properly announced in the *Federal Register* --
DR. ZIEMER: Right.
MR. GRIFFON: We understand that.
MS. HOMOKI-TITUS: -- and we have to do the determination to close and the holidays are coming up and there's a lot of work to be done, so you guys are going to have to decide now or you don't get to have a closed session.
DR. MELIUS: Well, we don't even have a date yet, so this makes it even more complicated.
MR. GRIFFON: I mean I would argue that we have all these cases redacted. We have redacted versions available. Right? For these first 20 cases?
DR. ZIEMER: They can be made available --
MR. GRIFFON: No, they -- they are. I mean they're ready, they're done, they went through

the process, so we can --

DR. MELIUS: I thought you had --

MS. HOMOKI-TITUS: We would have -- you have to -- is this on?

We have to finish up the redactions on the documents that SC&A gave us yesterday that we hadn't seen before, but the first report I think we have done.

MR. GRIFFON: So -- so I would -- I would say let's just force ourselves to use that and -- and --

DR. ZIEMER: You're suggesting we schedule a day?

MR. GRIFFON: Open.

DR. ZIEMER: With some closed time?

MR. GRIFFON: Well, forget the closed time if we have --

DR. MELIUS: I would leave some closed time at the end of the day -- I think...

MS. MUNN: But --

DR. ZIEMER: Are --

MS. MUNN: -- using fully-redacted cases really reduces the amount of information you can get.

DR. MELIUS: Yeah.

MS. MUNN: It really does. It's not just a

matter of taking out --

DR. ZIEMER: You're going to lose the job -- job title information.

DR. DEHART: You'd lose time of employment.

MS. MUNN: Yeah, time of employment and --

MR. ELLIOTT: It depends upon the case. You may lose job title, you may lose -- there's various information that you could lose, which the Privacy Act officer could deem -- if it was still in the report -- could be used to breach the confidence, so...

DR. MELIUS: Can I -- can I recommend that one thing the subcommittee might look at is -- is schedule a closed session and that the subcommittee do the comparison and -- and with both the open and -- the redacted and the non-redacted in the closed session so that you can -- we can make a determination how to do this in the future. 'Cause I mean this is a --

MR. GRIFFON: Yeah.

DR. MELIUS: -- it's a lot of work for NIOSH to redact, and it causes obviously problems -- you want to be open in terms of the committee, but I mean it's just -- but I think we really -- if we'd take a real look at, see how we could

operate with and without, I think it might be helpful.

MS. MUNN: Well, yeah, if your decision isn't going to be a scientific one anyway, then...

MS. HOMOKI-TITUS: So does that mean you want a closed subcommittee meeting, but not a closed meeting for the Board? Well, you guys just need to --

DR. ZIEMER: No, we're still -- we haven't decided yet.

DR. MELIUS: So I guess it would be an open subcommittee, leaving an hour or two at the end of the day closed, I think would...

DR. ZIEMER: I'm still having a little trouble seeing why you would put the closed part at the end. It seems to me you'd want to be looking at the --

DR. MELIUS: Either way, it doesn't --

DR. ZIEMER: -- at the front end of the process, discuss whatever issues you had with the individual cases, and then go out and talk about the rest.

DR. MELIUS: Yeah, that makes sense.

MR. GRIFFON: All right, why don't you do it that way -- but I'd say do the morning closed -

-

DR. ZIEMER: And you could -- you could also at that point examine whether or not -- what you would have to work with in the open session.

DR. MELIUS: Right.

MR. ELLIOTT: Let me propose this, see what your thoughts would be. We start at 9:00 on the first day with an open session that would -- for the subcommittee and whoever wants to show up for that. It could be the entire Board, if they wish, or it can be -- as long as we have a quorum for the subcommittee, and you take care of the minutes from this meeting for that subcommittee, which will be very short --

MR. GRIFFON: Right.

MR. ELLIOTT: -- so we maybe have -- have the open session only open for a half an hour or an hour. Then you'd go into closed session, say 10:00 o'clock to noon. You come out of that and you have an open session for the remainder of the afternoon.

MR. GRIFFON: That sounds fine.

MR. ELLIOTT: Okay? Does that work for everybody or does that seem palatable?

MR. GRIFFON: That's perfect.

DR. ZIEMER: Seems to be consensus. This would involve the individuals that were sort of on that original subset -- I'm trying to remember who they were, I think five individuals. You remember who you were?

MR. ELLIOTT: It could be anybody that shows up.

DR. ZIEMER: Everyone else could show up. But as a minimum, those individuals would have to be there. Who -- who was in that group? I was, Mike was, Tony, Mark --

MS. HOMER: Dr. Anderson.

DR. MELIUS: Henry.

DR. ZIEMER: -- and Henry.

UNIDENTIFIED: And Wanda?

DR. ZIEMER: Or Wanda, were you in that group?

MS. MUNN: I'm not sure which subcommittee we're talking about. I'm not that much of a politician, you've lost me. I don't know where I am.

DR. ZIEMER: We can look it up, I think it was Henry.

MR. GRIFFON: Henry --

DR. MELIUS: I know it was Henry.

MR. ELLIOTT: Yeah, Henry was in there.

DR. ZIEMER: Rich?
MR. ESPINOSA: I believe it's just a minimum of five, that you don't have to have the same members.
DR. ZIEMER: No, you don't have to, right. But as a starting point, we -- we had that particular group because it had some broader representation, which we wanted.
Okay. So we're looking then at one day that would involved the subcommittee, two more days for the rest of the items -- those items to include Board action then on that final document on those first 20. Presumably that group might also be looking at some things on the second 20 during that first day. If SC&A has the second 20 available, they would have those possibly to deal with, as well.
MR. ELLIOTT: Is that possible? I don't know if Dr. Mauro's here.
DR. ZIEMER: We don't know for sure 'cause that's coming up in less than two months.
DR. BEHLING: Dr. Mauro's not here so I'm going to have to speak in his behalf, and I guess one of the key factors here is the time. And I guess we have not yet decided firmly on a date

for this next meeting, or have we?

DR. ZIEMER: It's -- at the earliest, it's the first week of February. It could be the first week of February, which might be a problem, or the second week.

DR. BEHLING: That will certainly be a real pressure cooker for us --

DR. ZIEMER: Yeah.

DR. BEHLING: -- to get both the first and the second set of --

DR. ZIEMER: Right, 'cause you're going to be working on this first --

DR. BEHLING: Yes.

DR. ZIEMER: -- set. So perhaps the likelihood of the second 20 is not so great then.

MR. ELLIOTT: I agree, Dr. Behling --

DR. BEHLING: I would certainly put that on hold.

MR. ELLIOTT: I agree with you, I think it would be unlikely. But just so everybody knows, we will get the 20 cases to you and -- and --

DR. ZIEMER: You can be on your way with them.

MR. ELLIOTT: -- as we did, in CD's and to the Board members as soon as we're back in the

office. Those will be out the first of next week, I hope. We'll work towards that.

DR. BEHLING: And could I ask for some clarification? In the event that you're going to be asking for the second set of 20's, would you also want to have a preliminary draft report of those 20's that we can advance for you to review, which would certainly add another dimension to the limited time that's available.

DR. DEHART: Plus the conference call.

DR. MELIUS: Plus the conference call.

DR. ZIEMER: Yeah --

MR. GRIFFON: I don't think it's doable.

DR. ZIEMER: -- it looks like it's going to be unlikely. The answer's yes, we would want all those intermediate steps, yeah.

DR. BEHLING: Okay.

DR. ZIEMER: Okay, so the focus is going to be on those first 20. On the agenda for the general meeting would also be the Mallinckrodt Special Exposure Cohort petition. We would have -- we'd -- we'd have some more things on the Bethlehem Steel site profile to follow up on. What else?

DR. MELIUS: I would ask that we have the Mallinckrodt site profile review on the agenda, and that we have it on the agenda prior to discussing the SEC issue, 'cause I think doing it the other way's going --

DR. ZIEMER: Right, right.

DR. MELIUS: -- to be difficult. Larry, are we going to get our diskettes under our Christmas tree?

DR. ZIEMER: We have a number of our regular reports, as well.

MR. ELLIOTT: Remember -- again, I'd ask Dr. Behling to help us out here, but I think there's a deliverable on task two -- or the procedure reviews. That should be ready by the February meeting, you think?

DR. BEHLING: I think task three is ready, and if we can schedule that for the next meeting, we'll be prepared to provide you with a draft report. And again, I would ask your guidance as to how soon you want a draft copy made available both to NIOSH or to you, or both, so that you'd have a chance to review them prior to the meeting.

DR. ZIEMER: Well, I think on a procedure

review, probably a week before the meeting would be adequate. I think that's -- my take on it. Anyone else? It seems to be -- a week before the meeting is a final, drop-dead -- or earlier.

DR. BEHLING: Okay.

DR. ZIEMER: Thank you. Were there other items that we should consider on that agenda, Gen?

DR. ROESSLER: We often have an update on some scientific issue, and I think in view of our past discussions we might want to have somebody talk to us about ICRP-30 and 68 and 66 and whatever it -- I don't remember the exact titles, but I think in order -- if we're going to have to make a recommendation -- prefer to make a recommendation to NIOSH about which models they use as a result of the Bethlehem Steel profile, I think we need an update on -- ourselves on the two models that are under discussion.

DR. ZIEMER: Let's ask Jim if that's something that...

DR. NETON: I'm a little confused as to what the discussion topic is, the use of ICRP-30 versus ICRP-66?

DR. ROESSLER: It's 68, I think.
DR. NETON: 68 -- in relation to what issue? That was not brought up in the Bethlehem Steel review. There was an ICRP-74 -- 75 issue, which had to do with air sampling.
DR. ROESSLER: Okay.
DR. NETON: I think you might be thinking --
MR. GRIFFON: It came up in Savannah River.
DR. NETON: The Savannah River high five approach --
DR. ROESSLER: Yes, yes.
DR. NETON: -- and that was not so much a debate about the use of the models, but the fact that we would -- we relied on data that were analyzed using ICRP-30 when we committed to using 66.
DR. ROESSLER: 66?
DR. NETON: Right, the lung model. It has to do with the lung model, class S solubility versus class Y and that sort of thing, and we believe that we made an appropriate adjustment and that would be a topic of discussion for the next --
DR. ROESSLER: So we don't have to have an update on --

DR. NETON: I don't think there's an issue there that is beyond that, which is did we properly use -- was it appropriate that we used ICRP-30-derived values when we committed in our rule that we'd use ICRP-66.

DR. ROESSLER: Yeah, okay.

DR. MELIUS: And -- and can I just weigh in on that? I think when the Savannah River Site profile review is complete may be the time to make a determination, do we delve into that further or not to --

DR. NETON: I don't think that that's covered in the Savannah River profile.

DR. MELIUS: Okay.

DR. NETON: This is sort of one of those side Technical Information Bulletins. It may actually be covered in Hans's procedure review. Is that one of the procedures?

DR. BEHLING: No, the -- the procedure review is not covering the site profiles. It's strictly the 30 procedures that were identified to us by -- by NIOSH. So the issue that is under discussion from Dr. Roessler with regard to this ICRP-30 versus 66 will probably be addressed in the review of the Savannah River

Site profile.

DR. NETON: It's not in the profile, though.

DR. BEHLING: Well, it makes indirect reference.

DR. NETON: Okay. If not then, I think it will certainly be covered in the review of the first 20 procedures -- dose reconstructions, because it was raised in two or three of them --

DR. ZIEMER: Right.

DR. NETON: -- and we prepared a slight draft response for your -- your information, but we'll be prepared to talk about it in much more detail at the next meeting.

DR. ZIEMER: Okay.

MR. GRIFFON: And I think a more useful -- or maybe not more useful, but something that the Board had talked about before was -- was training in Cincinnati to go -- and I -- I was talking to Gen earlier about this. I thought, you know, if people were briefed on IMBA and -- and also at the same time brought through that SRS spreadsheet that I have that -- that is not completely user-friendly. I mean I've waded my way through it, and then there's another one for the 28 radionuclides, I think it's called a

max dose calculation spreadsheet or whatever. Those both are where you get your intake numbers to put into IMBA, and the how IMBA works, and that sort of ties into the ICRP models and, you know, you could -- that would be a good -- I think a good way, just so everybody's up to speed on what's going on with the --

MR. ELLIOTT: So let me be clear. Are you asking for kind of a walk-through of IMBA --

MR. GRIFFON: Right, but not -- not --

MR. ELLIOTT: -- for the Board in front of --

MR. GRIFFON: -- in the Board meeting.

MR. ELLIOTT: -- with the public --

MR. GRIFFON: I don't know that --

MR. ELLIOTT: -- at another Board meeting?

MR. GRIFFON: -- it needs to be at a Board meeting. I thought we'd talked about training in Cincinnati where we could go --

DR. ZIEMER: Wasn't that more on an individual or --

MR. GRIFFON: Yeah.

DR. ZIEMER: -- small group basis for those --

MR. GRIFFON: Right.

DR. ZIEMER: Not -- not everybody on this Board

is going to be interested in running IMBA, is my impression from talking to some.

MS. MUNN: I tried and failed.

DR. ZIEMER: Well, but -- but can't that be arranged on an individual basis?

MR. ELLIOTT: It can -- it certainly can be arranged on an individual basis. We welcome any of the Board members to our offices at any point in time and we'll, you know, give you whatever training or access you need.

DR. DEHART: It can be done by phone with -- with computer --

DR. ZIEMER: Right.

DR. DEHART: -- back and forth. That's the way I -- I worked it.

MR. ELLIOTT: It could be done that way.

MR. GRIFFON: I mean I'm not saying at a Board meeting. I'm saying -- yeah, on small groups or individually based on --

MR. ELLIOTT: Sure.

MR. GRIFFON: -- however, but I think -- you know, there's -- it -- it sort of helps to translate some of the summary reports, 'cause you say 28 nuclides, assuming worst case, and it refers to the Technical Basis Document, but

the spreadsheet's not part of that document. You've got to go -- you've got to get the spreadsheet and look at the -- you know. I don't know, I found it useful to wade through. Others might not want to.

DR. MELIUS: Just to follow up on Gen's suggestion, though, I think it -- that type of a session where we'd bring somebody in for a briefing and so forth on particular technical issues, maybe a way we want to follow up and try to resolve some of the issues that were raised, for example, in the Bethlehem site profile, so bringing in someone to talk about ICPR-75 (sic) or this -- the triangular distribution issue and so forth may be a way we can think about resolving it. I don't think it's ready for the next meeting, but at some point after that.

DR. ZIEMER: Well, there may be issues that that would be helpful.

DR. MELIUS: Exactly, and those may not be the ones.

DR. ZIEMER: Let's go back and see if we've identified all the main -- aside from the regular reporting things, are there other

issues for this next meeting that --

MR. ELLIOTT: I think I heard yesterday Dr. Mel-- or maybe it was today Dr. Melius suggested that -- and I believe you brought this up before at the last meeting that you wanted to hear more about our modifications to site profiles and what's the status.

DR. ZIEMER: Or the schedule for --

DR. MELIUS: Your process for and schedule -- sort of discussion of that, yeah, on how site profiles are to be modified and what's the best process for doing that.

DR. ZIEMER: And Roy?

DR. DEHART: We've talked around the issue of inadequate budget for continuing audit. Is this a time to begin to address that or try to find out whether we're going to have to go forward and recommend that additional --

DR. ZIEMER: Well, I think Lew told us that at the next meeting he would have additional information on when and what needs to be done on those audit -- or budget issues, and so I assume that Lew will follow up, or David will, and we'll have some -- and that certainly ought to be on the agenda.

MR. ELLIOTT: Yes, I -- I don't know that it'll be a standing item on the agenda, but I certainly think that next meeting you'll have an agenda item that talks about the task orders and the status of the task orders and the costs associated with those.

DR. ZIEMER: And remember, Dr. Wade is going to be working with the folks from SC&A to look at the incremental budget changes associated with these additional tasks -- they're sort of sub-tasks that the Board has placed upon our contractor in lieu of -- or in light of the handling of the first 20 cases and so on, as well as the -- the site profile review, so there are some additional costs. And Lew is going to work with them on that and he will be reporting back, as well.

Okay. And Jim?

DR. MELIUS: No, I actually don't have anything.

MR. ELLIOTT: Cori, could I ask you when you think you're going to have a final determination on which week is going to work best for the hotel?

MS. HOMER: I hope to have that today.

DR. ZIEMER: So we'll --
MR. ELLIOTT: That'd be great.
DR. ZIEMER: -- know very soon then.
MS. HOMER: Uh-huh.
DR. ZIEMER: Okay. Now what I'd like to do today, if we can do this, is identify dates for the whole year.
MR. ESPINOSA: There's not much year left.
DR. ZIEMER: Well, yeah, we're going to run out. We can identify dates for this year, can't we? There's the 15th, the 16th. I'm wondering if the Board would like to do time set-asides now at the front end of things so we don't get into this situation of having to rearrange calendars on down.
MS. MUNN: Yes.
MR. ELLIOTT: I asked -- I asked Dr. Ziemer if he would bring this to the Board, because we think -- from our perspective -- it makes a lot of sense to schedule -- have a schedule, a set schedule for your meetings so that we can plan our work to deliver our work in that schedule. And the way we've been functioning up to this point is look at everybody's calendars, figure out when we can meet and get it -- get it done.

If we have a set schedule, I think it's going to aid us in getting our work planned better and getting it in front of you.

DR. MELIUS: Well, my only caution is if we get too far ahead, try to -- just -- we don't know when certain meetings take place now, so we try to do next April or something -- not -- April 2006, that's too far into --

DR. ZIEMER: I'm talking about 2005.

MR. ELLIOTT: One year. One year.

DR. ZIEMER: The next handful of meetings, number one. Number two, and do it with the recognition that there may be situations, particularly on the Special Exposure Cohorts, where we have to have a, quote, emergency meeting, a one-day meeting, perhaps going to a location where the petition comes from, and addressing that as a single item on a -- on a -- like a one-day meeting. 'Cause that -- that could happen anyway, and we'd have to allow for that.

Let's see -- Tony?

DR. ANDRADE: Yeah. I was going to say that actually I was prepared, but I didn't bring my calendar along. I know more or less when my

other professional society meetings are and so on for pretty much the rest of the year, but if you could hold off until next meeting, I think maybe it'll give everybody a chance to prepare for such a thing. I don't think that we can do it right now, not today.

DR. ZIEMER: At least your day, you'd rather we didn't.

DR. ANDRADE: Not me.

DR. ZIEMER: Okay. Rich --

MR. ELLIOTT: Are you amenable to this concept, though?

(Multiple affirmative responses)

MR. ELLIOTT: So -- so if we do that, could you send your availability to Cori --

MS. MUNN: Yes.

MR. ELLIOTT: -- so that we could lock it in on -- let's say a quarterly basis?

DR. ZIEMER: Come back at our meeting and identify those slots that appear to be good ones?

MR. ELLIOTT: We could use your availability to identify --

DR. ZIEMER: For the whole year.

MR. ELLIOTT: -- which weeks the majority of

the Board, if not everybody on the Board, is available, and then come to you in February and say here's the weeks we've got planned for February, May -- or February's taken care of, so we're talking May, August and...

DR. MELIUS: I don't think we need to wait to February, though. I think we can do this by e-mail --

MR. ELLIOTT: Yeah, that's what I'm saying.

DR. MELIUS: -- and do some and then go back and forth, and if we respond to -- reply to everybody, then everybody can sort of -- we can sort of work out some things.

DR. ZIEMER: Cori can work that out with us.

DR. MELIUS: 'Cause there may be some that -- that --

DR. ZIEMER: Additional --

DR. MELIUS: -- Dr. Ziemer's going to have to make the call on.

DR. ZIEMER: Right. Additional guidance, though. How many times a year -- I said to Larry I'd sort of like to see us do four times a year, and then have some space for those special meetings if we need to. I don't know from a staff point of view -- they may prefer,

for example, six times a year, like every two months. Because as we move forward, we're going to be now in a position where we're going to be looking at some very specific things -- the dose reconstruction reviews, the site profile reviews and the Special Exposure Cohort reviews. Those are going to be the driving items before us, and that's going to be a fairly regular thing now.

I don't have a good feel for it. I'm -- I'm looking -- you know, I'm saying would four meetings of three days each be better or -- three days in a row is a pretty rugged schedule, actually. Or is six meetings of two days each better? But even on the two-day meetings, we end up with at least part of the group maybe having to do three days because of the preliminary reviews of the dose reconstruction reviews, and that's -- so a little feedback, what's your feeling on frequency? 'Cause we need to say to Cori, find four slots or six slots or something like that.

DR. MELIUS: Well, my view is that -- I think four three-day meetings may be workable. I think we have to have a real functioning

subcommittee, though, that could meet in between. And we're going to have to be willing to vest that subcommittee with some real powers to make some decisions on our behalf, to the extent that they're allowed to, in between -- at least to keep some of the processes moving and -- particularly with our contractor and so forth.

Secondly, that there has to be -- we can't wait until a meeting takes place, say in -- February 1st and then say well, our next emergency meeting or in-between meeting -- one-day meeting's going to be, you know, February 21st or something. I mean sched-- trying to schedule something, at least for me, and I know for Henry and some of the other people have -- with like three or four weeks notice -- is impossible. Now if we do it -- you know, set a date aside in between, or a couple dates aside for --

DR. ZIEMER: Identify emergency dates is what you're saying.

DR. MELIUS: Emergency dates, I think that would be -- be helpful, recognizing that we may or may not use them, but at least we'd have

them on the calendar and we'd know that they were available. And albeit there may be -- because of our contract, because of this SEC process, we may have to try to schedule something in between without a lot of notice. But to the extent we can avoid that, I think we're better off.

DR. ZIEMER: Other input? Yeah, Roy?

DR. DEHART: I would suggest that we look at the three-day meeting four times a year. That -- if we did it six times, actually it's going to take more time out of the office because it -- we have to travel. We're killing two days -- at least in my case -- almost every meeting we have, the beginning and at the end, for travel. So instead of two days, it become four days out of the office, versus five days if we have a three-day meeting.

MR. ELLIOTT: So as you send your availability in to Cori, please look -- I think, if you would, at -- like we're going to -- we've got February set aside, but look at -- target May, target August, target November, and then look at the months between each and say here's a couple days where we could -- I could be

available for emergency meeting or a special meeting. Does that seem reasonable?

MR. ESPINOSA: Say those --

DR. ZIEMER: February, May, August, November, and --

MR. ELLIOTT: Quite frankly, meeting in December --

DR. ZIEMER: -- I think we need to avoid --

MR. ELLIOTT: -- is just not good for us --

DR. ZIEMER: -- December.

MR. ELLIOTT: -- in the government.

DR. ZIEMER: I don't think it's good for most people.

MR. ELLIOTT: There's too many people with --

DR. ZIEMER: You have folks trying to burn up --

MR. ELLIOTT: We've got folks trying to burn up leave that they're going to lose, and it's so hectic with the holiday season, December is not a good month for us.

DR. ZIEMER: Okay. Is that agreeable then? We need to -- Cori, you want that information ASAP. Right?

MS. HOMER: Absolutely. Do we want to discuss locations or is that up for discussion at a

later time?

DR. ZIEMER: The key point here is to -- is to get the calendar --

MS. HOMER: Dates, uh-huh.

DR. ZIEMER: -- reserved. We're focusing on St. Louis for the February meeting.

MS. HOMER: Yes.

DR. ZIEMER: You want to -- you want to try to identify location for the one following that?

MS. HOMER: I don't know that that's possible. I guess OCAS will have to tell us what the...

MR. ELLIOTT: I think it's enough for us to know that this Board wants to meet in the general vicinity of the sites that we have claims at. Is that -- that's true. Right? That's your --

DR. ZIEMER: Right.

MR. ELLIOTT: -- consensus.

DR. MELIUS: And the second point is, we would like to be near SEC sites at the time we're --

DR. ZIEMER: Right.

MR. ELLIOTT: Understood. Understood, recognizing full well that we may be dealing with multiple SEC petitions and we can't visit everybody's site in that one meeting.

DR. ZIEMER: We might pick one of them.
MR. ELLIOTT: We can pick one of them. That's why we're looking at St. Louis for Iowa and Mallinckrodt, but yes, we understand that, too. So if -- if that's a general understanding that we have, could you allow us then to look at the work load in this context and see where those things are going to come to fruition and then strategically plan the meeting in that -- in those --
DR. ZIEMER: Any objection --
MR. ELLIOTT: -- locations that --
DR. ZIEMER: -- to doing that?
MR. ELLIOTT: -- that merit that meeting?
DR. ZIEMER: I don't think there's any objection. Let's do that.
MS. HOMER: Okay.
MR. ELLIOTT: We've heard you mention a number of sites -- Tampa being one that we weren't able to go to. But we'll work with that, if that's -- if that's okay with the Board.
DR. ZIEMER: Okay?
MS. HOMER: Okay.
DR. ZIEMER: You have enough at this point on that issue now?

MS. HOMER: On that issue, yes.
DR. ZIEMER: So please get your calendars -- information in.
MR. ESPINOSA: Just -- with that issue alone, you know, depending on where we travel to, also kind of makes the -- my calendar go back and forth 'cause there's some -- there's some places that I can fly back the day of the meeting and other places that I can't.
DR. ZIEMER: Yeah, this is true of many of us, I think. I know it's true of Wanda.
MS. MUNN: Always, no matter where you decide.
DR. ZIEMER: Always, yeah. Thank you. Okay. Other housekeeping things?
MS. HOMER: Other housekeeping items. Please write down your prep time, work group time, subcommittee time and divide your prep time -- or identify your prep time as closely as possible to what you spent it on, work group, subcommittee, et cetera, and provide that to Larry so he can initial it. I want to be able to submit your salary requests this week, if at all possible.
I've already recorded your Board and subcommittee time, so the prep time and work

group time is really all I need.
And also --
DR. DEHART: Could we have some blank paper? There's no pads on the table.
MS. HOMER: They're on the corner. Sorry about that.
MR. ELLIOTT: You can give them to me on paper now, or you can e-mail them to me --
DR. ZIEMER: Either way.
MR. ELLIOTT: -- at your convenience.
DR. ZIEMER: Get them in, though.
MS. HOMER: I'd prefer -- yeah, I need to have them by Friday -- Friday morning.
I've provided you with your earnings statements, and I want you to check your address on the bottom of your earnings statements. The human resources office has asked for address updates. If that is not where you want your W-2 to be mailed, fill out that home -- change of home address record form I've provided in your binder and just give that to me before we leave today. I want to make sure that you get your W-2s to the correct address.
The annual report to GSA is scheduled to be

approved by GSA and released this week. I don't know for sure that it will be 'cause I haven't spoken to committee management about it, but as soon as I receive it I will forward it to you.

If you have your CDs from IMBA and the analysis records, please provide those to me.

MR. ELLIOTT: We need to know who's given up their CDs 'cause we --

MS. HOMER: Yes.

MR. ELLIOTT: -- have to check this off, so...

MS. HOMER: I have to provide those to -- I believe Paula Coker*.

And for those of you that did not attend the INEEL tour last August, we were -- it was an interesting tour, for one. But the -- we were watching an SL-1 accident tape, I believe it was. We didn't get to finish it, so they provided us with a copy. If you want to check that out, let me know and I will be more than happy to send that to you on loan.

DR. ZIEMER: What format is that in?

MS. HOMER: VHS.

MR. ELLIOTT: VHS.

DR. ZIEMER: VHS? Okay.

MS. HOMER: I guess that's about it.

MR. ELLIOTT: We are -- as many of you know, we are going through the annual disclosure of conflict and conflict waiver generation. Many of you have been working through this with us. If you haven't, that's because your anniversary hasn't happened yet, but it will shortly happen, I'm sure, so we're -- just to let you know, we're working on that. So if you -- if there's any -- if there's any difficulties in that process, let us know because we seem to have a number of these floating -- they -- they route all around through CDC and the Department, and so we're trying to do our best to keep track of these, but if you don't get your waiver letter as soon as you think you should, let us know. Just drop us an e-mail.

MS. HOMER: Please let me know as soon as possible. I've been working with committee management to make sure that everything is on time and to where it should be.

MR. ELLIOTT: These become very important now that you are engaged in reviewing individual dose reconstructions and SEC petitions, as you know. That's what your waivers speak to, so we

want to make sure we're up to date on those.

DR. MELIUS: If we're -- you think -- some -- I received something in the mail recently, I think it's the ethics sign-off annual thing, isn't it?

MS. HOMER: Your 450, I'm sure.

DR. MELIUS: Yeah, but like it had a date on it that was -- on the letter or something that was like a month ahead of when I got it and, you know, it's overnighted to you. I mean they --

MS. HOMER: That's interesting.

DR. MELIUS: Yeah, something like -- something struck me --

MR. ELLIOTT: A month ahead of when you got -- like it was dated June 4th and you got it August 4th?

DR. MELIUS: Yeah, something like that -- or July 4th.

MR. ELLIOTT: So it had been laying around somewhere for a month?

DR. MELIUS: Somewhere it'd been -- somebody'd run them off at a time and then they mailed -- which isn't -- you know, nobody bugged me or anything. But you know, if you hear one of us -- if like I'm in trouble or somebody's in

trouble for not re-- being responsive, e-mail us or something and see if we got it.

MS. HOMER: I'll definitely do that.

MR. GIBSON: I got the same thing.

MS. HOMER: Did you really? Isn't that interesting? I'll have to --

MR. ELLIOTT: That's why I brought this up. I want to know where these things are at because they're floating all over the place.

DR. MELIUS: Either way, it was plenty of time before it was due, so it wasn't --

MR. ELLIOTT: Yeah.

DR. MELIUS: -- that one wasn't an issue. I worry more about this other one where you've got more people involved and...

DR. ZIEMER: Okay, any other housekeeping items?

MS. HOMER: That'll be it.

DR. ZIEMER: Okay. Thank you, Cori.

SCIENTIFIC RESEARCH ISSUES UPDATE

We're going to move along here. We have a scientific research issues update. This is the one that Russ ordinarily brings us, but I think today we have Brant -- is it Ulsh? How do we

pronounce -- close enough, right, Ulsh? Brant, welcome.

DR. ULSH: Thank you.

DR. ZIEMER: Give us the update.

DR. ULSH: I answer to anything close.

DR. ZIEMER: Anything close, right.

MR. ELLIOTT: Brant -- Brant is a health physicist who applied for a position in Jim's science team as a senior research scientist, and so he's moved from being a -- strictly a health physicist doing dose reconstruction review to now aiding the scientific aspects of our programs, so Russ was not able to be with us today and this gave Brant an opportunity to present to you.

DR. ULSH: Well, there went my first three slides.

MR. ELLIOTT: I'm sorry.

DR. ULSH: I'll be able to contribute a little bit to getting us back on schedule. I know it's been a pretty tough haul for -- for all of us.

As Larry mentioned, I am the new research health scientist for OCAS, and before that I was serving in a health physics capacity.

And if you'd allow me just a couple of seconds to give a couple of personal words, I managed to fly in last night in time to get to the public comment session. And this is only my second Board meeting. I went to the one in Cincinnati some time ago. And speaking for myself only, I found it very useful to get that perspective from the public, to hear all those stories last night of your experiences. And so, at least from my standpoint, please know that you've been heard, and it was valuable to me. I changed the way I'm going to deliver some of my comments today in light of what I heard last night. So thank you for -- for providing those perspectives.

Like I said, I know it's been a tough haul, so I'll keep my remarks pretty brief. But I would encourage any members of the Board to interrupt at any time -- I'll survive the interruption -- if there's a clarification that you need or if I'm not being clear.

So here's a list of the topics that I'm going to discuss with you today. I'm going to start with an update on compensation rates, and this will look very familiar to you. Russ Henshaw

gave you some numbers back in April and I'll just update those.

I'm also going to talk to you about some of the adjustments to the risk models that we use in our risk tables in IREP, some that we're considering and some that we're in the process of implementing.

Then I'm going to move on to tell you a little bit about what we're doing with regard to CLL and also a re-examination of the target organs that we use for dose reconstruction with regard to certain cancers of the lymphatic and hematopoietic systems. That's the blood cancers like leukemia and also lymphomas.

And I'll close with some remarks on our activities looking at occupational studies and what we might be able to do with those, and also a re-examination of how cancers are grouped in the risk models in IREP that we use.

Okay. So let's start with the compensation rates. As I mentioned, this is an update. These numbers that I'm going to present in the next few slides reflect the data that we have through September 30th of this year, and they include only claims for which we have heard

back from the Department of Labor about a compensation decision. So you might notice some discrepancies in the total number of claims that we say we've completed and the numbers that I present here because these are only the ones that DOL has given us a compensation decision on.

The results are going to be skewed by the efficiency process. As you know, our early case selection was impacted very heavily by the efficiency process, so we picked cases at either end of the compensability spectrum -- those that were most likely going to be compensable and those at the other end of the spectrum, as well. And so, as they say in the financial world, past performance is not an indication of -- or it's not predictive of future results.

So these results -- I've got written here they may not be predictive of future results. I would strengthen that and say that they are definitely not going to be predictive. If they are, it's just coincidence. We've moving into the middle of that compensability spectrum and so we can't really expect that the rates that

we see now are going to hold.
Unless otherwise noted, the numbers that I'm going to present to you show only those cases for which there was only one primary cancer, and I'll explain -- I'll point out a couple of situations where that'll make a big difference.
So with those caveats, here's the first set of cancers. They're listed by ICD-9 code, that's the first column there. In the second column, that gives you the number of cases that we've completed for each of those cancers, and then the third column tells you the compensation rates.
So you can see in this first group we've completed a fair number of colon cancers, and those have tended not to be very compensable. They -- the compensation rates for the rest of the cancers on this page are also fairly low, with the possible exception of oral cavity and pharynx where about ten percent have been compensated.
In this next group we come to lung cancer, and lung cancers comprise a very large percentage of the cases that have wound up being compensable, with about three-quarters. You

also see that liver cancers have been very compensable, but we have not done a lot of liver cancers yet. And about ten percent of the gallbladder cancers, as well.

About a third of the other respiratory cancers have been compensated, and we've done a fair number of those, in the fifties. About a quarter of the non-melanoma skin cancers, the basal cell carcinomas -- and this is the cancer for which that caveat I told you where we only consider the cases with one primary cancer, that's very important for the BCCs, basal cell carcinomas, because we frequently see with skin cancers there are multiple primary cancers. And those are not reflected in this -- this number here. And we've compensated about a quarter of the BCCs. Excuse me, DOL has compensated about a quarter of the basal cell carcinomas.

The squamous cell carcinomas, on the other hand, the SCCs have tended not to be very compensable. And none of the other cancers listed on this slide have been very compensable, either. I would point out the all male genitalia includes prostate cancers, and

we've done far and away more prostate cancers than any others. And those tend to be very low compensability.

Here you can see some more of the cancers. About ten percent of the urinary organs, excluding the bladder, have been compensated, and the rest have been pretty low.

And here the other endocrine glands, about a third have been compensated. And then we move into leukemias, which tend to be very radiogenic cancers, so as you might expect, a higher percentage of those have been compensated. We have not done a lot of leukemias yet, though.

Here's a few more leukemias, and finally the unknown primary cancers. You'll notice we've compensated about three-quarters. That's very reflective of lung cancer, because in cases where we have only a secondary cancer listed with no known primary, very often it reverts to the assumption that the primary site was lung cancer, so that's why those numbers are very similar. And finally for the multiple primary cancers, a large part of these are skin cancers, but not only skin cancers. There's

also a fair number where there are other types of cancers involved. About half of those claims have been compensated.

And that gives you a total of 3,731. I think our total now is about 6,000 that we've actually completed, but for the remainder we have not yet heard back from DOL. And that gives you a final tally of about 20 percent having been compensated.

Okay. Before I move on, this is a good place to stop and ask if there are any questions before I move on to the next topic.

(No responses)

Okay, seeing none -- well, I jumped the gun a little bit. Here's the big picture. I'm going to present this in graphical form for you. This is limited only to the cancers -- the types of cancers where we've completed greater than 30 claims. And you can see -- these are listed in decreasing order, so starting with lung, we've compensated about three-quarters, and moving down through the rest of the cancers down to about ten percent of the thyroid cancers.

About ten percent of the oral cavity cancers

and lesser numbers of the malignant melanoma, bladder, esophagus and squamous cell carcinomas.

Lymphoma and multiple myeloma, colon, breast, male genitalia are pretty low.

And there have been no claims compensated for this list of cancers: stomach, rectum, pancreas, connective tissue, female genitalia and nervous system.

Okay. So now I'd like to move into some of the adjustments that we're making to a few of our risk models, starting with the lung cancer model. We're evaluating this at the moment. The National Institute of Health has a new vers-- has a version of IREP where they have updated the lung model, and we are currently evaluating that for applicability to the NIOSH version. This update changes the way smoking is handled, and it also changes the methodology for considering alpha radiation. Basically the NIH model includes four more years of follow-up on the Japanese atomic bomb survivor cohort, and it assigns more weight to an additive model versus a multiplicative model.

Now our NIOSH -- our NIOSH version of IREP does

not presently include these updates because it came out before the datas that -- the studies that initiated this came out, a study by Pierce and Preston.

Now what does that mean to an average claimant, multiplicative versus additive? Our friends at SENES pulled together some numbers, and here's what it looks like. Just for a hypothetical claimant who received an acute exposure of high energy gammas, 50 rem -- and this is a male, exposed at age 20 and diagnosed with lung cancer at age 40. And what you can see here is that for non-smokers, the current version -- the current NIOSH version of IREP tends to be a bit more -- tends to yield a bit higher number for probability of causation. But for all of the smoking categories, the NIH model yields a higher probability of causation.

Now if we change this to a chronic exposure of alpha -- to alpha radiation, but keep all the other parameters the same, you see a similar pattern but less of a difference. For the non-smokers the NIOSH version is very slightly more claimant-favorable, and for the smoking categories the NIH version tends to yield

higher PC results.
The differences between the two models. NIOSH -- the current NIOSH version is more claimant favorable for people who have never smoked and for females exposed at older ages. The NIH version gives higher PC results for male smokers and for females exposed at younger ages.
I might also mention here that the NIH version includes a dependency on age at exposure, and also at attained age.
And so in response to this update to the NIH version that the National Cancer Institute recommended, OCAS has commissioned five experts to review whether or not we should also adopt this model. We expect to have those recommendations back in mid-February.
We're in the process of adjusting our thyroid model, and the reason that we're doing this -- this gets down in the technical weeds a little bit, and I'll try to make it understandable. But if I don't, please let me know.
The IREP -- the thyroid model includes data from two types of studies, first the Japanese bomb survivors, and also from childhood X-ray

studies. When we combined those datasets or when NCI combined those datasets, they applied a reduction to the effectiveness of the childhood X-ray studies, based on the assumption that X-rays are more carcinogenic than the high-energy gamma rays that the atomic bomb survivors were exposed to.

Here's what this update means to a typical claimant. There are a couple of points I want to point out here. First of all, notice that this affects a very limited age window, between -- I think the youngest exposures that we have are about 15 years of age, and it only goes up to age 20.

The second thing to notice is that the adjustment results in a higher -- slightly higher PC in all cases. The reason that we see that is because the update removes that reduction that was applied to the childhood X-rays. The reason that we're doing that is because, upon examination, NCI discovered that the risk coefficients that they were getting from the childhood X-ray studies were in fact not different -- not significantly different from the Japanese atomic bomb survivors. And

so applying that reduction was inappropriate, they decided. And so the reason for that is possibly fractionation.

If you compare an acute exposure of X-rays to an acute exposure of high-energy gamma rays, the X-rays will be more efficient. But that's not what we have here with the childhood X-ray studies. They got a little bit of dose today, a little bit tomorrow, a little bit next week. So the dose was fractionated. We know that that type of exposure regime is less efficient at causing cancer, and so that's probably why they didn't see any difference, so they're removing that reduction.

And this update that we're in the process of making will bring us into alignment with the NIH model. It is al-- it is claimant-favorable, and it also only affects a very small number of cases.

We're also updating our bone model in IREP. We previously modeled the latency period -- the latency relationship for bone cancer to that for other solid tumors. But upon re-examination, NCI decided that in fact the latency relationship for bone cancer more

closely resembled that for thyroid, and so they changed that so that the latency period now for bone cancer will be modeled on the thyroid. This is also a claimant-favorable adjustment in all cases, and it also will affect a very small number of cases.

Okay, chronic lymphocytic leukemia. This is a topic that has generated a great deal of interest, I think. In response to that, the Health and Energy-related Research Branch of NIOSH, HERB, held a public meeting this past July in Washington, D.C., and they empaneled a group of experts to look at the assumption that there is no relationship between ionizing radiation exposure and CLL. And that's pretty much conventional wisdom in radiation epidemiology.

And this group of experts took a look at the data, and they decided that the evidence is actually inconclusive. It doesn't say that there is a relationship, but it doesn't say that there's not a relationship.

They identified some real problems with the data. First of all, inappropriate lag periods were used. Other forms of leukemia tend to be

very fast-developing, and they have lag periods typic-- on the order of about five years. Well, that's not really appropriate for CLL. It's a very slowly-developing disease, much -- it's distinct from the other forms of leukemia. There's also a classification and diagnosis issue. Up until recently, diagnosis of CLL was based on cell morphology. In other words, you looked at the cells under a microscope and, based on what they looked like, determined that you were looking at CLL. But the problem is that there are other related types of leukemia, for instance, hairy cell leukemia -- which, by the way, is a covered condition under our program. So it's not too hard to see that someone who might have had hairy cell leukemia had a non-trivial chance of being mis-diagnosed with CLL, and they would not be eligible for coverage under our program. So that's a real problem.

That has changed recently with the advent of molecular biology techniques. It's much more definitive of a diagnosis, but in the early days it was a bigger problem.

There's also the problem of transference

between the two populations, between Japanese atomic bomb survivors and the North American population that we're dealing with. The problem there is that Asian populations have a very low background incidence of CLL compared to North American populations. So there is a question of relevance there.

In light of those problems we are reconsidering our exclusion of CLL from EEOICPA. And we have commissioned five experts -- you can see a pattern here; we like to commission experts to get their opinions -- to review the basis for exclusion of CLL. Those reports are coming in now. We expect to have them this month.

If appropriate, once we've received all those opinions, we will initiate rule-making to change the PC rule and include CLL, if appropriate. If we do that, that would be very significant because we would be the only radiation compensation program in the world to cover that condition.

Okay. Target organs for hematopoietic and lymphatic cancers. These are the leukemias and lymphomas. We are re-examining which target organs we use in these cancers. What I mean is

-- take for instance external radiation exposure, radiation that comes from outside the body. It's measured on a film badge, but we don't apply that number directly. We apply an organ dose conversion factor. So we figure out what fraction of what was measured on that badge actually reached the organ of interest. So you can see it's pretty important to pick the right organ 'cause we have different factors for different organs.

And the question that's motivating this re-examination is how does the site where you find a lymphoma, for instance, relate to the site of the original radiation injury. In other words, if you find a lymphoma in a lymph node in your armpit, do we use the lymphatic tissue as the target organ? Might it be the lung? Might it be the bone marrow? The bone marrow is where lymphocytes start as stem cells, so where did the actual radiation injury occur?

Well, these are pretty technical questions, so we've secured the services of a hematologist to help us review the target organs we pick for lymphomas. As long as we have a hematologist on board, we decided to throw in the leukemias,

as well, although we don't really have as many questions there. We're much more confident in our target organ selection for the leukemias.
Okay. We're nearing the end here. Just hold with me for a couple more minutes.
Occupational studies. This is also a topic that has generated great interest among the Board, I think also the public. We are in the process of assembling a database of worker cohort studies, and we're looking specifically for dose response data that we can use to either modify our existing risk models or to come up with entirely distinct risk models.
I did a first cut on the literature search for these studies, and I found very easily 167 studies, but I guarantee there will be more. I did this right before I started getting ready for this meeting and kind of put it on hold for that. Once I start digging into this first group of 167, I will find more. That total, that 167, includes 153 peer-reviewed journals and about a dozen NIOSH reports.
Here's how it breaks down by populations examined. Far and away, about -- at about three-quarters, the largest group of these are

nuclear workers, about three-quarters. And that's a good thing, because that's of course the most relevant type of study that -- that we could have, all other things being equal.

We've also included an equal num-- about an equal number of uranium miners, radiologists, air crew type studies, and a few more general studies.

Dovetailing with that last project, that occupational study project, is a re-examination of the way cancers are grouped in IREP. This was originally done with the Japanese bomb survivors. Biological plausibility was certainly considered, but the motivator was, for certain rare types of cancer, there weren't enough numbers to come up with a risk model. And so they were combined together to come up with a workable risk model.

We're taking a new look at that, a fresh look at the way that was done. And there are three criteria that we're using. The first thing that we're going to look at is the availability of risk coefficients for individual cancer types. And an example here is salivary gland, can we parse that out from the oral cavity and

pharynx model? Might we be able to split up multiple myeloma and lymphoma? And of course prostate, we're interested in whether or not we can split the prostate out from the other male genitalia. Those are just examples. They're not meant to be exhaustive.

A second criteria that we use -- that we're looking at is transport between populations. I mentioned that with regard to CLL, but the question also applies to some other cancers, as well. And the question here is -- we're looking at the appropriateness of transferring groups of cancers from the Japanese population to the North American population versus doing that on an individual basis. We're taking a look to see whether that was appropriate in all cases.

And finally the application of more recent or different risk coefficients for individual cancer types. An example here is a study published a couple of years ago by Dale Preston looking at nervous system cancers in the A-bomb survivors, and also some melanoma numbers that Elaine Ronn* put out a few years ago. Those are just a couple of examples.

And so that concludes my prepared remarks, and I'd be happy to entertain any questions you might have.

DR. ZIEMER: Okay. Thank you very much, Brant. Let's open the floor for questions. Gen Roessler?

DR. ROESSLER: Before you started I thought I was going to have a lot of questions, but you answered every one of them. I guess my impression at this point is that -- well, I'm impressed that NIOSH indeed is keeping up to date very much on the scientific developments, and it looks to me like it's -- most of the changes are claimant friendly.

DR. ULSH: Yes, yes, they are. We would certainly have a higher bar to jump if we were going in the opposite direction, if we were making it less claimant friendly. Although keep in mind, with the lung model it's not an across-the-board claimant-favorable move. I --

DR. ROESSLER: But what you're doing is valid, and I --

DR. ULSH: I hope so.

DR. ROESSLER: I mean my interpretation is that everything that you've introduced as new

science is valid --

DR. ULSH: Thank you.

DR. ROESSLER: -- based on more data and more evaluation and more expert evaluation.

DR. ULSH: Thank you.

DR. ZIEMER: Brant, many of these epi studies, even the larger ones, are still seen as lacking the statistical power, for example, of the Japanese studies.

DR. ULSH: Right.

DR. ZIEMER: In fact, that's one of the main shortcomings, and perhaps one of the reasons they have had less stature as sort of benchmarks.

DR. ULSH: Right.

DR. ZIEMER: However, there are some groups that are doing -- I guess you would call it sort of meta-analysis, combining many studies and pulling those together. I think there's maybe some European groups doing that, as well as US. Are the one -- articles you're reviewing, are you -- you're going beyond those individual studies and looking at those pooled studies, as well?

DR. ULSH: Yes. Yes, where appropriate we will

check out whether or not we can do some meta-analysis. I think the study -- the European one that you mentioned, you might be thinking of the IARC 15-country study --

DR. ZIEMER: Yes.

DR. ULSH: -- which is --

DR. ZIEMER: Yes, exactly.

DR. ULSH: -- expected -- I don't know exactly when, but yeah, it's on the horizon.

DR. ZIEMER: Some of those studies reach pretty large population groups when you pool them.

DR. ULSH: Right.

DR. ZIEMER: And hopefully the statistical power will be there and allow us to have a little more reliable risk coefficients.

DR. ULSH: Well, you hit it dead-on. The problem with occupational studies is they -- because of the lower numbers involved, they don't typically have the power of the Japanese studies. On the other hand, they tend to be more relevant in terms of the types of exposure that the --

DR. ZIEMER: Yes.

DR. ULSH: -- populations receive.

DR. ZIEMER: Right, they are more chronic

exposures of the type that we have in the workplace, so that's --

DR. ULSH: So there are pluses and minuses there, you hit it.

DR. ZIEMER: Okay. Other -- Gen Roessler again? No. Mark?

MR. GRIFFON: I just have a question about the CLL.

DR. ULSH: Yeah.

MR. GRIFFON: In the cases -- the early -- you mentioned potential for mis-diagnosis --

DR. ULSH: Right.

MR. GRIFFON: -- especially among the earlier cases. Have you made any policy decisions to view them as hairy cell -- or --

DR. ULSH: We haven't really got that far. We're still wrestling with the question of whether or not to include CLL, but --

MR. GRIFFON: Right, but in that case you could -- you know, it would be claimant favorable, obviously.

DR. ULSH: One would think, yeah.

MR. GRIFFON: Yeah.

DR. ULSH: Those are ideas that we have talked about in terms -- if we do decide to include

CLL, the next question of course becomes what risk model do you use, and that's -- that's the hard part. We haven't really begun to wrestle with that yet, but yeah, those types of considerations will come into play, for sure.

DR. ZIEMER: Tony?

DR. ANDRADE: Brant, what -- what sort of general results have you seen from the worker studies insofar as the miners -- the miner population is concerned? In general what sorts of things are you seeing --

DR. ULSH: Higher lung cancers.

DR. ANDRADE: Higher lung cancers or --

DR. ULSH: Oh, yeah, for sure.

DR. ANDRADE: -- a lower threshold for lung cancer?

DR. ULSH: I'm not quite sure what you mean when you say that.

DR. ANDRADE: Well, for a given exposure -- okay? -- for an inhalation exposure --

DR. ULSH: Yeah.

DR. ANDRADE: -- chronic, over a long period of time --

DR. ULSH: Right.

DR. ANDRADE: -- how shall I say it, lower

concentration to the point where you see the onset of cancer?

DR. ULSH: I'm not quite sure how to answer your question. What I can say is that in the uranium miner population there is definitely -- it's pretty well accepted that there's increased incidences of lung cancer.

DR. ANDRADE: Right.

DR. ULSH: In terms of a dose response relationship, I haven't dug into it yet enough to -- to be able to say what they're seeing, you know, and whether we'll find any useful data in terms of a dose response relationship other than that they do have a higher incidence.

DR. ANDRADE: Higher -- well, okay, yes. I mean we knew that, but is there anything new coming out of that? The other -- the other problem with the miner population was that a lot of -- a lot of miners tend to be smokers, as well.

DR. ULSH: Right, right.

DR. ANDRADE: And so when you mix the alpha radiation with the smoke, that's always a deadly combination. Even in dog studies that's

been shown to be the case.

DR. ULSH: Sure.

DR. ANDRADE: Is there -- is there anything new emerging?

DR. ULSH: Jim has jumped up. He might have more to add than I do.

DR. NETON: The uranium miner data has a unique conundrum in the sense the irradiation of the sensitive cells is very different than you might experience from say a uranium-exposed cohort working in a rolling mill, for example. Typically the lung cancers in uranium miners show up in the third and fourth bifurcations of the tracheobronchial tree, and that has more to do with physics and aerosol deposition patterns of the ultrafine aerosols than -- than what you experience with the particle size distribution in an occupational environment. The point is, it's not necessarily -- the risk -- the risk coefficients are not necessarily relevant to our -- our population other than the uranium-exposed population, which we do have some.

DR. ULSH: Well, and the radon -- the radon-exposed population, right.

DR. ZIEMER: I noticed Owen was about to make a

remark. Can you add to that, Owen?

DR. HOFFMAN: (Off microphone) Yes, Brant (unintelligible) --

DR. ZIEMER: For the record, Owen, give the --

DR. HOFFMAN: Owen Hoffman. Brant, really fine presentation. I just wanted to add an item of clarification. When you showed the bar graph --

DR. ULSH: Yes.

DR. HOFFMAN: -- of the probability of causation and the comparison between the new update to be consistent with the NIH approach and the old -- or the current approach with NIOSH-IREP for lung cancer in smoking categories, of course that's the comparison at the upper 99th percentile -- the upper 99th credibility limit of PC. The differences between the approach are marked at lesser percentiles of the -- of the distribution of PC. But because there is -- there is always some fraction of the interaction of either approach that's multiplicative, they tend to come closer together and that's why they look so similar throughout those categories.

DR. ULSH: Thank you, Owen. I should mention -

- I should have mentioned this earlier. Those numbers were prepared for us by SENES, so Owen is really the expert on -- on those numbers. Thanks, Owen.

MR. ELLIOTT: We should talk a little bit about process here. According to our rule, probability of causation rule, we're required to bring to the Board any substantive change that we would make or propose to make in our risk models. And what you've seen here today in Brant's presentation is some of the -- some imminent effort in that regard. We are tasking, as you've seen indicated in his slides, subject matter experts to bring scientific opinion to bear on these particular questions. We will bring that forward with our proposal, if there is a proposal, for substantive change to this Board and get your thoughts and your comments on that. We're not at that point yet.

We're probably as close as we're going to get for thyroid, I think. We're probably looking to you today to say what are you -- what's your thoughts about thyroid. We don't -- we didn't commission any subject matter experts. It's

pretty straightforward in our mind that that's something we ought to do and we ought to make that change and incorporate it immediately. It is for a small group. Those very -- people in our case file load that would have started work at a very young age, and it's a very limited number.

But the other -- the other issues that Brant has raised on CLL, that's a rule-making effort. Once we get our subject matter experts' comments in place and we work up our rule-making effort, we'll come forward with pub-- you know, public comment in that per-- in that effort and seek the Board's comment as part of that like we've done in our other rule-making efforts.

And then lung cancer model adjustment, we'll see what our subject matter experts say about that, bring a proposal to the Board on that.

DR. ULSH: Bone cancer's in the same category as thyroid.

MR. ELLIOTT: Yeah, bone cancers -- as I said, we're seeing nods around the table about bone and thyroid. I think we're ready to make those changes happen.

DR. ZIEMER: Larry, are you asking for formal action on those --

MR. ELLIOTT: I think it's --

DR. ZIEMER: -- today or is this a heads-up for next time?

MR. ELLIOTT: Well, you -- you can -- you could -- you have an option here, I believe. You could say to us that you want to see more -- more informative work done on -- on either one of those, or you could be satisfied with what we presented. Basically you've heard about the lung for a couple of other sessions from Russ, so it's not a new topic. The thyroid I think you've heard once before. You haven't seen these data that SENES helped generate for us. These are new. But they show you the slight changes that these modifications would result in, so you have an option I think to say to us, if you're satisfied with what you see, they're -- we think they're based on sound science, I mean limited as it is. But what's your pleasure?

DR. ZIEMER: While you're thinking about your pleasure, the thyroid model adjustment, as I look at it, doesn't really look to be an

adjustment -- at least -- or maybe in that little window of age 18 to 20 there's a slight --

DR. ULSH: Exactly.

DR. ZIEMER: -- nudge on the midpoint of the range, but -- and it's all captured within the error/era* of it, so it might have a little effect on a few cases.

DR. ULSH: It's very slight, and it is a very low number of cases, yeah.

DR. ZIEMER: So that's the only -- that is what your recommendation is then on the -- on the thyroid model, to basically alter that factor for that -- what is it, people who started to work before age 20?

DR. ULSH: Yeah, they were exposed before age 20.

DR. ZIEMER: Only the exposure -- years it occurred before 20.

DR. ULSH: Exactly.

DR. ZIEMER: Which for --

DR. ULSH: There's not many.

DR. ZIEMER: Not many people and it's a very small number of -- a couple years at most for those for whom it's in operation.

DR. ULSH: Right.

DR. ZIEMER: Okay. Who had a comment on that? Yes, Tony?

DR. ANDRADE: I was just curious as to when the jury's supposed to be back in insofar as your SMEs on the other research efforts that are going on. Or -- well, not research, but their efforts to consider the data.

DR. ULSH: CLL, we expect to have them all back this month. The lung cancer SMEs, back by mid-February. The lymphatic target organs, that's not a panel. That's just one --

DR. ANDRADE: Person.

DR. ULSH: -- one hematologist, and it'll come back pretty quick. I can't say exactly when, but pretty quick.

DR. ANDRADE: I would like -- I would like to suggest that we either have an update or perhaps the result of their consideration presented at our next meeting in February, if that is possible.

DR. ULSH: I have no objection to that.

DR. ZIEMER: The update on these others?

DR. ANDRADE: Yes.

MR. ELLIOTT: Please consider what we would

bring you as -- what we would like to bring you would be our proposal, and so yes, we can certainly give you an update, but my intent would be --

DR. ZIEMER: That would be the update.

MR. ELLIOTT: My intent would be to come before this Board and say here's our proposal, our recommended -- recommendation for modification. And it's -- we're not trying to put any criteria on what substantive is here -- a substantive change. We see these as fitting that model. We want to bring them before you and have the public observe this process and see what changes are being proposed here.

DR. ZIEMER: The thyroid probably is just on the borderline of being substantive, but -- comment? Jim and then Roy.

DR. MELIUS: Comment I guess is -- one is sort of practical, and I'm -- our next agenda's already pretty tight and I'm not sure there's a lot of time there, particularly if we're going to be discussing these and a procedure in some detail and so forth, but we -- we can see. The other one -- question I have is a practical one. From your point of view and perspective

in terms of adopting these, is it easier to do them like as a group, so you know, do -- do we wait and do them all -- or is it easier to do them incrementally --

MR. ELLIOTT: I think --

DR. MELIUS: -- and just adopt them as we --

MR. ELLIOTT: I think we're ready to take on thyroid and we're -- and bone. We can make those changes if -- if there's no objection. That's what I'm looking for. Is there an objection to us doing that?

DR. ZIEMER: We'll take formal action here in a moment. Roy, did you have a comment?

DR. DEHART: I felt prepared to comment on thyroid, having some familiarity with the literature. I think that the direction you're proposing is appropriate and I would suggest we go forward.

A second question I would have, as well, do you automatically go back into the records that you have where thyroid has been an issue and recalculate?

DR. ZIEMER: Yes.

DR. ULSH: For those cases for which this change would -- would have an impact, we would

definitely go back to look and see if it might change anyone's decision, definitely.

DR. ZIEMER: For the record, I'd simply like to call for a motion to have the Board endorse these modifications, first to the thyroid model and then to the bone model, as described. Is there such a motion?

DR. DEHART: I would move that we adopt the thyroid adjustment as provided.

DR. ROESSLER: Second.

DR. ZIEMER: Okay. You're wanting to act separately on them?

DR. DEHART: I'm not as comfortable to go forward with the -- with the bone.

DR. ZIEMER: Okay. We'll do the thyroid first. Discussion on the thyroid model?

(No responses)

It seems to be fairly straightforward. All in favor, say aye.

(Affirmative responses)

DR. ZIEMER: Opposed, no? Any abstentions?

(No responses)

DR. ZIEMER: So the Board endorses proceeding with the thyroid model.

Just for clarification, on the change to the

bone model, this has to do with the latency period --

DR. ULSH: Yes, it does.

DR. ZIEMER: -- where previously they used for the latency period an ill-defined or --

DR. ULSH: It was other solid tumors.

DR. ZIEMER: -- a generally defined...

DR. ULSH: I can give you a couple more details, and if you --

DR. ZIEMER: How -- what will be the new -- tell us how it changes then so --

DR. ULSH: Yeah.

DR. ZIEMER: -- under the new latency period, what...

DR. ULSH: Before, with the other solid tumors -- and Owen, perhaps you can correct me if I say anything wrong -- for the cancers that occurred very shortly after exposure, so we're talking about within a -- what, two, maybe three years, Owen? -- the PC value was zero. It was a zero. When we switch it over to the thyroid, it gives a very low but still positive PC result. That's the major impact.

Do I have that about right, Owen?

DR. HOFFMAN: Yes.

DR. ZIEMER: Yes, and didn't we have one like that before where we went from a zero step function -- or is this the one?

DR. ULSH: I think that was the thyroid -- the thyroid used to be that way --

DR. ROESSLER: We had a leukemia one, I think, that was similar.

DR. ZIEMER: Well, this is a similar sort of change.

DR. ULSH: Yes, a similar sort of change.

DR. ZIEMER: It actually takes that period between exposure and onset of the tumor and -- it's sort of like under the old system. If you were a day early, it didn't count --

DR. ULSH: Yes, exactly.

DR. ZIEMER: -- and then the next day it was okay to count it. And they're saying well, let's make that more of a --

DR. ULSH: Smooth function.

DR. ZIEMER: -- smooth function.

DR. ULSH: Right.

DR. ZIEMER: That's the nature of the proposed change.

DR. ULSH: And it is claimant favorable in all cases. It doesn't result in a penalty for

anyone.

DR. ZIEMER: Yes, Leon?

MR. OWENS: Dr. Ziemer, I'd like to make a motion that the Board allow NIOSH to move forward with the bone adjustments.

DR. ZIEMER: Okay. Is there a second to that motion?

MR. PRESLEY: I'll second it.

DR. ZIEMER: Seconded. Discussion? Yes, Jim?

DR. MELIUS: And I apologize, I had to take a phone call and got -- missed some of this, but I think it would be helpful to these future discussions of these, and even maybe to this one, to actually have a written proposal from NIOSH on what the changes are going to be, rather than just slides and then your verbal description, captured in the record of the meeting.

MR. ELLIOTT: That's fair and we can do that. We just thought you'd seen these two --

DR. MELIUS: And I'm not --

MR. ELLIOTT: -- several times before and knew the background on it, so -- but I understand your point.

DR. MELIUS: And I'm not saying that would

change how I would vote or feel on bone, but I just think for future -- if you want -- feel ready to take action, come -- let's have a proposal so we -- that we can refer to and adopt and I think it would be easier for everybody.

DR. ZIEMER: It appears the Board is ready to act on this one. All in favor, aye?

(Affirmative responses)

DR. ZIEMER: Any opposed, no? And any abstentions?

(No responses)

DR. ZIEMER: Thank you. Then NIOSH will incorporate these changes right away, and also go back and check previous dose reconstructions to determine if there are significant changes to probabilities of causation for other cases.

DR. ROESSLER: Take a break.

DR. ZIEMER: Yes, that completes this discussion, and we're on schedule for a break -- 15-minute break and we reconvene at quarter of. We have a public comment session coming up.

(Whereupon, a recess was taken from 2:35 p.m. to 2:50 p.m.)

PUBLIC COMMENT

DR. ZIEMER: Know that the sooner we go -- started, the sooner we'll be finished. It's been a marathon for many of the Board members today. Thank you for bearing with us.

At this time on our agenda it's the period for public comments. The first commenter this afternoon will be Joyce Brooks from Livermore. Joyce, are you here?

MS. BROOKS: (Off microphone) Yes.

DR. ZIEMER: Yes, please take the microphone. Thank you.

MS. BROOKS: (Off microphone) Right here?

DR. ZIEMER: That's fine right there, sure. Thank you. Just make sure that it's on.

MS. BROOKS: Thank you. Okay, I am Joyce Brooks, a claimant and the co-leader of the Sick Worker and Family Member support group here in Livermore. My husband Carl worked at Livermore Lab for 32 years. He did everything from machining beryllium, uranium, and other substances, to engineering work. I knew he was very smart, even though he did not have a college degree. And when I reviewed his

records, I saw the commendations he received. I was truly amazed.

I also need to tell you that one of the most difficult things in my life was watching the person I love die because he was unable to breathe. I won't go into details about my case, because it is a beryllium case, except to share a couple of details that I think apply to dose reconstruction work.

While working at Livermore Lab Carl traveled to many sites to work, such as Rocky Flats, Y-12, Pantex, Bendix, Paducah, and for long periods of time every week on the corporate jet to Nevada Test Site. He was exposed to radiation, as well as beryllium. Although he believed in the end that the beryllium killed him, I also saw that his immune system was weakened, and I believe that was due to the radiation exposure that he had.

The reason I bring this up is that the Lab supposedly gave me all of his records, but many of his records from these other sites, especially dose readings, are not available. Therefore, if I was filing under cancer claim, the dose reconstruction would not be complete

without all these records. This is an important point because so many in our support group are in this situation.

Although my claim has been denied three times, I now feel fairly confident because of the medical evidence that I put together about Carl's lung problems prior to 1993. The only reason I am currently in this position is because of the help of Tri-Valley Cares, the Government Accountability Project, and Dr. Lawrence Fortas* at the Medical Screening Program at University of Iowa.

The programs that are being funding (sic) are not really helping us. Because of this, many people have given up and many will not apply because they feel it is impossible.

I want a fair hearing. I can accept whatever the result, payment or no payment. I just want a fair shake for myself, my family, and for all the families. And I want to fulfill my commitment to Carl to find out what happened to him.

I appreciate so much that you have held this meeting in Livermore so that so many of the support group who are older and sick could

come. I feel optimistic if we all work together we can come up with a model here for service, for the site profile, and for cooperation between the community and the government.

Thank you for allowing me to speak. I appreciate the important work you are doing, and I hope that we can build something together that helps the sick workers and their families, and that we all feel proud of. Thank you.

DR. ZIEMER: Thank you very much for your comments. I'm sorry, I turned off here.

Thank you very much for your comments to us today. Next I have Beverly Wooster, I believe it is. Beverly, are you here? Thank you.

MS. WOOSTER: I'm not prepared like my predecessor, but my husband, David Wooster, worked for the Livermore Lab from 1958 until 1991 when he died of lymphoma, which I personally know was brought on by his exposure to radiation. Much of that time he was working at Nevada Test Site, but was also mentioned by my friend that the people from the Lab travel -- traveled a lot. And they went to a number of places that are not on your list of where --

the places that you use for checking the amount of radiation and so forth.

I do recall one trip that he came home from, a field trip -- sometimes he was gone for weeks at a time. And when he came home he told me that they'd been working in a tunnel, that there was a geiger counter put up outside the tunnel and when he came out he set off the geiger counter rather loudly. Now they're not, so far as I know, given any extra clothing. He continued to wear whatever he took with him on the trip, and this was just an example of some of the other things that could happen besides all the radiation from the test site.

That's all. Thank you.

DR. ZIEMER: Thank you very much again for sharing that with us. Those two individuals, Joyce and Beverly, are the only ones that had signed up, but I do want to give opportunity if there's -- yes, sir, please. And identify for the record your name.

MR. GLENN: Okay. I -- I'd like to sit down, if I may, because --

DR. ZIEMER: You certainly may, yes. You can sit right there and they'll provide you with a

mike. That's good.

UNIDENTIFIED: I'll hold it for you.

MR. GLENN: Okay, thank you. My name is David Glenn. I'm a health physicist. I'm also a Ph.D. in physics, experimental and theoretical. I was a Lab employee from 1966 to about 1991. I had a -- there was a three-year break in there, but at that time I also worked at the Test Site. During that time I was a physicist, devoted almost entirely to containment of underground nuclear tests, and I directed many of those efforts. I published almost 100 papers in that area, 60 or 70 are out in the open literature.

Review of the NTS test schedule is approximately -- I'd like to review that for you. Approximately 1,000 tests have been conducted there. Prior to -- prior to 1963 several hundred nuclear air blast tests occurred. In that time -- this is in the open -- there's -- there's a pamphlet that shows you the announced tests -- as many as six in one day occurred there on -- on an occasion -- on one occasion. This is published in the open literature, as I mentioned.

Now that -- tests were suspended because of the contamination in the populated areas in the -- like in Utah, and I think you're probably well aware of that. Then we started underground tests, and I became intimately involved with that effort. And I worked -- and I'm going to give you an example of what the test site is like.

After you've had these hundreds of air blast tests, there's no effort at all made to contain those because, being air blasts, you know, there's no way you can do that. The radiation just spreads over whichever way the wind blows, and it's deposited typically on the surface, what doesn't blow off the site.

An example, because I worked in a high yield series of tests, a selected group of wives were granted the opportunity to make a day tour of the test site. The tour director was Roger Ide*. He took them to the Sedan Crater, and he told them they can only spend five minutes there because -- for viewing on the viewing platform because of the high level of radiation.

Now I was on a committee that evaluated -- on

many committees, I should say, that evaluated nuclear test sites for many, many years at -- at the -- at the LLNL, never considered whether a site was unacceptable because of contamination levels. What was the primary concern was whether or not that site had characteristics, geologically speaking, for containment. That was the only goal -- only site -- only reason.

Finally applied in July of 19-- 2001 to this program, submitted eight years' blood tests and an oncologist's findings. Application rejected as not recognized cancer. I cited the fact that my high mitotic index in fact proved it was a cancer. They submitted my application then and my appeal to the National Institute of Health, and they agreed with me that both forms of cancer that I have, polycythemia vera and thrombocytosis, are cancers. So one and a half years later they accepted my application and resigned -- assigned me an ID of 10,643 -- which, to a certain extent, I should have been accepted a year and a half prior to that.

Now they talk about here as a bone marrow not being accepted, but in fact is -- the cancer

that I have often progresses into leukemia. About a year and a half ago my white count started up and my doctor was somewhat concerned, and he gave me what's called bone cores out of my hip, and I've had three since because of the high level of my white count. Fortunately I did not have any sign of Philadelphia chromosome or of one other "blast" so that they could not identify that. I had not progressed into leukemia yet, but that is a natural progression from my disease that'll occur over probably the next few years.

And so what I'm speaking now -- actually I have no recriminations about my service at the Lab, that they have done this to me, because if I could do it all over again, I would in fact do it. Because I feel humbled when I see, every day, young men that are killed in Iraq. I have given very little in comparison. Yet I feel that I would like some remuneration because of the expenses associated with my treatment. Sometimes they are in excess of $1,000 a month. And so I'm sorry to have taken up your time and I'm not in better voice. Thank you.

DR. ZIEMER: Thank you very much. You

certainly don't need to be sorry for sharing your story with us today. Thank you.

Are there any other members of the public who do wish to speak to the Board today? Yes, ma'am, please -- and identify yourself for our recorder, please.

MS. BLEWITT: My name is Beryl Blewitt and I live in Stockton. I'm here to speak for my son, David Dwight Blewitt, who as a very young man went out to Livermore Lab and was a driller. He drilled the soil and I'm not sure that I can really describe in an intelligent way what his work was like because I wasn't there and I'm not trained in that. But he is -- he's unable actually to come here and speak to you himself because he is not emotionally able.

He went to Lawrence Livermore Lab as a young married man and would have done anything that they told him to do. And in drilling for -- drilling the soil, much strange substance was spewed into the air and they all touched all this stuff and there were many chemicals around. And we feel quite sure that beryllium was one of them because he continued to do this

work for quite a long time, maybe four years, until he just wasn't able to continue.

And now he has a very short memory. He is not able to focus on things. He has -- he is very, very depressed, constantly, every day. He has been given by this group, or was given about two years ago, this -- these forms that he was told to take to the doctors whom he visited with, and he has visited with at least 15 different doctors and has told them that he doesn't feel well. He doesn't know what's wrong with him. His stomach constantly hurts. He has no drive, no ambition, nothing. He's depressed, and he wants the doctor to help him find out what is wrong. And the doctors all said oh, I understand you worked at Lawrence Livermore Lab? Yes, sir. Well, try these pills, and if they don't help you, try these, try these, try these, try these. He must have had between 50 and 100 different kinds of pills -- which made him more ill. He would throw up. He would sleep for 20 hours at a time. He would be completely disoriented and have no memory.

One doctor -- and we asked -- I said David, ask

the doctor if he can put you in touch with someone who can diagnose you more specifically, because none of this is helping. It's making it -- it worse. David would fall on the ground unexpectedly. He was in his thirties. His children were frightened. What's wrong? We don't know. Well, take these pills, these pills and these pills. And he would vomit. He would sleep. And nothing made him better. So I said see if you can find a doctor who knows something about the action of those chemicals on the human body and maybe we can trace down and see what's wrong. And if they say no, there's nothing here, it's all in your head, that's one thing. But I don't think that it's in his head 'cause I have seen his reactions. His wife threw up her hands and said I don't want any more of this. She divorced him. Because of the heavy financial impact on -- all the drugs, buying all these drugs and throwing them out, they were not able to keep their house, so they lost their house.

What does David have now? Two sons who wonder about him. Are you a druggie, Dad? That's all he has -- and me. I'm not an eloquent speaker.

I have prepared nothing. I just know this from first-hand experience. If you have a question you'd like to ask me, I'd like to help by answering. But unless you direct me, I don't know how to expand further except to say that one doctor found a lump about that big around at the base of his skull. He didn't know what it was and he said well, we'll watch it for a while. So three or four months went on and nothing changed. They continued to take brain scans and that sort of thing, and it didn't change in its diameter or in any other way within that three or six-month period, so they didn't know what it was. They didn't want to operate because it would be possibly fatal if it were incorrectly done and they didn't know what it was all about anyway.

So my request is, is there some way that I can reach someone here to put me in touch with some doctor somewhere who will help me and help my son? Thank you.

DR. ZIEMER: Thank you.

MS. BLEWITT: Is there a question?

DR. ZIEMER: Your -- your remarks have been heard by a variety of folks from different

agencies, and perhaps after the meeting someone may be able to direct you. I -- I don't know the answer to your question at this point, but we've heard what you've said and it -- it appears to me that this may be a Department of Labor issue. It's apparently not involving a cancer case, which we're dealing with here, but perhaps there are some here -- but thank you for sharing that with us, yes.

Were there any others -- members of the public that did wish to speak today?

Okay, thank you very much. We'll proceed with our agenda items.

BOARD WORKING SESSION

We're going back to our Board working session. We have a number of -- a variety of items we need to finish up here quickly.

First of all, the quality assurance and the conflict of interest plans for our contractor, SC&A. Those are in your notebook. These are the final versions which, as I said, had mainly editorial changes from the -- from the versions that we looked at at our previous meeting. I'd like to ask Hans or any of the SCA people, can you confirm for us there are no substantive

changes other than those editorials that we talked about last time?

DR. BEHLING: To my knowledge, no. I think we've pretty much discussed the issues that we need to address in our revised version here, so --

DR. ZIEMER: And most of those changes were labeling some -- can you remind us of what those changes were? The notebooks have the new version but not the old. Or do you recall what the changes -- just describe the changes.

DR. BEHLING: Well, I'm not sure which document we're referring to.

DR. ZIEMER: The conflict of interest plan --

DR. BEHLING: Well --

DR. ZIEMER: -- and the quality assurance plan. You had some --

DR. BEHLING: -- there were some --

DR. ZIEMER: -- a number of places where you were changing some minor wording things.

DR. BEHLING: The person who could probably address that better than I can is Steve Ostrow, who is one of our SC&A team members, but I'm not really sure -- I've signed all the documents he's asked me to sign, but quite

honestly --

DR. ZIEMER: Okay.

DR. BEHLING: -- the specific changes that have been incorporated I'm not that familiar with, so I'm going to defer to Dr. Ostrow, perhaps in writing, if there's an issue that needs to be resolved here.

DR. ZIEMER: I'm not aware of any issue that needs to be resolved. I'm simply pointing out to the Board that we had -- we had in essence agreed with the substance of the documents and we wanted a clean version --

DR. BEHLING: Okay.

DR. ZIEMER: -- for final action, which is what you have provided for us, so then --

DR. BEHLING: Okay.

DR. ZIEMER: Is the Board prepared to actually take action today?

(Affirmative responses)

DR. ZIEMER: Yes, we are? Okay. Motion to approve the quality assurance and the conflict of interest plans? Tony?

DR. ANDRADE: So moved.

DR. ZIEMER: And seconded?

DR. DEHART: Second.

DR. ZIEMER: Are there any questions or discussion on those? Apparently not.
All in favor, say aye?
(Affirmative responses)
DR. ZIEMER: Any opposed, no?
(No responses)
DR. ZIEMER: And any abstentions?
(No responses)
DR. ZIEMER: Okay, then those two stand approved and are in effect. For all practical purposes, they were in effect anyway, the quality assurance and the conflict of interest, but we needed to finally approve them.
I wanted to clarify or make sure that the working group -- which is Tony Andrade, Mark Griffon, Rich Espinosa, Wanda Munn and Mike Gibson -- that you have a formal wording of your charge for -- this is the working group now that will be in place before our next meeting. We're calling this the -- it says here case and audit review work group. This is the work -- it's the dose reconstruction --
MR. GRIFFON: Case review work group.
DR. ZIEMER: Case review, yes. The charge is to meet with NIOSH and SC&A personnel on an ad

hoc basis as they carry out their activities to resolve and to clarify issues that have arisen in the dose reconstruction reviews, and to conduct preliminary review of the SCA report that addresses the issues raised by NIOSH. That -- that's the charge that comes from the Chair to you for your work.

The implication is that if the two groups meet in person -- that is, face-to-face -- that you will be there pres-- we want a Board's presence there. You are not making any decisions on behalf of the Board, but you are there to provide a Board presence as they seek to resolve or deal with differences. And then any subsequent report that comes out of that -- that is, revisions the SC&A may make -- you will do a preliminary review of that prior to its coming to the Board for action.

So this is mainly to assure that that presence is there. If it turns out that NIOSH and SC&A find that they need to meet by telephone rather than in person, then we want to make sure that you are involved in the teleconference, as well.

It was also agreed that -- for example, on a

face-to-face meeting -- that at least three of the five would be present there. We weren't mandating that all five be present, but if -- if possible, but at least three of the five. So that's just to clarify the charge to the working group.

Any questions on that? This does not require any action. I'm just clarifying -- the Chair has established the work group and is giving this charge for them for the next meeting.

MS. MUNN: Will you be chairing it, Dr. Ziemer?

DR. ZIEMER: No, that -- Tony will be chairing it, yes.

MS. MUNN: That's what I remembered. I wanted to be sure.

MR. GRIFFON: And Paul, I guess -- I'm just sort of -- it's probably going to happen in January, so will we have e-mail contacts from -- from you to --

DR. ZIEMER: Tony will take the lead and make sure -- and -- and -- and I want to make sure that both NIOSH and SC&A are both aware of this, that Tony needs to be kept informed, and please inform the Chair, as well, if and when -- or when such meetings occur. I'd simply ask

that that be done. Okay. And NIOSH will -- NIOSH will actually make sure that it occurs. Right?

MR. ESPINOSA: Tony, would you like a list of available dates, maybe for January?

DR. ANDRADE: That would be helpful. However, I think that really we're going to be kind of at the mercy of when it's most convenient for NIOSH and for SC&A to meet. So I will -- I will try and get that information out to you as -- as soon as I can. I will either be calling Larry and/or Jim for NIOSH and John or Joe for SC&A.

DR. ZIEMER: Okay, thank you. Let's proceed then. We had a question on the status of the Q-clearance access. Who raised that issue? Was that -- Jim had raised it. Maybe -- maybe -- I think it was just a request for a report on that, and is there anyone here that can tell us where that stands? I know that -- I believe either John Mauro or Joe had written a letter -- Larry does --

MR. ELLIOTT: I can help out, I think.

DR. ZIEMER: Can you tell us the status of that?

MR. ELLIOTT: I hope. I hope I can. The two -- two individuals from Sanford Cohen & Associates that applied for Q clearance have now received their background checks and have been, I believe, granted the top secret clearance necessary for HHS. We have sent a letter to DOE asking them to expedite transfer of the Q based upon the background check and top secret status of those two individuals. Both individuals are with one of the teaming partners with Sanford Cohen & Associates, so Salient has to go forward to DOE and -- and explicitly make the request to make this happen and make the transfer, but we have entered a letter on their behalf to make sure that that is expedited, so it should be forthcoming. It should be imminent.

DR. ZIEMER: So that's moving along then. Thank you. And I think all that we asked for was that status report. Next --

MR. GRIFFON: Before we get off that, were there any issues -- I think it's only Savannah River where there's been -- where SCA is still having data access issues. Are those -- is that an ongoing issue or is that -- most of

those been resolved?

MR. ELLIOTT: Jim, can you speak to that -- or Stu? Stu's got that?

MR. HINNEFELD: Are we on? Yeah. It's not resolved, but we're resolving. We're engaged with Savannah River. There is an open request for documentation that I kind of put into three categories, mentally. There was some copied information apparently at Savannah River that the understanding was Savannah River was going to send to Sanford Cohen & Associates that didn't get there. And I don't have an update on that, but I'm -- have asked the question. I think I -- I know who had the custody or who -- who had control of the documents at Savannah River, so I -- I'm pretty confident that will be pretty soon.

There was an itemized list of documents in the letter that they -- that Sanford Cohen & Associates sent to us saying can you help us get these things. Some portion of that is being burned onto a disk and should be available shortly after Christmas. A portion of it -- there was apparently some misunderstanding about what the request was

for, and so I have clarified the request back to Savannah River in terms of what exact documents are -- were being asked for.

And then there were some microfilm images that were requested, certain specific microfilm images off of certain specific spools of microfilm, which is proving pretty problematic for Savannah River to obtain and pull off. And so a suggestion from Savannah River was that perhaps the principal from SC&A could go to Savannah River. They would make access available to the film machine and copying so that that person could select the images desired and -- in that fashion, and they thought -- Savannah River thought that would be quicker than -- than having the specific person at Savannah River who had to go look at it, who could interpret the images and knew what was being asked for, to have time to go do it. Okay?

Third category in the letter was actually a new request within the past week and a half having to do some things that we do have control of, and we should have that from our contractor relatively -- relatively straightfor--

relatively soon. There was a request for minutes of a meeting where no minutes were taken, no minutes were generated, so I don't know exactly what we do about that, but -- I don't know if there's some notes that can be compiled or not, but that is the status of the Savannah River request.

DR. ZIEMER: Okay. Thank you, Stu. Yes, Hans?

DR. BEHLING: Could I ask Mr. Elliott to clarify who the two individuals are whose Q clearance is imminent, because I think --

MR. ELLIOTT: I'll do that off-line with you. Okay? I don't do that in public.

DR. BEHLING: Okay. But there are multiple people and on -- on -- and I just -- you know what my role is.

MR. ELLIOTT: Understood, but I --

DR. BEHLING: Right.

MR. ELLIOTT: If you're familiar with national security interests, these people with Qs are supposed to protect that information, so I'll share that with you before we depart.

DR. ZIEMER: John Doe and John Smith.

MR. GRIFFON: Are there -- are there -- just to follow up on that, are there any other out--

outstanding data requests that -- that are problematic, I guess, either SCA or...

UNIDENTIFIED: Well --

MR. GRIFFON: It sounds like no is the answer, I don't know.

DR. BEHLING: That I'm not sure of. The people who are requesting that information are members of the SC&A team, and two of them were here, but I'm not really party to that particular request so I'm not in a position to comment.

MR. HINNEFELD: I don't know of any outstanding questions, although there was a request for access for site experts at the Hanford facility for -- as part of the profile review, and the contact at Richland, how-- or DOE Richland office, for SC&A to make contact with to arrange those discussions has been provided to SC&A, and that should proceed -- they will run into vacation issues for the rest of December. It'll be unlikely that they'll have very much success at all talking to anybody at Hanford until after the first of the year.

DR. ZIEMER: Okay, thank you. Another carryover item we had from our earlier work session was the wording of some caveats that

would appear on future copies of our contractor's reports -- dose reconstruction review reports. We had tasked Tony during the break to come up with those caveats, which would include the statement that the report had not yet been accepted by the Board and that it had not yet been reviewed by NIOSH, or something to that effect, and you were going to -- you perhaps had some additional -- do you want to tell us what you are proposing, Tony?

DR. ANDRADE: Sure. Of course this is my draft. I have -- it certainly can be edited as -- as you see fit. However, it does incorporate the elements that I also brought up during the discussion of develop-- about developing this particular set of caveats and disclaimers, if you will. What I can do is read it.

DR. ZIEMER: Yes --

DR. ANDRADE: The recorder can take it and --

DR. ZIEMER: -- you're going to propose this and let's see.

DR. ANDRADE: -- we can either act on it now or I can send it around by e-mail to everybody, but --

DR. ZIEMER: No, we need to act on it in open session, so --
DR. ANDRADE: Okay.
DR. ZIEMER: -- we'll either --
DR. ANDRADE: All right.
DR. ZIEMER: We'll either accept it or reject it or do something with it. We're going to --
DR. ANDRADE: Okay.
DR. ZIEMER: You're going to propose and we'll dispose.
DR. ANDRADE: All right. There are some abbreviations here, but these could be spelled out. The ABRWH and SC&A note that the attached report is predecisional -- all in caps. This implies that the contents regarding NIOSH methods herein have not been reviewed by the ABRWH or NIOSH for -- first dash -- scientific accuracy -- and second dash -- or applicability within the context of the provisions of -- and I think this is correct -- 40 CFR 22. Is that dose reconstruction?
MR. ELLIOTT: 82.
DR. ANDRADE: 82. 42?
MR. ELLIOTT: 42 CFR part 82.
DR. ZIEMER: Incidentally, I believe the

statement on technical accuracy probably won't be correct. That will have been done, will it not? Or factual accuracy.

DR. NETON: (Off microphone) Not technical (unintelligible).

DR. ZIEMER: What were the words that you used?

DR. ANDRADE: I said scientific, but I don't know if factual is even there. I thought that we had agreed that it would be reviewed for privacy information. Okay?

DR. ZIEMER: Yeah.

DR. ANDRADE: Okay. So I'll reread the last phrase there -- has not been reviewed by the ABRWH or NIOSH for factual accuracy or -- second dash -- applicability within the context of the provisions of 42 CFR 22, dose reconstruction, period.

UNIDENTIFIED: (Off microphone) 82.

DR. ANDRADE: 82. 82, okay. This also implies that once -- that once reviewed by the ABRWH, its conclusions are subject to change, comma, or deletion, period. Hence, this report is for information only and notice is given that premature interpretations regarding its conclusions may be irresponsible.

DR. ZIEMER: Okay. And that is your proposal?
DR. ANDRADE: Yes.
DR. ZIEMER: And you're making that as a motion then --
DR. ANDRADE: Yes.
DR. ZIEMER: -- and I'll ask for a second, and then we'll discuss it.
MR. PRESLEY: Second.
DR. ZIEMER: Seconded. Actually I believe there's three different sort of parts to this, the first part being that this is -- you said the Board and SCA note that this is predecisional?
DR. ANDRADE: Right.
DR. ZIEMER: And has not been reviewed for factual accuracy or applicability within the requirements of 10 CF -- not 10 -- of 42 CFR 82. Is that -- am I correct so far?
DR. ANDRADE: Yes.
DR. ZIEMER: That's -- that's part one.
DR. ANDRADE: One.
DR. ZIEMER: Part two, this also implies that once --
DR. ANDRADE: Reviewed.
DR. ZIEMER: -- reviewed, the -- what, the

content or the --

DR. ANDRADE: By the ABRWH --

DR. ZIEMER: Uh-huh.

DR. ANDRADE: -- its conclusions are subject to --

DR. ZIEMER: The report's conclusions here, you're --

DR. ANDRADE: Yes.

DR. ZIEMER: -- not the Board's.

DR. ANDRADE: Are subject to change or deletion.

DR. ZIEMER: All right. And the third part is?

DR. ANDRADE: Okay. Hence this report is for information only and -- well, we can throw this other stuff out -- that premature interpretations regarding its conclusions -- the report's conclusions -- may be irresponsible.

DR. ZIEMER: Okay. Now what I'd like to do, I think, is -- with your permission, is divide the motion into three parts, because I can see -- at least it appears to me that one might favor portions of this and be concerned about other portions and -- or want to handle them in a different way.

Is that an agreeable approach or do you want to do it as one whole fell swoop?

DR. ROESSLER: I'd like to try the first -- all in one...

DR. ZIEMER: Well, let me open the floor for discussion and we'll just do it that way. It's one motion right now.

Let me point out something, just as kind of a -- sort of informational item here. I believe that the report is the report. That report is not subject to change -- I mean that's the -- they -- they will be delivering to us the product. That's -- the task says bring us your report. What is -- I'm trying to differentiate here between what we do with it.

Now it's true, we could say go back and give us a different report, or we could say the -- the conclusions may not be accepted or may -- or whatever. I'm not sure we want to necessarily say that the report itself is going to change.

DR. ANDRADE: I didn't --

DR. ZIEMER: You know what -- how I'm trying to distinguish between --

DR. ANDRADE: Right.

DR. ZIEMER: -- what we do and what our

contractor's done. They bring us a report, which I think in a sense is the final product.

DR. ANDRADE: Right.

DR. ZIEMER: We can always go back and say we don't -- we didn't like that report; we want a different one.

DR. ANDRADE: That's why I said the report's conclusions, I didn't say the report was subject to change.

DR. ZIEMER: I gotcha.

DR. ANDRADE: But maybe conclusions is too closely tied to the report, hence there -- there may be a better word.

DR. ROESSLER: Interpretations?

MR. GIBSON: Content of the report?

MR. PRESLEY: Interpretation of the report.

MR. GIBSON: Content or its findings?

DR. ZIEMER: The thrust of what we want to accomplish, I believe, is to indicate that the Board may accept, may reject or may change what it believes its con-- the Board's conclusions may be different from the report's. That's what we're trying to point out.

DR. ANDRADE: Right.

MR. GRIFFON: Why don't we state it that

simply? I mean, you know...

DR. ZIEMER: Once reviewed, the -- once the report is reviewed, the Advisory Board may reach conclusions that differ from those in the report.

Is that -- is that the thrust of it? You're simply trying to point out that this -- at this juncture it doesn't represent the Board's view, and the Board's views may or may not be different.

DR. ANDRADE: That's fine.

MR. GRIFFON: And then the last part of Tony's sentence there would be -- and therefore this report is for information purposes only. I agree with that. The part after "only" I have a little bit of heartburn about. I could agree with everything up till the "only", probably.

DR. ANDRADE: That's --

MR. GRIFFON: Yeah.

DR. ANDRADE: That's where I...

DR. ZIEMER: Well --

DR. ANDRADE: The part after that is...

DR. ZIEMER: -- let me take the second part and see if you want -- you're regarding that as a friendly amendment? Do you want to just say

this also implies that the re-- the report's conclusions may not -- or the Board's -- the Board's positions -- position may not be the same as the --

DR. DEHART: May differ.

DR. ZIEMER: -- may differ from the report's conclusions. Okay.

DR. ANDRADE: That's fine.

DR. ZIEMER: So the second part would be the Board's position may -- after review, the Board's position may differ from the report's conclusions.

And then the third one -- Mark, you're proposing, I think --

MR. GRIFFON: The Board's positions or the Board's recommendations?

DR. ZIEMER: The Board's position -- positions and recommendations --

DR. DEHART: There are no recommendations in there, per se, are there -- in that report?

MS. MUNN: The Board's conclusions.

DR. DEHART: But the conclusions.

MS. MUNN: Uh-huh, the Board's conclusions.

MR. GRIFFON: Positions is fine, I guess.

DR. ZIEMER: The Board's positions may differ

from those -- from the report's conclusions. And then the third item would be this report is released for information only, and that premature interpretation regarding its use may be irresponsible.

Mark, you're proposing that the last phrase be dropped, and I think I'll interpret that as a proposed amendment and ask if there would be a second to dropping that phrase -- and it's seconded. Any discussion on dropping the phrase? Yes.

DR. ANDRADE: That was my whole driver. Okay? That was my bottom line driver for even volunteering to put this together. That, I believe, has to be in there. I am sick and tired of personalities taking things out of context. I believe either that word stays or we just change the word.

DR. ZIEMER: Other -- other comments on that? Wanda?

MS. MUNN: I think a statement of that type definitely needs to be there. I would tweak the words a little bit, but from my perspective, this statement is part and parcel of the message that needs to be conveyed.

In the same tone, I would begin that statement with the reader should be cautioned, or the reader should be warned that -- before the rest of the words flow.

DR. ZIEMER: Be cautioned that what?

MS. MUNN: That this document has not seen the light of day.

DR. ZIEMER: Well, we basically said that in the first two items.

MS. MUNN: I know, but I'm -- I'm speaking to two different things here. First I'm responding to the question with respect to the final statement, and I'm also saying in addition to that, before any of the beginning statement, I would have added the reader should be cautioned or the reader should be warned.

DR. ZIEMER: Well, the reader should be cautioned that this report is for information only? Is that still friendly? And that premature interpretation of its conclusions --

MS. MUNN: And interpretation of its conclusions is unwarranted and unwise, I would say.

DR. ROESSLER: How about unprofessional? We need to tone it down maybe a little bit.

MR. GRIFFON: Yeah.
DR. ZIEMER: Well --
DR. ROESSLER: Shouldn't have quite so much emotion.
DR. ZIEMER: -- unprofessional, irresponsible, all are pretty judgmental. It seem-- why can't we just say please don't do it.
MR. GRIFFON: And interpretation of -- of -- I was just going to stop it at "is premature", or --
DR. ZIEMER: The reader should be cautioned that this report is for information only and premature --
MR. GRIFFON: And drawing conclusions from this report at this point --
DR. ZIEMER: Is unwarranted --
MR. GRIFFON: -- is premature or is --
DR. ZIEMER: How about drawing premature conclusions is unwarranted? How would -- is that --
UNIDENTIFIED: (Off microphone) That's fine.
MS. MUNN: How about just drawing conclusions?
DR. ZIEMER: Is that strong enough, Tony, without being too harsh, or --
DR. ANDRADE: That's like -- that's like

putting a really big fat boxer's glove my right hand instead of letting me hit it with a fist.

DR. ZIEMER: That's sort of what I'm trying to do.

Well, look, can I make the glove any smaller and still...

DR. ANDRADE: I'll accept that. That's fine.

DR. ZIEMER: Drawing premature -- drawing premature -- what was it?

DR. ROESSLER: Interpretations.

DR. ZIEMER: -- interpretations, I can't read my own writing at this moment -- interpretations regarding its content is not warranted -- is unwarranted?

MR. PRESLEY: Is unwarranted.

MR. GRIFFON: Either way. Paul, can I -- can I --

DR. ZIEMER: I'm going to send Tony after you.

DR. ANDRADE: One of my cousins.

MR. GRIFFON: Can I ask to go back to the beginning part again, just to -- just to hear --

DR. ZIEMER: I will read you what I have, and I may need help.

The Advisory Board -- ABRWH, the Advisory

Board, and SC&A note that the attached reports -- report is predecisional and has not yet been reviewed for factual accuracy or applicability within the requirements of 42 CFR 82 -- is that the right one?

This also implies that the report's -- this implies that the report's conclusions -- I'm trying to read my writing. This -- this implies that the report's conclusions have not been reviewed by the Advisory Board -- wait a minute. I've made so many changes I'm having trouble reading this. This implies that until reviewed by the Advisory Board, the report's conclusions are subject to change or deletion. The reader should be cautioned that this report is for information only, and that premature interpretations regarding its conclusions are unwarranted.

MR. GRIFFON: I'm con-- now I'm a little confused 'cause I thought you were going to change that part of subject to change or deletion to the Board's positions may differ.

DR. ZIEMER: That's where I -- I've made so many changes that I can't read it. Yes, I found it. Yes, the wording is the Board's

positions may differ from the report's conclusions, rather than subject to change or deletion.

Now do you want to see this before you somewhere on the board or...

MR. GRIFFON: (Off microphone) I don't know (unintelligible) time but...

DR. ZIEMER: Are you comfortable enough, with some -- some polishing, that --

MR. GRIFFON: Just that front end I wanted to discuss for one more --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- one more --

MS. MUNN: And me.

MR. GRIFFON: The factual accuracy review, I thought -- I thought that was going to take place prior to --

DR. ZIEMER: Yes, that's why I asked that question originally when --

MR. GRIFFON: Yeah.

DR. ZIEMER: Was factual accuracy the words you used in your -- or was it technical -- it's factual.

DR. ANDRADE: Okay, I said scientific.

MS. MUNN: Scientific.

DR. ANDRADE: But I mean --
MR. GRIFFON: Yeah.
DR. ANDRADE: -- it implies factual. When Dr. Melius was here, I --
MR. GRIFFON: That was different, though.
DR. ANDRADE: -- thought it was agreed that this process --
DR. ZIEMER: Factual accuracy would -- would occur.
DR. NETON: There is a factual accuracy review by NIOSH, but the Board certainly hasn't done any factual accuracy review, and that's what I was interpreting that to say, but...
DR. ANDRADE: Exactly. And I thought that key in the review process would be that SC&A sends the report to NIOSH, and there is perhaps a factual accuracy review, but most importantly, there will be a Privacy Act review, and then it's sent out --
DR. ZIEMER: So you're talking about a review by us.
DR. ANDRADE: Yes.
DR. ZIEMER: Okay, understood. Are you ready to vote on the motion? Yes, Wanda?
MS. MUNN: One more requested word change. In

the very first line, instead of "note", can we say "warn" -- "warns" rather than "notes", because this is intended -- the entire statement is intended to be a warning, a cautionary statement.

MR. GRIFFON: How about "cautions"?

MS. MUNN: We've used "caution" down below, but -- I really have no objection, I just think "notes" is kind of a --

DR. ZIEMER: Does "cautions" --

MS. MUNN: -- weak...

DR. ZIEMER: -- sound okay with everybody?

MS. MUNN: "Cautions" is fine with me.

DR. ZIEMER: Okay. We ready to vote on this? We may have to do a little polishing, but you understand what the content will be. Okay. Yes, Leon?

MR. OWENS: Would you read the entire language, please, Dr. Ziemer, for my --

MR. GRIFFON: This is just a test, you understand.

DR. ZIEMER: I'll try to read --

MR. GRIFFON: We want to see if you can.

DR. ZIEMER: Somebody take notes.

MS. MUNN: Someone write this down.

DR. ZIEMER: Okay. One, the Advisory Board and SCA caution that the -- that the attached report -- attached -- or that this report --

UNIDENTIFIED: (Off microphone) It should be attached.

UNIDENTIFIED: (Off microphone) This is a cover...

DR. ZIEMER: Okay. Well, doesn't this have to be stamped on the report? It should be in the report, not a -- not a -- not as a cover letter. I think it should be stamped on the report.

UNIDENTIFIED: Okay.

DR. ZIEMER: Caution that this report is predecisional and has not yet been reviewed for factual accuracy or applicability within the requirements of 42 CFR 82.

Two. This implies that the report's content, until reviewed by the Advisory Board, is -- until reviewed by the Advisory Board, may differ -- this is the one I'm having trouble with all my mark-up. This implies that the --

MR. GRIFFON: Board's positions may differ.

DR. ZIEMER: That until reviewed by the Advisory Board, the...

MR. GRIFFON: No, no, no.
DR. ZIEMER: The positions in the report may differ from -- or the -- wait a minute.
MR. GRIFFON: One -- this implies that once reviewed by the Advisory Board --
DR. ZIEMER: Yes, that -- there's the word, once reviewed --
MR. GRIFFON: -- the positions may --
DR. ZIEMER: This implies that once reviewed by the Advisory Board, the Board's positions may differ from the report's conclusions.
That's the word I missed, once. Okay, thank you.
Three -- we okay, Leon? Okay.
Three, the reader should be cautioned that the report is for information only and that premature interpretation regarding its conclusions is unwarranted.
MR. GRIFFON: And just one question that I just thought about. At the very beginning we say the Board and SCA caution. I don't know that we can speak for SCA in our -- in our -- just a -- just a question I have.
MR. PRESLEY: Shouldn't it just be the Board cautions?

MR. GRIFFON: Yeah, yeah.
DR. ZIEMER: We're asking SCA to put this in the report.
MR. GRIFFON: That's true.
DR. ZIEMER: We can ask them to do that, and so this caution would come from us and from our contractor.
MR. GRIFFON: Okay. I just wanted to point that out.
DR. ZIEMER: I believe we can do that. Anyone disagree?
Are you ready to vote on this then? Mike, you have a comment?
MR. GIBSON: One more comment. I think we may be better served -- it's just my opinion -- that we turn this around to make it positive and say that it's the Board's intention to share all information that we're legally allowed to share with the public until we have to enter into deliberations, yada, yada, yada. However --
MR. GRIFFON: The Board cautions, yeah.
MR. GIBSON: I mean make it -- make it that we're trying to make ourselves --
MR. GRIFFON: That's a good point.

DR. ZIEMER: It's certainly a good point. Do you regard that as a friendly amendment, or you can add that -- we could add that as an addition, as a separate motion, if you wish? You just want --

MR. GIBSON: (Unintelligible)

DR. ZIEMER: I -- it sounds like -- does it sound like a friendly amendment that we don't go through the voting process here? Give us your wording on that. Now you have to do it.

MS. MUNN: We the members of the Advisory Board --

MR. GIBSON: The Advisory Board on Radiation and Worker Health strongly believe that the public has the right to information -- public information, and we will -- has a right to public information. This report is predecisional -- this report has not been reviewed by the Advisory Board -- and however you want to finish it up.

DR. ROESSLER: Just tie it together with the however.

MR. GRIFFON: Yeah, go into the however. The Board --

DR. ZIEMER: The Advisory Board strongly

believes that the public has a right to early access to its --

MR. GIBSON: To public information.

DR. ZIEMER: Well, the public has a right to public information --

MR. GIBSON: That's right.

DR. ZIEMER: -- to early access to the Board's --

MR. GIBSON: Work products or predecisional --

DR. ZIEMER: The Board --

DR. DEHART: This information, just -- early access to this information.

DR. ZIEMER: To the information herein.

MR. GRIFFON: Yeah, that's fine.

DR. ZIEMER: However, and then the rest of it. We okay on that?

Thank you, that's a good suggestion.

MS. HOMOKI-TITUS: Can you just read that over?

DR. ZIEMER: I don't know if I can.

MR. ESPINOSA: Motion to adjourn?

DR. ZIEMER: You want everything or just this last addition?

MS. HOMOKI-TITUS: Just the new part.

DR. ZIEMER: The Advisory Board on Radiation and Worker Health strongly believes that the

public has the right to early access to the information contained herein. However -- and then we can continue with the cautionary stuff.

MS. MUNN: Can we not say in accordance with the strong position of the ABRWH --

DR. ZIEMER: Yes.

MS. MUNN: -- regarding --

DR. ZIEMER: That's a better --

MS. MUNN: -- public access --

DR. ZIEMER: That's a better way of saying the same thing. In accordance with the --

MS. MUNN: Strong position --

DR. ZIEMER: -- strong position --

MS. MUNN: -- of ABR--

DR. ZIEMER: -- of the Advisory Board --

MS. MUNN: -- on Radiation --

DR. ZIEMER: -- to provide the public with early access --

MS. MUNN: To provide all possible access -- or you know, all -- it's -- it depends on which way you want to cast the light.

DR. ZIEMER: In accordance with the Advisory Board's strong position that --

MS. MUNN: Regarding open access --

DR. ZIEMER: -- that the public should have --

DR. DEHART: (Off microphone) (Unintelligible) use transparent?

DR. ZIEMER: -- have what, open access?

MS. MUNN: Uh-huh.

DR. ZIEMER: -- to the information contained herein --

MR. GRIFFON: No.

DR. ZIEMER: Now I've lost some continuity here. In accordance with the Advisory Board's --

DR. ROESSLER: Well, saying the Advisory Board unanimously -- something and make a sentence out of it.

MS. MUNN: In accordance with the na, na, na, na, na, na, na, this material is made available for public viewing, then period. However...

DR. ZIEMER: Now this is -- this is starting to get a little thorny for a last-minute -- would you like the Chair to simply -- I think we know the intent of this. Do you want to do the wordsmithing at the table or do you just want to authorize -- and if you don't like the way -- and we're going to -- this is going to appear -- what -- what we'll do is get a version that you can see and look at and really embrace. I

think we're going to get too fragmented here. We'll have something that they can use before the next meeting, if necessary. And if it isn't quite right, we'll -- is that agreeable? I want you to vote on this and tell us this is the idea, and we may have one or two words that aren't quite right --

MR. GRIFFON: But the intent will remain.

DR. ZIEMER: Huh?

MR. GRIFFON: The intent will remain.

DR. ZIEMER: The intent is there. Allow us a little bit of -- of wordsmithing. Wanda, you can help me get that sentence before you leave today.

MS. MUNN: I will.

DR. ZIEMER: Okay. Now let's vote on this and move forward. All in favor, aye?

(Affirmative responses)

DR. ZIEMER: Any opposed, no?

(No responses)

DR. ZIEMER: Any abstentions?

(No responses)

DR. ZIEMER: Good, we'll -- we'll polish that up. Thank you. And -- and Liz, we'll get you a -- some kind of clean copy before we leave

here. Okay? Or do you need it today?

MS. HOMOKI-TITUS: Just whenever. It doesn't have to be today.

DR. ZIEMER: Oh, okay.

MS. HOMOKI-TITUS: I was just a little lost on it.

DR. ZIEMER: Now the other item I have on this, but we -- we may have already solved it, at least for the next meeting. That's the dose reconstruction subcommittee's role as we go forward.

MR. GRIFFON: We've solved it for the next meeting?

DR. ZIEMER: No, we haven't, for the long range. But Mark, that was --

MR. GRIFFON: Yeah.

DR. ZIEMER: You asked that that be on the work group agenda at least, so --

MR. GRIFFON: Yeah, I mean understanding that it's a little late in the day to -- to wrap our brains around this, I -- I think that -- you know, the original intent had about eight scope item -- as we pointed out the other day, and especially -- you know, I don't mind the idea of four Board meetings a year, but with that in

mind, I think we're going to have issues about what goes on in those three-month periods. There -- there could be activities where we need some sort of Board process to take place to keep things moving along, you know, and I think that was part of the original idea of the formation of the subcommittee, that we could do -- do some of those functions on behalf of the Board and --

DR. ZIEMER: Right.

MR. GRIFFON: You know, some of those scope items I think involved even the interaction with the contractor on issues -- clarification of scope was one thing. Certainly the notion of trying to do some of these roll-up reports ahead of time, then to bring to the Board so that everyone didn't have to go through every -- every piece. And I think also the original intent of the subcommittee was to sort of have a rotating -- and I know now we have everyone on listed, but I thought we were -- originally intended to have initial five people, and then sort of rotate it so we rotated the burden of --

DR. ZIEMER: Right.

MR. GRIFFON: -- of that work.

DR. ZIEMER: And also to use them as the teams, as we did before.

MR. GRIFFON: Right.

DR. ZIEMER: One of the issues now that will be an ongoing issue with that is that any time that subcommittee is going to meet, we have to go through the announcement process. It's an open meeting.

MR. GRIFFON: Right, right.

DR. ZIEMER: And the only -- only way to authorize that group to act on our behalf is to specify, I believe in advance, what they're authorized to do and --

MR. ELLIOTT: That's correct.

DR. ZIEMER: -- Liz or somebody -- in other words, they do not have a free hand simply to act for the Board -- sort of an ad hoc basis. It has to be specified in advance, you are authorized to make a decision on our behalf on this particular issue. So that all has to be --

MR. ELLIOTT: No, no, you cannot authorize them to make decisions. You can authorize them to perform work --

DR. ZIEMER: Oh.
MR. ELLIOTT: -- and bring a recommended decision to the Board --
DR. ZIEMER: Oh, it's to perform work.
MR. ELLIOTT: -- or recommended product to the Board.
DR. ZIEMER: They cannot act on behalf of the Board then -- I mean --
MR. ELLIOTT: They can act on behalf of the Board in doing work --
DR. ZIEMER: But not decisions.
MR. ELLIOTT: -- but not making -- not coming forward with a decision that the rest of the Board has to swallow.
MR. GRIFFON: Right, right. And -- and I -- I -- you know, I almost think that what we've done for this -- between now and next meeting, by setting up the work group to work with NIOSH and SCA with those first 20 cases, I sort of originally viewed that as sort of a subcommittee task, that that's what the subcommittee would be doing. Now maybe -- I mean -- you know, the only thing -- the only reason I wouldn't want to continue that function with a work group is actually two-

fold. One is that work groups aren't supposed to do ongoing work, as we've heard before. And secondly, that it -- you know, it would appear maybe to be as these behind-the-doors process that we want to -- you know, we want to try to keep this as --

DR. ZIEMER: Right, and if it's --

MR. GRIFFON: -- as much open as possible.

DR. ZIEMER: If it's a subcommittee, if you're going to have, for example, three or four or five people do all 20 cases for a particular batch, then there's a tremendous burden on --

MR. ELLIOTT: No. If you have the subcommittee do this, you have to have a *Federal Register* notice. It has to be available to the public --

MR. GRIFFON: Right, I -- I understand.

MR. ELLIOTT: -- in an open forum --

MR. GRIFFON: I'm trying --

MR. ELLIOTT: -- or a closed forum, depending upon --

MR. GRIFFON: Right, right, right.

MR. ELLIOTT: -- the discussion topic.

MR. GRIFFON: I understand.

MR. ELLIOTT: If you have a work group do it,

it doesn't have to be publicly announced. I'm not --

MR. GRIFFON: I know.

MR. ELLIOTT: -- steering you one way or the other, I'm just trying --

MR. GRIFFON: Well, I --

MR. ELLIOTT: -- to remind you of what a work group can do versus a subcommittee.

MR. GRIFFON: I understand. I --

DR. ZIEMER: Our understanding was the ongoing routine handling of these, in essence, removes it from being eligible for work group kinds of activities. It's --

MR. ELLIOTT: That is correct.

DR. ZIEMER: It's a repetitive kind of function that is --

MR. GRIFFON: Right.

MR. ELLIOTT: But I understood this work group is to deal with this first --

DR. ZIEMER: Oh, this --

MR. ELLIOTT: -- 20 cases.

MR. GRIFFON: Yeah, this one, but --

DR. ZIEMER: Oh, no, no, no, no. Oh, this -- this work group that we just described was to -- to deal with those first 20 in the sense of -

-

MR. GRIFFON: Yeah.

DR. ZIEMER: -- getting that final report in place.

MR. GRIFFON: But I'm saying for future -- yeah.

DR. ZIEMER: Yeah.

MR. GRIFFON: Moving forward, but --

DR. ZIEMER: But moving forward in terms of handling on-- upcoming cases and so on --

MR. GRIFFON: I mean can we -- can we assign a new work group each time we -- you know, I --

DR. ZIEMER: I think the answer no, since it's a reoccurring --

MR. GRIFFON: Because it's a --

MR. ELLIOTT: Because the charge you're giving is the same charge, you're just realigning the work group. That's not going to work. FACA won't let you do that.

MR. GRIFFON: That's what I mean, so this is what I've been struggling with for the last year is how can -- you know, we want to have the ability to work with the contractor, but the subcommittee process makes it difficult.

DR. ZIEMER: Very difficult.

MR. GRIFFON: On the other hand, we -- you know, you want to -- openness to the process.
DR. ZIEMER: Right, it's very difficult.
MR. GRIFFON: So it's very difficult, right.
DR. ZIEMER: Yeah.
MR. GRIFFON: But I think, you know -- one reason I think we have to do something is, you know, we've got -- I guess I'm getting tired of throwing up our hands and saying -- you know, 'cause we're going to have train wrecks like we did the other day at every meeting, where we come with 20 cases and as a full Board we try to sort through them and we -- we get nowhere.
MR. ELLIOTT: We've been over this ground and over this ground, and I thought you'd come to a decision that a subcommittee was the way you wanted to go, that -- that it would be a public forum --
MR. GRIFFON: Right.
MR. ELLIOTT: -- unless you needed to have a disc-- closed session discussion on Privacy Act-related --
MR. GRIFFON: Right.
MR. ELLIOTT: -- stuff.
MR. GRIFFON: So that's what I'm saying. I

think we just have to set up some in between the meetings prob-- or I don't know if we -- if it's premature to set them up, but we have to try to time that --

DR. ZIEMER: To set up what, though?

MR. GRIFFON: So --

MR. ELLIOTT: I think that's the key. I think you have to come -- I think what's -- what's being missed here is you have to tell the subcommittee what it is you want them to do at the next -- their next scheduled meeting. Of the eight -- eight tasks within their charge, they have to understand what they're to be working on. That's the authority the Board gives them. You go work on task three this next meeting. That's what we want you to do. Come back with --

MR. GRIFFON: And I'm saying -- I'm saying the charge would be similar to what the work group is charged with this time, that the charge would be to -- you know, it -- I'm not saying for the subcommittee to do all 20 cases. I'm saying we have the same process where we assign cases to all -- all members of the Board, and then --

DR. ZIEMER: And then take the wrap-up and then --

MR. GRIFFON: The member -- all -- each two-team group submits their comments to the subcommittee, and the subcommittee meets with SCA/NIOSH and goes through this deliberative process to come out with a final roll-up report to bring back --

DR. ZIEMER: To the full Board.

MR. GRIFFON: -- to the full Board, yeah. That's the notion -- that's what -- sorry, maybe I wasn't very clear with that. And then, you know, I -- I mean it's -- certainly we have everybody on the subcommittee --

DR. ZIEMER: So the only real difference in what we did this time would be that that sub-- that part of the subcommittee would get the -- the stuff from each of our teams and -- and assist in the wrap-up process --

MR. GRIFFON: Right.

DR. ZIEMER: -- prior to the full Board.

MR. GRIFFON: Right.

DR. ZIEMER: And that could either be done in a separate meeting -- you know, a couple of weeks before the meeting --

MR. GRIFFON: Or the day before.
DR. ZIEMER: -- or it could be done the day before.
MR. GRIFFON: Right. Right.
DR. ZIEMER: In which case it would be doing what we did Monday of this week.
MR. GRIFFON: Yeah, but we -- we -- but we didn't do it.
DR. ZIEMER: Well --
MR. GRIFFON: That's what I'm saying.
DR. ZIEMER: Well --
MR. GRIFFON: I mean where you're putting that middle step in there to get some of that work done, the real work where you take 20 cases and you look for tren-- I mean summarize all -- you summarize what you can from the 20 cases. You're not going to go case -- you're not going to come back to the Board and say okay, let's go through case one, case two, case three. You're going to say out of this batch, here's some of what was found.
MR. ELLIOTT: That's function number seven of your --
MR. GRIFFON: Right, right.
MR. ELLIOTT: -- subcommittee ta-- charge.

MR. GRIFFON: I remember writing it, yeah.
MR. ELLIOTT: Function number seven says compile the review panel's recommendations and findings, including dose reconstruction review summary reports, site profile review reports, for submission to the Board.
MR. GRIFFON: Right.
DR. ZIEMER: Right.
MR. GRIFFON: Right. So that -- yeah, that was the original intent of the way we worked this up. And I think one thing we'll have to deal with in the subcommittee meeting is probably part of it, at this point, is going to have to be closed because we are going to be dealing with the -- the case -- you know, the individual cases and the Privacy -- you know, the identifiable information. We might be able to draft -- in that meeting I think we have to try to draft a summary, and then maybe have a second part of that meeting -- maybe it's only an hour or so -- that -- that we reveal that summary and go over that summary.
DR. ZIEMER: You're still seeing this as the meeting that occurs the day before the full Board, as opposed to somewhere back --

MR. GRIFFON: Either way. It could be back or it could be the day before, right. So I'm -- I guess -- I don't know, do -- I didn't know that we had to make a motion to task the subcommittee with something that's already listed as a task.

DR. ZIEMER: It's already there.

MR. GRIFFON: Okay, that's what I was -- yeah.

DR. ZIEMER: It's already tasked.

MR. ELLIOTT: My point was just that the subcommittee needs to have a general understanding from the Board as to what it's going to do at that meeting, that's all.

MR. GRIFFON: I agree. I agree.

MR. ELLIOTT: I mean which one of these things -- you know, I think it's covered, but if what we're talking about is rolling up reviews into a general summary, that's number seven.

MR. GRIFFON: Right. Right. Right.

DR. ZIEMER: Okay? So no actual -- no particular action is needed here. I mean it basically is covered, but we have to do it.

MR. GRIFFON: Right. We have to schedule it. We have to do it, yeah.

DR. ZIEMER: Have to schedule it.

MR. GRIFFON: Yeah.
MR. ELLIOTT: I'm sorry this is so complex, but to -- one thing we have to be very careful with is when you decide you need to close session, we have to provide a determination to close, and the only thing that can be discussed in that closed session is what is announced as being the purpose for the closed session.
DR. ZIEMER: Right.
MR. GRIFFON: So you're saying we can't lay out a long-term schedule because we won't know exactly what's going to be covered in --
DR. DEHART: Well, you don't need closed session for that.
MR. ELLIOTT: No, I don't think I'm saying that. I'm just saying that if you know you're going -- your subcommittee is going to have a closed session to do this type of work, then that's the only thing that can be done in that closed session.
MR. GRIFFON: Yeah.
MR. ELLIOTT: That's all I'm saying.
DR. ZIEMER: You would have to announce that for each one.
MR. ELLIOTT: In the open session of the

subcommittee, you can take on any number of these --

MR. GRIFFON: I gotcha.

MR. ELLIOTT: -- these charges.

MR. GRIFFON: I gotcha, okay.

MR. ELLIOTT: You know, as long as that Board knows that's what the subcommittee's going to do.

MR. GRIFFON: I gotcha, okay.

MR. ELLIOTT: But for the benefit of the public's understanding and getting at this issue of transparency --

MR. GRIFFON: This is what's going on.

MR. ELLIOTT: -- just the whole idea of going into closed session just gets -- is a burr under people's saddle. And we're required to make sure that the determination to close speaks specifically to why it's -- why the meeting is being closed, and that's the only conduct of business in that closed session.

MR. GRIFFON: No, right, I understand. I agree, yeah.

DR. ZIEMER: Okay?

MR. GRIFFON: So I -- I think we're set -- I mean the next meeting we have a subcommittee

meeting set up. Right?
DR. ZIEMER: Right.
MR. GRIFFON: And we have a closed session that we're --
DR. ZIEMER: Right.
MR. GRIFFON: -- talking about. Have we decided what the closed session item -- discussion item is? It's those 20-case roll-up report that --
DR. ZIEMER: It's basically --
MR. GRIFFON: We're covered for the next --
MR. ELLIOTT: That's my understanding.
DR. ZIEMER: Yeah, right. And it's covered under that.
MR. GRIFFON: Right.
DR. ZIEMER: Okay. Any other -- are there any other items that we need to discuss today?
MR. GRIFFON: Just -- well, just related to this whole thing. I mean the only other thing is, in between -- in be-- I'm just trying to think of the communica-- ongoing communication questions. While SCA's working on these obviously the subcommittee can't, as a body, communicate or direct or -- so right now I think what -- what's -- Paul, you've been

speaking on --

DR. ZIEMER: You're talking about the work group or the --

MR. GRIFFON: No, no, I'm talking about ongoing work by the subcontractor on site profiles, on --

DR. ZIEMER: Oh.

MR. GRIFFON: -- case reviews --

DR. ZIEMER: Right.

MR. GRIFFON: -- whatever, if -- if there's -- there's a request to you for -- I -- I guess all the direction for the subcontractor between these meetings has to come from you at this point. Right?

DR. ZIEMER: There will be some direction for the subcontractor that actually will come from Dr. Wade, who will --

MR. GRIFFON: Right.

DR. ZIEMER: -- and David Staudt, who will work with them on establishing whatever incremental cost increments are associated with what looks like some additional work within the task, and -- and we --

MR. GRIFFON: Okay.

DR. ZIEMER: -- basically authorized Mr. Wade

to proceed to do that on our behalf, so that -- that will occur, and I think he's already set up some time to -- to work with them and define what that will be, and identify the cost -- incremental costs associated with that. Other than that, the contractor has its scopes of -- scopes of work for the various tasks, which it's following, I'm --

MR. GRIFFON: And if the -- I guess the things I was thinking about is if -- if, down -- if it becomes an issue of access to records at a certain site or certain --

DR. ZIEMER: Oh --

MR. GRIFFON: -- other work they're doing --

DR. ZIEMER: -- when those things occur, what actually happens is that John Mauro typically -- -

MR. GRIFFON: Notifies --

DR. ZIEMER: -- send -- or -- or one of his staff, but usually it comes through John. I get noted on it, Larry gets noted on it. Usually the action involves NIOSH people in assisting, for example, in getting these clearances and so on, that -- that sort of thing. But typically I'm notified as these

things occur. When these -- when these contacts occur or there's access requested, they're supposed to keep me notified on that so we know what the contractor's doing relative to --

MR. GRIFFON: I'm just trying to think through things that --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- that would unnecessarily hold up, you know, their work or their progress, so I -- but I think we're --

DR. ZIEMER: Yeah.

MR. GRIFFON: -- okay.

DR. ZIEMER: Okay. You may not really believe it 'cause you're all tired, but we're actually early. Anyone have some other things they want to talk about for 20 more minutes?

If there's no further business to come before us, we stand adjourned till next time.

(Whereupon, an adjournment was declared at 4:15 p.m.)

C E R T I F I C A T E

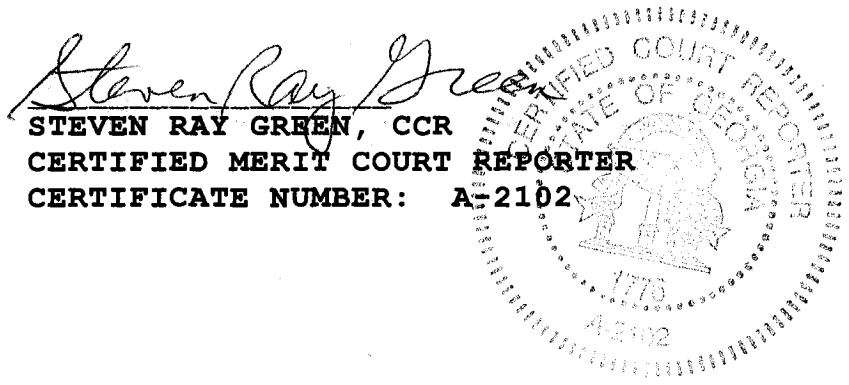
STATE OF GEORGIA :

COUNTY OF FULTON :

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the 15th day of December, 2004; and it is a true and accurate transcript of the testimony captioned herein.

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

WITNESS my hand and official seal this the 23rd day of January, 2005.



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