National Institute for Occupational Safety and Health (NIOSH)

Worker Outreach Meeting for Portsmouth Gaseous Diffusion Plant (PORTS)

Meeting Date: April 22, 2008, 10:00 a.m.

Meeting with: Security Police and Fire Professionals of America (SPFPA) Local 66 in Piketon, Ohio

NIOSH Worker Outreach Team:

Larry Elliott, Director, National Institute for Occupational Safety and Health (NIOSH), Office of Compensation Analysis and Support (OCAS)

James Neton, PhD, Associate Director for Science, NIOSH, OCAS

Mark Lewis, Advanced Technologies and Laboratories (ATL) International, Inc., Senior Outreach Specialist

Mary Elliott, ATL, Technical Writer/Editor

Also in attendance:

Michael Gibson, Chairman of the Worker Outreach Working Group, Advisory Board on Radiation and Worker Health

Kathryn Robertson-DeMers, Sanford Cohen & Associates (SC&A)

Proceedings:

[Name withheld], Safety Officer of Security Police and Fire Professionals of America (SPFPA) Local 66, convened the meeting at approximately 10:00 a.m. SPFPA Local 66 represents the security force at the Portsmouth Gaseous Diffusion Plant in Piketon, Ohio. The union's president, [name withheld], joined [name withheld], along with two former members of the security force [names withheld]. The union had requested this meeting to provide additional documentation to NIOSH concerning the radiation safety program at the Portsmouth Plant with regards to the security force. [Name withheld] stated that he had documents that the U.S. Department of Energy (DOE) and its contractors were not making available to NIOSH. He expressed his frustration that DOE was asked to review the draft report by SC&A on the Portsmouth Site Profile since it did not include those documents.

Mr. Elliott responded that NIOSH requests the documents from DOE that are used to write the site profiles. If NIOSH does not know that a particular document exists, they cannot make a request unless they become aware of its existence. Because the site profiles are "living documents," NIOSH reaches out to current and former workers to supplement the official documents that are provided by DOE and its contractors. The workers' input helps NIOSH understand the actual workplace procedures, which are not always the same as the "standard" written operating procedures. If the workers provide documentation that warrants changes in the way the dose reconstructions are done, the risk model will be adjusted and the site profile will be revised to include the new information.

[Name withheld] stated that his frustration was not directed at NIOSH as an agency, but at the process which seems at times to overlook "unique" situations and to dismiss volumes of information that stakeholders feel is relevant to the process.

[Name withheld] stated that the department numbers were changed so frequently while he was the safety officer for the guards' union that he found it difficult to track the guards' radiation doses on the quarterly ALARA radiation safety reports. He produced a copy of a quarterly ALARA report showing that 68 security guards (including himself) of the 210 who worked during that period "flagged," or reached the plant's allowable limit for radiation exposure, as did 62 of 63 material handlers. He commented that he found this "significant." As the union safety officer, he used the badge numbers to identify the 68 individuals who had reached their dose limits during this period and determined that they were working in the X-744-G, X-344, and X-705 buildings and the X-326 HASA vault. Mr. Elliott commented that the mean dose value (difference of 67 and 17) was interesting. [Name withheld] stated that if the security guards had been rotated like the material handlers, their dose rate would have been lower. He said that putting together the information from the POEF report of the internal investigation by [name withheld] and the CDC Health Hazard Evaluation by John Cardarelli and Steven Ahrenholz changes the entire picture of the dosimetry program at the plant, and could possibly change the way that NIOSH looks at dose reconstructions for the security guards. The report ([name withheld] did not state which) states that as many as 1,000 badges per quarter were estimated.

Mr. Elliott explained that because many Portsmouth EEOICPA claimants are eligible for compensation under the Special Exposure Cohort (SEC) class, their cases do not require dose reconstruction. The U.S. Department of Labor (DOL) only sends NIOSH the cases that are not eligible for the SEC class for dose reconstruction. Since NIOSH is tasked with performing the dose reconstructions for these cases as accurately as possible, the purpose of the meeting is to gather any information that can aid in that task. To date, NIOSH has received a total of 977 cases from the Portsmouth site from DOL – more than any other Ohio facility, including Fernald. Dose reconstructions have been completed and reports have been sent to claimants for more than 850 of these cases. NIOSH has sent completed dose reconstructions for 776 of the 850 cases back to DOL for recommended decisions. DOL has returned 153 of the 826 cases to be reworked for various reasons such as additional cancers or when site profile revisions warrant a Program Evaluation Report. One case has been pended, possibly to determine eligibility in the SEC class. As of the meeting, 184 of the cases requiring dose reconstruction have been determined to be compensable and 631 cases have been determined to be non-compensable.

[Name withheld] commented that he has seen several individuals' dose reconstruction reports in which the second dose reconstruction yielded a lower probability of causation (POC). He cited one case in which the individual's first POC was 34.6%, and the second POC was less than 10%. [Name withheld] stated that he had seen the individual's dose records and knew that he had received rem dose working in the PW vault and transferring cylinders with the "blue goose" from the X-345 to the SST trucks. The claim was denied and the DOL adjudicator said that his dose was figured on 3.5% assay, which made the claim noncompensable. [Name withheld] stated that the documents he was providing during the meeting showed that security guards worked in areas where 90-97% assay cylinders were stored, and that the neutron dose from those cylinders should have been enough to put the claim above 50% POC. Dr. Neton responded that the current Portsmouth Site Profile includes a neutron dose for the guards in the dose reconstruction as the result of information received during the second meeting with unions from

the Portsmouth plant. [Name withheld] asked what assay NIOSH is considering. Dr. Neton answered that the default assay in the site profile is lower, but NIOSH can consider a higher assay if the work conditions are known – not all workers were around the higher assay uranium.

[Name withheld] stated that security guards were locked in the HASA vaults in the X-345 and X-744G Buildings when the plant operated in high security mode. They often worked 12-hour shifts and ate their lunches in the vaults. [Name withheld] said that this increased the possibility for ingestion, as well as inhalation from the leaking cylinders in the vaults. [Name withheld] added that this was common as late as the 1980s and early 1990s before the Tiger Team Reports were written. He recalled that there were often seal problems on the cylinders that were kept in the X-326 Building where the 97% assay uranium was stored, so there was potential for both internal and external exposure. [Name withheld] stated that if NIOSH examined the [name withheld] report, the dosimetry methods may be questionable. He emphasized that the "bad bar codes" in the report represent the humans that were wearing the badges.

Dr. Neton returned to the topic of the uranium assay. He stated that if a worker was badged for photon dose, then NIOSH can derive a neutron dose. In the site profile, the neutron to photon ratio is fixed at 0.2, so if a worker was never monitored for neutron dose it can be developed by taking the entire dose the worker received (including the missed dose) and estimating the neutron dose. NIOSH has methods of dealing with these issues in the proper context. [Name withheld] stated that the union feels that the dosimetry records that DOE provides to NIOSH are incorrect. Mr. Elliott stated that he would make certain NIOSH re-examines the assay issue further with Oak Ridge Associated Universities (ORAU), the contractor team that is responsible for revising site profiles and performing dose reconstructions.

[Name withheld] explained that the 97% assay uranium was not kept in only one area in the plant, but was moved throughout various departments in the plant, sometimes 20 cylinders at a time. The turbine blades that were used to push the material were also moved throughout the plant in open baskets with forklifts.

[Name withheld] described an incident in the X-326 Building in which a leaking cell housing in the 90% assay area froze the pipe next to it (stopped the flow of uranium hexafluoride gas). An OCAW (Oil, Chemical and Atomic Workers) union welder and a carpenter went in to warm the pipe with acetylene torches to get the material moving again. They used a Rimbaud detector to find the leak by locating the area with the highest concentration of neutrons to locate the leak. A guard was required to be present the entire time to keep material from being diverted from the area. They worked under slow cooker conditions – the welder for just over three hours, the carpenter for two hours and 45 minutes. The quarterly report for that period showed 3.8 rem for the welder, 2.5 rem for the carpenter, and 1.8 rem for the guard, who was not as close to the leak as the others. [Name withheld] went to review the hard copy records, but was not permitted to make copies due to Privacy Act restrictions. As the Safety Officer for the guards' union he was permitted only to look at the records of that union's members. [Name withheld] was the OCAW Safety Officer at the time, so he reviewed the records for his union's members.

The dosimetry department transferred the quarterly readings to disks, and then sent them to another area to be archived on magnetic tape. An index card file was kept so the tapes did not have to be retrieved from the other building. The 3x5 cards with the employee's name, department, and identification number showed the employee's dose by quarter. If there was a "bad badge" or high rem dose above the quarterly limit, the dosimetry department estimated the

worker's dose based on a worker in the same job classification with a lower reading and gave the first worker 10 mrem above that dose. Dr. Neton asked whether the worker got an explanation of why the badge was bad and asked [name withheld] to define the time period. [Name withheld] replied that the time period would have been approximately 1995-96, when the plant was using thermoluminescent dosimeters (TLDs). [Name withheld] said that he and [name withheld] were present when the badges were read. Plant protocol stated that if there was a high reading, or the badge holder was cracked or tampered with, the badge was to be bagged and saved for an investigation. The worker was to be interviewed, but the company did not follow its own procedure. Dr. Neton said that NIOSH had heard this information before. [Name withheld] interjected that the [name withheld] report showed that quarterly numbers for destroyed badges were significantly high for both guards and material handlers.

Dr. Neton stated that the DOE Laboratory Accreditation Program (DOELAP) protocols were the same using similar devices when he ran the dosimetry programs at Argonne National Laboratory and Fernald. It is not unusual to have a certain amount of false positives from any number of things, including putting the device through laundry and coming into contact with phosphate detergent. He asked if the false positives were documented in a report. [Name withheld] responded that they were not, and that information came out in the report by [name withheld] and later in depositions. Mr. Elliott verified that NIOSH has the [name withheld] report. [Name withheld] stated that the opinions of the persons altering the badges should be considered suspect since that sort of activity is not sanctioned by DOELAP.

[Name withheld] stated that instead of preserving the bad badge holders per procedure, they were placed in the trash and the worker was assigned a new holder and barcode. He said that he often did not see anything wrong with the badges that were discarded and was told by dosimetry department personnel that the worker could not have that amount of dose. [Name withheld] said that it would be considered "lucky" if the reader was calibrated every 60-70 reads. [Name withheld] said that documents that were written around the same time as the [name withheld] report could be used to develop a timeline. [Name withheld] alleged that the DOE contract gave the company monetary rewards for safety practices and that DOE benefited financially when the company was privatized and DOE moved to an oversight role.

Dr. Neton stated that the [name withheld] report does not suggest discrepancies of the magnitude being discussed; it specifically addresses a 26 millirem (mrem) dose being changed to "0," but not the 2+ rem doses that [name withheld] was suggesting were being changed to a coworker dose. [Name withheld] responded that when he was injured on [date withheld], he asked [name withheld] to request documents because he feared they would be changed. At that time [names withheld] discovered hidden records. [Name withheld] said that his records have been altered so that there are now two sets of the incident record, the medical record, and his badge record, and that the company and DOE have suppressed the hidden documents, yet no one has ever asked how the company could go back and forth between those records without ever being discovered. He said that the incident was widely known throughout the plant. It was covered up until an employee came forward in late 1994 to say that the records had been changed, yet no agency conducted an investigation until 15 months later. Mr. Elliott noted that there were three sources of documentation of the accident (incident, medical, and dose reports). [Name withheld] indicated that the [name withheld] report was never given in full to the guards' union; he was only able to obtain it with a federal subpoena.

Representatives of the two unions at the Portsmouth plant asked NIOSH to conduct a Health Hazard Evaluation following [name withheld] accident. John Cardarelli and Steven Ahrenholz were sent to conduct the investigation. [Name withheld] described the events following Dr. Cardarelli's request for archived tapes of dose records from 1992-94 for a high-assay area where they were enriching fuel for military programs. The plant safety director told Dr. Cardarelli that the archived tapes contained five layers of data, but Dr. Cardarelli was later told that there were at least 12-15 layers of data after a delay of several hours. Days later, [name withheld] was told that plant manager ordered the hard copy records to be destroyed since the archive tapes were useless. [Name withheld] explained that the hard copies of the dose records were kept in the audiovisual room and that anyone who wanted to view them had to be given access because the room had an alarm system. [Name withheld] said that he personally observed two OCAW workers taking the hard copy records to the wood chipper. He stopped them and tried to intervene, but was unsuccessful in his attempt to stop them. Subsequently, [name withheld] filed a complaint with OSHA (Occupational Safety and Health Administration) on the grounds that federal law requires medical records to be retained for 30 years. OSHA cited Lockheed Martin for destroying the records.

Dr. Neton inquired as to the timeframe of the records. [Name withheld] replied that they covered the period between 1988 and 1994. Dr. Neton asked if the records showed beta, gamma, and neutron results, to which [name withheld] replied, "Yes." Dr. Neton asked [name withheld] if the 3x5 cards were the only hard copy records that were kept, to which [name withheld] replied that a worksheet was kept of the estimated dose but was often changed. Dr. Neton questioned whether NIOSH would get any records if they asked DOE for records from 1988 to 1994. Mr. Elliott asked if [name withheld] meant that there were no records for the guards or for the entire workforce. [Name withheld] replied that he personally witnessed the guards' records going through the chipper, but was later told that some records for the material handlers were also destroyed. [Name withheld] added that the workers who were asked to destroy the records went to their union leadership but were afraid to admit their wrongdoing at a higher level for fear of retaliation by the company.

Dr. Neton stated that the Portsmouth Site Profile includes co-worker models through 1992, which indicates that there was data available. [Name withheld] explained that if the dose was too high when a guard's badge was read, it would be deemed a "bad" badge and a barcode was used to give the worker an estimated dose. The estimated dose would be put on the archive tape and the 3x5 card, so it became the "official" dose of record instead of the actual dose. Dr. Neton noted that the point being made was that the cards showing that these doses were changed no longer exist, so there is no evidence to confirm the actual dose readings. [Name withheld] contended that the "official" dose of record that NIOSH used for the model is not accurate. [Name withheld] suggested that the [name withheld] report admits that investigations were not properly done and segments of the records were changed, so any dosimetry data the company provided to NIOSH is corrupted. [Name withheld] said that Dr. Cardarelli's CDC report stated that when the badges were processed at the Portsmouth plant, no accounting was made for the "slow cooker" effect, meaning that the neutron dose was incorrect.

When Dr. Neton asked if they knew how many badges were changed during a badging cycle, [name withheld] estimated that as many as 400 to 600 of the 2500 to 3800 total badges may have been changed quarterly. Mr. Elliott stated that if one-third of the doses in the data provided to NIOSH have been adjusted as they indicated, it could possibly cause problems. [Name withheld]

stated that instead of providing the POEF document following the OSHA citation, Lockheed Martin settled so that they did not have to submit the document. [Name withheld] said that, even though the 30% figure could have been the same every quarter, the records were not capturing the highest exposures. Dr. Neton stated that NIOSH needs to look at the procedures that were used to adjust the readings since there were DOELAP accreditations in place at the time. [name withheld] reiterated that the methods reported in the [name withheld] report would never be sanctioned by either NAVLAP (National Voluntary Laboratory Accreditation Program) or DOELAP.

Mr. Elliott asked for the typical number of badges that would be investigated in a quarter. Dr. Neton explained that the number of false positives in a badging period is depends on the environmental conditions under which the badges are worn. He stated that it was not unusual for 10-15% of the badges at Fernald to show false positives. [Name withheld] said that when security guards were present as observers at jobs in high security areas, they had special reads that were activity specific (for example: the 1.8 rem reading for the guard mentioned earlier). Dr. Neton stated that when a TLD shows a high reading, there is a glow curve when it is heated up that indicates whether or not the exposure is actually due to radiation. He noted that 30% seemed to be on the high side.

[Names withheld] explained that badges were normally left in the plant, but if a badge went missing, a temporary badge was issued. The [name withheld] report stated that the plant issued 300 temporary badges a day to Lockheed Martin employees. Temporary badges were also issued to contractors who were typically only on site for two weeks to a month at a time. [Name withheld] said that the temporary badges are monitored as such.

[Name withheld] related a conversation with [name withheld] of the Nuclear Regulatory Commission (NRC) during which [name withheld] asked that his comments remain off the record. [Name withheld] was concerned that the DOE legacy issues would overlap some of the NRC issues. [Name withheld] made documents available to [name withheld] and was asked why he was providing them. He replied that he wanted medical cards for all of the security officers – basically to give them special cohort status. [Name withheld] explained that the SST drivers had asked for and received a special separation package that included full medical retirement because they were also working in the high radiation areas under the same conditions as the guards.

[Name withheld] asked if it was possible for the security guards to have a special cohort within the Special Exposure Cohort (SEC). A discussion followed to clarify the term “special cohort.” Mr. Elliott and Dr. Neton confirmed that the security guards are included in the SEC class for the Portsmouth plant through the end of 1991. [Name withheld] again cited the timeline that could be established using the documents that the SPFPA is providing to NIOSH to prove that records were kept “outside the realm of integrity.” He proposed that NIOSH work together with the SPFPA to establish the integrity of the records.

Mr. Elliott stated that the purpose of the meeting was to answer the questions being raised about the validity of the information being used in dose reconstructions for the workers that are not a part of the Portsmouth SEC class and the question of another SEC class for Portsmouth has been raised before. Dr. Neton stated that original class extends through 1992, but the SPFPA could petition for another class to be added to the SEC. Mr. Elliott added that only the period during which the plant operated under DOE contract is eligible to be included in the cohort. The group discussed briefly the transition between DOE and NRC regulation of the Portsmouth facility.

[Name withheld] stated that the SPFPA's primary concern is that the manipulated data provided to NIOSH to use as the basis of the models for the Portsmouth plant is the primary reason why more dose reconstructions are not reaching the 50% POC required for EEOICPA Part B compensation.

Dr. Neton acknowledged [name withheld] statement that badge results were changed with no technical justification for those results and that the evidence of those changes was destroyed. [Name withheld] concurred. Dr. Neton said that the NIOSH co-worker model in the Portsmouth Site Profile shows that the 95th percentile value for the highest exposed worker after 1981 is 120 mrem for the entire year, including the missed dose component, a difference of a factor of 10 compared to the 2 rem dose that was mentioned earlier. He asked where the guards were working that they could have gotten such high exposures. [Name withheld] responded that they were sitting inside the open HASA vaults where the highly enriched uranium (above 90%) was stored in 24-inch carts containing 5-inch cylinders during the period from 1980 through 1994.

[Name withheld] described the environment in which the guards worked around the clock, 365 days a year, on a raised platform that was the top of the vault:

- A trash sorting area was to the north.
- The process area was to the north and east. The process workers were in fresh air just across the fence while the guards sat inside the vault.
- To the south was the area where the cylinders were filled.
- To the west was another vault where the very highest enriched uranium was stored.
- The cells were located above the vault.

During this time, the guards often worked 16-hour shifts. One guard would bring lunch back to the others and they ate together on top of the vault.

[Name withheld] said that there were conflicting reports that the alarm went off on the argon gammagraph the morning of his accident. The incident report stated that they did not work, but the union leadership challenged that in their own documents, which were suppressed. The DOE investigator included a statement by the plant manager that the alarm did not go off. Other later reports, including the Tiger Team investigation, also stated that the cell alarms were shut off. He said that the point he was making is that security guards are often in areas where leaks are not detected because the alarms do not work and he feels that they are paying for it with their health. That is the reason they are bringing hard documentation forward to NIOSH to work together to clear the information.

Mark Lewis referred back to Dr. Neton's question regarding the changes and stated that he was the safety representative for the OCAW local at the time of the incident. He recalled that the seals on the cylinders had started to break down, causing them to leak. During that time, it was not unusual to see higher badge readings for many of the workers in the production area. [Name withheld] said that the DOE representative was very aware of the situation.

[Name withheld] described a large fire that started in the X-326 building because oil baths were not shut off before a side purge was burned off. He stated that the firefighters and security guards who must be present during these purges are exposed to the byproducts being burned off

during the purges. [Name withheld] stated that incidents such as this need to be considered as part of these workers' exposures to acknowledge that there are scenarios for deep tissue dose.

[Name withheld] cited the [name withheld] report, which states that the CAS system was blocked by barrels and would be of no use in the event of a subcriticality incident. This, combined with such factors as alarms that are turned off, creates a situation in which workers have no idea that they are being exposed. He said that rare medical conditions are becoming commonplace among the workers and former workers from the Portsmouth plant. Seven people in the security department have been diagnosed with ascending aortic aneurisms. The usual odds of developing this condition are 1 in 144,000, yet there are seven people among a group of fifty that have this condition. [Name withheld] said that such situations would seem to indicate a need for another cohort. Mr. Elliott stated that Part B is for cancer only, but that these workers can put in a claim for compensation under Part E. He said that the program must be carried out in conformance with the law. [Name withheld] stated that the union wants to bring it to NIOSH in hopes that their claim will be investigated from the top down.

[Name withheld] referred to a letter between two department heads at the plant that asked about the guards' working hours. He recalled that the guards were often required to work 12-hour shifts and occasionally 16 hours. Their work schedules often alternated daily between 12- and 16-hour shifts due to a shortage of personnel. He added that DOE regulations prohibit personnel carrying firearms more than 16 hours in a 24-hour period unless under attack or in an emergency. When Mr. Elliott asked him the timeframe he was speaking of, he replied that it was from 1984-97 and that he had worked nearly three work years during one years' time. [Name withheld] said that it was common to work 60 to 80 hours a week. [Name withheld] said that he knew of instances where one guard put in 110 hours in one week.

[Names withheld] continued to describe potential scenarios for high exposure. It was common for SRT (Sudden Response Team) members to accompany the fully loaded transport vehicle containing about twenty 5-inch cylinders of high assay material from one point in the plant to another. The SRT agent could not leave the truck until all the cylinders were received and secured, which sometimes took several hours.

Dr. Neton said that a dose of 5 mrem per hour is assumed for workers in proximity to 5-inch product cylinders. He stated that during dose reconstruction, NIOSH assigns a 1.2 rem dose per year to security guards when using a maximizing dose. [Names withheld] again cited the dose reconstruction that had a lower POC on the second submission. Dr. Neton described the efficiency process that was used to reconstruct doses during the early years of the program. NIOSH has the values for the upper and lower bounds for possible scenarios and these values are applied to overestimate the doses. When the dose reconstructions are reworked for the second time with more realistic information, the doses tend to go down. [Name withheld] said that he routinely saw 2.3 rem doses on the quarterly reports. He alleged that because these records were destroyed, NIOSH did not receive this information with the records that were provided by the company. Dr. Neton acknowledged that this is reason enough for NIOSH to review some of the procedures that were used at the Portsmouth plant. [Name withheld] said that there are sworn depositions by the people who were ordered to alter the records. Dr. Neton stated that there likely is someone on the technical side that may attest that the readings were falsely high and that there was a list of things to judge them against, but they didn't document it. That leaves NIOSH in a difficult situation in which they must ask which is the more reasonable given that there is no

longer any data. [Name withheld] again countered that if the methods were held to the DOELAP standards, they would never be sanctioned.

Mr. Elliott summed up the action items that he wanted to take back to NIOSH for further examination:

1. Look at the modeling for the security guards in the site profile to examine whether it gives an upper bound that covers the guards' exposure to high assays.
2. Look at the assay percentage that is presented in the site profile versus what today has been described as 97% assay, or 90+% assay throughout the plant.
3. Look at the full dose reconstruction model to determine if it accounts for appropriate levels of dose and consideration of the plant's adjustments of dose in the 1989 to 1996 timeframe during which as much as one-third of the data may have been adjusted.
4. Look at the overtime effect on dose reconstruction.

[Name withheld] described how the NIOSH Hazard Health Evaluation by Dr. Cardarelli and Dr. Ahrenholz led him into numerous other investigations into the causes of [name withheld] injury. He said that the plant manager told him that he would prove that [name withheld] got "0" dose. He realized that while he was talking about internal dose from ingestion, the plant manager was talking about external dose from radiation. [Name withheld] described the dosimetry badges at the HASA vaults that read the background radiation, which was then subtracted from the badge reading. Dr. Neton said that NIOSH is aware of that issue and accounts for it when it is known.

[Name withheld] suggested that a fifth action item should take a look at the how the database was corrupted by using records that were "purposely and willfully destroyed" by the same group that provided them. He said that the SPFPA also disagrees with the "0" doses that resulted when the background dose was subtracted from the badge reading. Mr. Elliott responded that the issue is addressed in action item #3.

A discussion ensued regarding the details of the [name withheld] report. Dr. Neton commented that the issues the SPFPA are raising with NIOSH are much broader than the report, which documents one badge with a reading of 26 mrem being changed to "0" dose. [Names withheld] contended that their timeline that is represented by all of the documents being submitted will give a much larger picture. Mr. Elliott and Dr. Neton acknowledged that they understood the significance of the documents.

[Name withheld] noted key points of the [name withheld] report:

1. There is not a reliable database;
2. Employees were not properly trained;
3. There was a lack of supervision;
4. Equipment was not calibrated correctly;
5. "Buckets" of dose;
6. Each barcode for an estimated dose represents another employee's dose being changed;
7. The manager had a system "back door" to change the dose without leaving a paper trail; and

8. Family members were sometimes brought in to assist.

Dr. Neton responded that it is necessary to separate some of those issues from what is applicable to the dose reconstructions. Mr. Elliott recalled that [name withheld] had addressed some of those issues when NIOSH last met with union officials from the Portsmouth plant. He acknowledged that NIOSH had examined how to use those issues to improve the dose reconstructions. Mr. Elliott commented that today's meeting addresses broader, more general problems with the procedures at the Portsmouth plant.

Mr. Gibson assured the members of the SPFPA that the documents would be examined to determine how they can best be used. A discussion followed regarding which documents would be useful. [Name withheld] provided a list of the documents.

Mr. Elliott added more action items:

6. Respond to the allegation that the database is corrupted.
7. Examine the [name withheld] report and other documents being submitted.
8. Look at the background radiation issue.

[Name withheld] volunteered to develop the timeline that may "help put the puzzle together." Both he and [name withheld] related their personal experiences that led them to develop the information.

Mr. Elliott stated that NIOSH's purview is limited to the compensation law. NIOSH will sort through the information and determine what can be used to the best advantage of the claimants from the Portsmouth site. He stated that the law calls for dose reconstruction, taking into account data that may be missing, destroyed, or corrupted, and making adjustments to the benefit of the claimant.

[Name withheld] adjourned the meeting at 12:15 p.m. for lunch.

[Name withheld] reconvened the meeting at approximately 1:30 p.m.

The SPFPA members revisited some of their key points from the morning session of the meeting. [Name withheld] called for corrective action to remove corrupted data from the dose reconstruction modeling based on the reports that they had brought to the table. He stated that the SPFPA was giving NIOSH the documents to correct the data that was deemed "bad" in 2000 when EEOICPA was signed into law.

[Name withheld] commented that he found it inconsistent that the union had provided SC&A with the information for their review of the Portsmouth Site Profile, yet NIOSH still needed the documentation for further investigation. He observed that there is not yet a working group for the site profile and asked if it would be possible for the union to put one of their members on the working group when it is formed.

Mr. Elliott replied that the working group is made up of members of the Advisory Board who are appointed to study the SC&A draft report on the Portsmouth Site Profile. NIOSH and others also participate as necessary. He said that the SPFPA and other interested parties can be notified and may participate, either in person or by phone.

[Name withheld] reiterated the importance of looking at all of the documents to get a clear idea of what they illustrate as a whole. Mr. Elliott assured him that NIOSH will be certain to use the

information that best serves the claimants; but he cannot say that NIOSH will be able to make the statement that the union was wronged. Mr. Elliott said that he can only make the case to the Board and to answer the action items that he is taking back to NIOSH.

[Name withheld] asked how the union can be invited to the working group. Mr. Elliott stated that the information can be found on the NIOSH/OCAS Web site, or he can be put on a distribution list to receive OCAS Web updates.

More discussion followed on the dosimetry program and issues that the union has with reports and procedures they feel are not in line with acceptable standards. They related conversations with management personnel regarding these issues. The group read excerpts from the documents that they were providing.

[Name withheld] requested a formal response on Mr. Elliott's action items. Mr. Elliott replied that he would be happy do so.

[Name withheld] adjourned the meeting at approximately 2:15 p.m.