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-THIRD MEETING

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

The verbatim transcript of the Meeting of the Advisory Board on Radiation and Worker Health held at the Red Lion Hotel, 802 George Washington Way, Richland, Washington, on April 20, 2004.

C O N T E N T S

April 20, 2004

TRANSCRIPT LEGEND

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(By Group, in Alphabetical Order)

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Professor Emeritus
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Elysian, Minnesota

AGENDA SPEAKERS

(in order of appearance)

Dr. Jim Neton, NIOSH

Mr. Pete Turcic, DOL

Mr. Tom Rollow, DOE

Dr. Jim Neton, NIOSH

Mr. Russ Henshaw, NIOSH

STAFF/VENDORS

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

AUDIENCE PARTICIPANTS

DAY

CARY, ANNETTE
COLLEY, ROBERT G.
DEHART, JULIA
EBY, KRISTIN
ELDER, DIANA
ELDER, ROBERT D.
KUDING, SYLVIA
LOVE, MARGUERITE E.
MAST, VERN
OLSON, JOYCE
RINGEN, KNUT
SCHAEFFER, D. MICHAEL
SMITH, ROBERT L.
STALEY, KENNETH D.
TOOHEY, DICK
TRENT, FRANK
WILLIS, T.L.

AUDIENCE PARTICIPANTS

EVENING

ADAMS, HUGH
AMADOR, ROBERT
BARKER, DIRK
BATES, CHARLES R.
BEECROFT, DONNA ALLRED
BERENETT, ROSE S.
BERGSTROM, AGNES
BIERLONI, THEO K.
BONE, SYLVIA
BOOKER, GARY P.
BROWN, E.B.
BROWN, PAUL
CHAMBERLAIN, TAPLEY B.
CHAMBERS, DONNA
CLAPHAN, F.D.
COLLEY, BOB
COOK, BETTY G.
DAUGHERTY, DOUGLAS C.
DAVID, JOHN
DUNCAN, HEATHER
EBY, KRISTIN
FESHUM, VIRGINIA P.
FLEMING, R.M.
HALSTEAD, CHARLES M.
HARRISON, B.W.
HAYS, CAROL
HARTLEY, DAN R.
HENNING, MICHAEL E.
HENSLEY, JANEL
JAHNKE, LOUISA
JARMSON, E.R.
KNIGHT, LAURA M.
KNOWLES, RANDY
KOLEBER, MARGARET
LEDFORD, CLIFF AND PEGGY
LEWIS, MARK
LILLION, ERIC
LOZIER, VERNON W.

LOZIER, VIRGINIA R.
MANUEL, MR. AND MRS. JAMES L.
MARTIN, KEITH A.
MASTROGIUSEPPE, RON
MCCALLUM, ROBERT
MERCER, CHRIS
MILLER, RICHARD
MITCHELL, C.J.
MOORE, CHARLES W.
MORSE, ROCCO J., SR.
MULLEN, LOIS
MYERS, CHESTER B.
NEWBILL, MATT
OGLESBEE, GAI
O'NEILL, ED
OVERSTREET, ROBERT W.
PATRICK, LINDA FOR LAURENCE PATRICK
PHILLIPS, CHESLEY W.
PHILLIPS, NATHAN
PIERCE, BRENDA PRINGLE
POWAUKEE, SHIRLEY
RAY, VELMA
RICHMOND, OLDEN
RUGGLES, ROBERT
SAMSON, E.R.
SCHNECK, LESTER
SHATELL, CHARLES W.
SMITH, MARY S.
STALEY, KEN
THOMPSON, BARBARA J.
TORRES, HENRY B.
TRENT, FRANK
UNDERWOOD, DAVID H.
VAN DYKE, KATHY
WALLACE, STEVEN L.
WALLACE, VIRGINIA
WELCH, MERLAINE E.
WERST, KENNETH E.
WILLIAMS, ROSIE LEE
WILLIAMSON, JIM
WILLIAMSON, NINA
YATES, ROY

P R O C E E D I N G S

(9:00 a.m.)

REGISTRATION AND WELCOME

DR. ZIEMER: Good morning, everyone. We welcome you to this meeting of the Advisory Board on Radiation and Worker Health. This is the 23rd meeting of this Board. I was reflecting on that earlier today. I've been on a number of boards in my lifetime, but I don't think I've been on any that have met 23 times in two years, but this is a hard-working group.

My name is Paul Ziemer. I serve as Chairman of this Board. You -- those who are visitors, members of the public and others, you will notice the placards in front of each individual, and that will serve as an introduction to who the various members are.

Mark Griffon is not here this morning, but he would certainly want you to know that he ran the Boston marathon yesterday and is on his way here from Boston, so Mark has bragging rights on that accomplishment, I guess. But he will be joining us a little later in the meeting.

Let's see, and the Board is a little bit confused here because we've changed the seating arrangement. Dr. Roessler is sitting where the Chair usually does and I'm sitting over on the side today, so we've

shuffled things around. It helps keep the Board alert, you know.

We would like to remind everyone, including Board members, to please register your attendance. There are registration books in the back on the table. If you've not already done that, please do that sometime yet this morning.

Also, for members of the public who wish to address the Board, there's a sign-up sheet there. You may realize that as you look at the agenda that we have set aside an evening session at 7:00 p.m. this evening here for -- devoted to public comment, and you're welcome to sign up for that. If the agenda permits during the daytime hour here -- and we have a number of members of the public here -- we might be able to squeeze in some comments even earlier than that for those who might be interested before the afternoon session is over. I can't guarantee that; we'll see how things go. But if we have time, we may be able to permit some public comment as well this afternoon.

There are also handouts on the table to my right. This includes not only the agenda, but various presentation materials that are being utilized by some of our speakers today, as well as various documents involved with past actions of this Board that might be

of interest to you. So please avail yourselves of any of those that you think might be of interest to you.

We're pleased to have with us today some special guests. Well, you're all special, but we do want to recognize a couple of individuals. Shawn Bills, who is with Senator Patty Murray's office -- and Shawn is over here (indicating), and then Joyce Olson, who's chief of staff for the tri-cities office for Congressman Doc Hastings. Joyce is here and Joyce, being a local person, has agreed to give us a few words of welcome, as well. So Joyce, the podium is yours.

MS. OLSON: Good morning, everyone. On behalf of Congressman Doc Hastings, welcome to the tri-cities. Welcome to a special corner of this world. Your fellow Board member, Wanda Munn, invited Doc to be here today to greet you in person, and first of all, you should know that Doc (sic) is well-known in this community as a leader and she's held in high regard for her service to the city of Richland and organizations like Girl Scouts of America and also on a committee called Citizens for Medical Isotopes that promotes the use of medical isotopes for the treatment and diagnosis of cancer. And so Doc considers Wanda to be a very knowledgeable person and appreciates her expertise on issues especially pertaining to the nuclear industry.

So Wanda invited Doc and Doc is very sorry he couldn't be here in person to say hello to Wanda and to extend a special welcome to each of you, but I have the pleasure of doing that on his behalf.

To make your visit here a little bit more intriguing as you're doing your work, I just wanted to share a few local factoids with you.

Did you know the tri-cities is situated in one of the world's most productive and diversified agricultural growing regions? Perhaps last night you had a chance to sample some of the wines produced in this region. Everything from apples and asparagus to mint and grapes and potatoes and alfalfa is grown here in abundance.

And did you know that this region had two very special visitors about 200 years ago, Lewis and Clark, and they were part of the corps of discovery expedition dispatched by President Thomas Jefferson, and they came through and explored this region. And in a book written by Walter (Inaudible) and also referred to in Lewis and Clark's journals, they mention that when Lewis and Clark camped at the confluence of the Snake and Columbia River, they were greeted by 200 men singing and beating their drums. I think you'll find my greeting to you a little bit far less dramatic, but

I hope that some day you can explore our Native American heritage and early history.

Did you know that the towns in this area, particularly Richland, are the legacy of the secret Manhattan Project developed during World War II to produce plutonium for our nation's first atomic bomb? And actually that's a fact you probably do already know, and on that note, I'd like to tell you that Congressman Hastings is very interested in the work that you are doing. It's important to promote and encourage healthy and safe workplaces. And in looking back at Hanford and the number of workers that worked at Hanford during World War II and on the Cold War effort, he recognizes that many of them possibly suffered from exposures. And he has acknowledged that our nation has the responsibility to aid in the care of those who suffered during their service at Hanford.

Lastly, Congressman Hastings appreciates the progress that you're making in dealing with some of these very tough and sensitive and emotional issues. And finally, it is his sincere hope that your meeting here in Richland today and tomorrow is very productive and informative. Thank you very much, and welcome.

(Applause)

DR. ZIEMER: And thank you, Joyce, for that

welcome to all of us here today.

We're going to now proc-- oh, I almost overlooked our distinguished Executive Secretary, Larry Elliott, who usually has an opportunity also to officially greet us at this point. Larry?

MR. ELLIOTT: Thank you, Dr. Ziemer. On behalf of the Secretary Thompson, Department of Health and Human Services; Dr. John Howard, the director of NIOSH, I'd like to welcome the Board to Richland. And to the public, we welcome you to this meeting. We think it's very beneficial and informative. We hope that the public finds the work of the Board to be such and to find how the Board does its work in this open public setting. We look forward to a productive and informative two days. Thank you.

REVIEW AND APPROVAL OF DRAFT MINUTES

DR. ZIEMER: Thank you, Larry. We're now going to proceed with the agenda as you have it in your booklets, the first items being the review and approval of draft minutes. We have two sets of minutes to review and approve today. One is for our meeting -- the 21st meeting which was held in Augusta, Georgia on February 5th and 6th, 2004. And then the second one is the 22nd meeting, which was actually a telephone conference call meeting held March 11th, 2004.

The minutes of the Augusta meeting were distributed to the Board members about a week ago so that they would have an opportunity to read them before they came to the meeting. Our Board minutes, I might point out -- particularly for members of the public -- are rather extensive. They include more than simply the actions of the Board, but they do give a fairly detailed summary of the discussions so that you have context for the various things that were done. So for example, this last set of minutes comprises somewhat over 50 pages. In fact, one could argue that it was a good thing we left the page numbers off so the Board members didn't realize how long they were. But we will instruct our keepers of the minutes next time to include page numbers so that we have a little easier time tracking where changes may need to be made.

But with that being said, let me now call for any additions or corrections to the minutes of the February meeting held in Augusta, Georgia. And again we are looking for substantive changes. If you have minor typographicals, you can pass those on to Cori or to me later. Dr. Roessler?

DR. ROESSLER: On the second page of the Executive Summary, right at the top, this was a summary of Pete Turcic's talk. There's a very impressive

number there, $742 million. I think that that needs more detail because I think that number refers to more than just radiation compensation. And I looked later in the rest of the minutes and I couldn't find any detail later on on that.

DR. ZIEMER: Yes, this --

DR. ROESSLER: Do you see where I'm --

DR. ZIEMER: -- this is the Department of Labor report and could -- you're asking for a clarification of that number or --

DR. ROESSLER: Well, I think it could be misleading since -- I think it's probably not just radiation compensation.

DR. ZIEMER: It's not -- it's not the number for payouts from the portion of the program that -- for which this Board is responsible.

DR. ROESSLER: And since the minutes are related to this, I think we need another line in there explaining that.

MR. ELLIOTT: You are correct. I don't believe that -- I think Mr. Turcic stepped out, but I -- this number, $742 million, is for beryllium, silicosis, the SEC cancers and cancers that have been dose reconstructed.

DR. ZIEMER: So can we agree that we will ask

that that clarification be added to the minutes? We'll put the proper words in there, basically to describe what Larry Elliott has just said and we will make that correction. Okay.

Dr. Andrade?

DR. ANDRADE: If we move beyond the summary section and just into the actual minutes themselves, on the OCAS program status report -- let's see, one, two -- three pages in there's a comment made by myself noted about halfway down the page, starts that I noted that while I was anxious to see the SEC rule completed, et cetera, et cetera -- it goes on to say that it has nothing to do with dose reconstruction except for the fact that the rule proclaims that if dose reconstructions cannot be done -- and I think some words were left out -- parties might be eligible to apply for SEC status. I think those words would change the entire context of that statement.

DR. ZIEMER: Does everyone see the paragraph that's being referred to? (Reading) Dr. Andrade noted that while he's anxious to see the SEC rule completed, it has nothing to do with dose reconstructions except for the fact that the rule proclaims that -- and then you're asking that it say if?

DR. ANDRADE: That if -- and then dose

reconstructions cannot be done as stated there --

DR. ZIEMER: Uh-huh.

DR. ANDRADE: -- parties might be eligible to appeal for SEC status.

DR. ZIEMER: And then what about the rest of the sentence there?

DR. ANDRADE: The rest of the sentence stands.

DR. ZIEMER: So that he doesn't see any connectivity... Okay. Is there any objection to adding this clarification phrase that Dr. Andrade's suggested?

(No responses)

DR. ZIEMER: Without objection, we'll make that correction.

Any others? Dr. Roessler?

DR. ROESSLER: This is a bit difficult without page numbers, but under site profile updates, when Dr. Neton was talking -- it's maybe ten pages into the minutes.

DR. ZIEMER: Main topic, site profile updates?

DR. ROESSLER: Right, now go back --

DR. ZIEMER: It starts on the left side of the double page. Right?

DR. ROESSLER: Now I'm looking at the minutes. Mine are not --

DR. ZIEMER: Oh, okay.

DR. ROESSLER: Anyway, but then go back about four pages -- and of course this is one of my favorite topics --

DR. ZIEMER: Back toward the front or --

DR. ROESSLER: No, toward the back, go four more pages --

DR. ZIEMER: All right.

DR. ROESSLER: A paragraph that starts with occupational medical dose, and you recall that that is one of my favorite topics.

DR. ZIEMER: Yes.

DR. ROESSLER: When you find it, I'll tell you what my question is.

Okay, in the middle of that paragraph it says an X-ray is taken with a collimated beam. Other organs not in the field of view would be irradiated, and I think that's probably true. I mean I think that's what was said, but I wonder if that might be confusing because it would seem to me that other organs not in the field of view would not be irradiated.

DR. ZIEMER: Well, technically that's certainly correct, they would possibly received some

scatter radiation, but this --

DR. ROESSLER: I think maybe this sentence --

DR. ZIEMER: This is summarizing what Dr. Neton said. An X-ray is taken with a collimated beam. Other organs not in the field --

DR. ROESSLER: ... of view might -- I think it means that it might be included, to be claimant-friendly, or something along that line, because we talked last time about --

DR. ZIEMER: Well, Dr. Neton is here, maybe he can clarify -- were you referring to scatter here or...

(Pause)

DR. NETON: Okay, let me just get my bearings here. An X-ray taken with a collimated beam -- other organs not in the field of view would be irradiated. That's true, even if they had a collimated beam, there would be scatter and would irradiate the organs, so that statement is true.

DR. ZIEMER: Right.

DR. ROESSLER: That's what I suspected.

DR. ZIEMER: So that's what you're referring to?

DR. NETON: Yes, that's what I was referring to, scatter radiation from -- from even a well-

collimated beam would have scattered radiation in the body.

DR. ROESSLER: Maybe just to --

DR. ZIEMER: So other organs in the field of view would still be irradiated from scatter.

DR. ROESSLER: Due to scatter.

DR. NETON: Due to scatter.

DR. ROESSLER: I guess I'd say might still be irradiated due to scatter.

DR. NETON: Correct.

DR. ROESSLER: Okay.

DR. ZIEMER: So the proposed change then would be might be irradiated due to scatter -- simply a technical clarification. Thank you very much.

Tony, you have another one?

DR. ANDRADE: Right. One double page over, same section, near the top of the page. There was a question that I asked about -- I asked it of Dr. Neton and it says Dr. Neton referred to whether -- Dr. Neton referred to natural. He meant whether it was processed in its natural form. It's -- processing it naturally does not make any sense.

DR. ZIEMER: He meant -- insert the word "whether"?

DR. ANDRADE: Whether it --

DR. ZIEMER: Was --

DR. ANDRADE: -- was processed --

DR. ZIEMER: In its natural form.

DR. ANDRADE: -- in its natural form.

DR. ZIEMER: As opposed to processed naturally.

DR. ANDRADE: Right.

DR. ZIEMER: Any objection to that clarification?

(No responses)

DR. ZIEMER: Thank you. Without objection, we'll make that change. Others?

(No responses)

DR. ZIEMER: If there's no changes, we can have a formal motion to approve the minutes as corrected.

DR. ROESSLER: So moved.

MR. PRESLEY: Second.

DR. ZIEMER: Moved and seconded to approve the minutes as corrected. Any final comments or discussion?

All in favor, aye?

(Affirmative responses)

DR. ZIEMER: Any opposed, no?

(No responses)

DR. ZIEMER: Any abstentions?

(No responses)

DR. ZIEMER: No, okay. Dr. DeHart, do you have a comment?

DR. DEHART: We have been changing format of the minutes almost continuously. I would urge that we hold to his format. It's the easiest to read and to follow and I commend this document.

DR. ZIEMER: You like it without the page numbers, is that -- with page numbers, if we could. So noted.

Is that -- that's Dr. DeHart's view, but others like some other version better? It appears not. Thank you.

If we can turn to the 22nd meeting, these minutes you did not have in advance. This is a summary of the telephone call. It's a single topic discussion. These are very brief; however, if you have not had a chance -- well, you got your packet last night. If you did not have a chance to read these, the Chair is willing to have action deferred until tomorrow. I'd point out, however, this is a very short set of minutes.

MS. MUNN: I'd appreciate tomorrow.

DR. ZIEMER: We can delay till tomorrow.

Others -- okay, it seems to be a consensus that we delay action on those meetings unt-- or minutes until tomorrow, and we will take those up during the housekeeping session in the morning.

PROGRAM STATUS REPORT

We'll go ahead then with the next item on the agenda which is the program status update. Jim Neton is going to make that presentation.

DR. NETON: Thank you, Dr. Ziemer. Is that --

DR. ZIEMER: Is that a rheostat behind you there? Can we lower the --

DR. NETON: There's a lot of them. Is that too low? Okay.

Thank you, Dr. Ziemer. It's my pleasure to be here in Richland to present the NIOSH program statistics -- appreciate the nice weather that was arranged for us to be here. The last time I was here, in January, I think we had ten inches of snow on the ground, which is unusual around here.

This is the standard format -- or standard presentation that you've received over the last few Board meetings, but it's gotten a little bit of a facelift and I think you'll find there's more graphics in here, a little prettier to look at, anyway, and

organized a little differently, and maybe a slide or two that you haven't seen before.

The first slide shows the number of cases that have been referred to us from the Department of Labor. This is as of April 15th. We've popped over the 16,000 mark, so we're steadily increasing. The proportions from the different district offices of the Department of Labor are remaining fairly constant. We have about two-thirds of the claims from Seattle and Jacksonville combined, and Cleveland and Denver constitute about a third of the other claims. Of course Seattle and Jacksonville encompass some of the major DOE facilities such as Savannah River, Hanford and the Oak Ridge reservation, which largely accounts for the number of claims we're seeing in that -- in those district offices.

This is a histogram that shows the cases received by quarter from the Department of Labor. As you can see, we popped at almost -- over 2,900 claims in the summer of -- end of the summer of calendar year 2004 and have been dropping steadily down to around 200 claims a week on average right now, although I think we're -- pardon?

MR. ELLIOTT: 2002.

DR. NETON: 2002, yeah -- 2002, I'm sorry.

And we're seeing about 200 claims a week coming in the last month of the quarter for -- quarter three in '04 is just for the first half of April statistics, so that's why the numbers seem so low. We expect that that will be at least as equal to quarter two after the end of the month is over.

This slide depicts the number of requests we sent out to the Department of Labor -- I mean Department of Energy. We've sent out 15,373 requests that represent 13,897 cases. The number of requests of course exceeds the number of cases because we have multiple work histories for a number of our claimants. The other thing I'd point out is even though we have 16,000 cases in-house, a couple thousand of those are from Atomic Weapons Employer sites, therefore the number is lower. We're fairly -- we keep fairly close with the requests for information to the Department of Energy. There's rarely a one or two-week backlog in getting those requests out to -- to Energy. So if you add the 2,000 AWE claims which we don't request information from Energy for most of the cases, we're right around 16,000 -- pretty close.

We've received 14,711 responses, representing over 13,000 cases.

We do request that we receive a response from

the Department of Energy within 60 days. If they cannot provide a response within 60 days, we ask that they notify us and provide a reason why that response can't be met. And we've had a fairly good relationship, as you know over past Board meetings, in getting these responses in from Labor -- or Energy. They've been quite responsive. We do show some claims that are outstanding over 60 days, and in fact we have a few -- a few, actually 114 -- that are over 150 days. Those claims -- we're working with Energy on those to try to move those forward. They typically represent claims that are either very early in the process -- you know, late '40's or even mid-'40's -- or have some bioassay records, particularly for internal dosimetry, that we're trying to capture that don't exist in retrievable form. They're either in databases or something to that effect where we actually need to -- they need to write a little database to get them to us. But we're working very closely. We do put out a monthly report to Energy informing of their performance and coordinate our effort to make sure that we both agree as to which claims are still outstanding.

Telephone interviews I think has been a fairly successful program. ORAU has done an excellent job at keeping up with these interviews. We've done

13,127 interviews for -- at least one interview per case. Many cases have multiple interviews required because there are multiple claimants per case. And we've sent some reports out to 12,000 -- almost 12,300 drafts to the claimants.

The capacity of 200 to 300 is well in place. The interview process is not the pinch point in this process at all, and I think it's a fairly well-running machine at this point.

This is a histogram of the number of interviews done by month since 2002. And as you can see, it's sort of an inverse of the number of claims received from Labor. Where in Labor we had the big bolus here and then going down, you can see that we're going up. It's kind of like a reverse lognormal distribution. But you can see we've had months where we've done over 1,700 interviews.

This is the statistics for where we are in the dose reconstruction process. We have 4,338 claims staged for dose reconstruction. And what that means is that the claimant has received a letter notifying them of one of the select-- one of the -- from ORAU telling them that their dose reconstructor will be assigned. We also have received some response from the Department of Energy indicating that there is some available

exposure information. And most often the site profile for that site has been done, or some other technical document that would allow us to move the dose reconstruction forward.

We also have -- this is a cumulative process, so there's 4,338 staged. There's also 1,020 that have been assigned to dose reconstructors. That means that a dose reconstructor has physically been assigned. There's a name attached to that file and it's in the person's queue to be done. These claims are what we call our hoppers. We fill the hoppers, ready to move out, and they would be the next -- they would -- these would be very close to having completed dose reconstructions.

We've sent out over 2,700 draft reports to claimants, of which 2,319 -- well, we sent 2,714 and we've sent 2,319 finals to the Department of Labor. The disconnect here is that we require the OCAS-1 form to be signed before we can move it to the Department of Labor. That can take time. A claimant has up to 60 days to sign the OCAS-1, so there's always a slight lag between the number that we have in the hands of the claimants and the number that are in Department of Labor. In some cases where you have multiple claimants, there may be ten claimants per case, it

takes some time to accumu-- do all the close-out interviews and acquire the OCAS-1 forms.

This is just a histogram that shows our production by month. And you can see within the last year, starting in April of last year, those 2,700 claims have been put -- most of those have been put out in the last 12 months. Our production is increasing. The month of April of course is not complete. We're optimistic that this histogram will exceed the March production goals. We're working very hard to do that. And I think -- if you can bear with my imagination, I think you can see a nice trend going upwards. I might argue that a linear quadratic equation could be fit to that. But we are -- we are moving forward and moving towards our goal of 200 dose reconstructions per week.

The final dose reconstruction reports, as I indicated, should mirror the drafts that go out, the only difference being the waiting on the OCAS-1's to be signed -- close-out interviews and the OCAS-1's being forwarded to Labor. So this fairly closely mirrors our experience with the drafts going out the door.

This is a new slide I don't think you've seen before. It might need a little explanation. The X axis here is claimant number. As you may know, we assign every claimant a unique I.D. number starting

from claimant 1 and moving out through claimant 16. So what this portrays in blocks of 1,000 is how many claims we've done per block of 1,000 claims. So we've done 253 dose reconstructions out of the first 1,000 claims we received.

I think it's interesting to see that the slope does tend to go in the right direction, that being that we are concentrating efforts to move out claimants earlier in the process when we can. However, we also have a policy that if a claim can be done and processed with the information that we have at hand, we're not going to hold them up, either. So that's why you see a fair number of these being done, as well. But in general, I think the trend shows our efforts to try to move the earlier claims out in a priority manner.

This is a little busy, I suppose, but it's really a combination of the three histograms I showed before, this being the number of claims that we've received from the Department of Labor, the orange or reddish line -- or the yellow line is the draft dose reconstructions sent to claimants, and the red line is the final dose reconstructions sent to the Department of Labor. I like to look over in this area where I think in the month of -- two months, February and

April, I believe, we actually exceeded the number of claims going back to Labor than we received from them. So in a small way, we're starting to reduce the backlog of claims that are in our possession. We hope that this trend continues and we can rapidly start to chew into the backlog a bit faster.

This slide depicts the administratively closed analysis records that we have in-house. What this means is that the number of claims that have been in the hands of the claimants for more than 60 days and an OCAS-1 form has not been received and the claimant is not forthcoming with any additional information. Per our regulations, we can administratively close the dose reconstruction, send a letter to the claimant notifying them that we have done so, and copy the Department of Labor. At that point the Department of Labor may close the case itself. So there have been a number of these -- not a tremendous number, but there's 14 claims or cases that have -- people have received administrative closure letters from us.

Of course the dose reconstruction is -- can be reopened if the claimant signs the OCAS-1 form or provides additional information.

Dr. Ziemer?

DR. ZIEMER: Jim, you have an extra slide on

your handout. Did one get skipped or --

DR. NETON: That's possible. Which one is it?

DR. ZIEMER: Well, it appears just before this one in our handout.

DR. NETON: Just before this one...

UNIDENTIFIED: The reworks.

DR. NETON: Oh, the reworks. Maybe -- yeah, maybe the...

(Pause)

DR. NETON: Somehow they got swapped in the computer. Okay. This is a slide that's titled "Reworks". What this depicts is number of claims during those time periods that have been returned to us from the Department of Labor. They've been through the entire process. The claimants received the draft, they signed the OCAS-1, the close-out interview's done. We sent it to the Department of Labor and, for a variety of reasons, it comes back to us to be redone.

There are a number of reasons. They can range from the claimant has developed an additional cancer in the time period that the dose reconstruction was being processed. There could be an issue with the ICD-9 coding, the type of cancer coding that was on the original referral. There could be differences in

employment dates. The claimant will look at it and point out that their employment record was not exactly as depicted -- those type of issue.

It doesn't look like a large number, but if you add those all up, it constitutes about five percent of our workload going back to -- that goes to Labor comes back to us for a rework. We have committed and negotiated this, that we would like to get these reworks done within 60 days because the claimant's already received it, they've signed the OCAS-1.

In general, it's possible for us to do that because many of these reworks are adding a month or two of employment or an additional cancer that isn't very difficult to reconstruct. However, there are some cases where there are blocks of cancers or unique cancers that require -- if we'd done the efficiency process, for example, for a cancer and then the claim has a very low probability of causation, and then an additional cancer comes in that would require us to do a full analysis, it would require a lot of additional work, and sometimes it's not possible for us to do those in 60 days. But we do our best to get those out -- out the door.

I think you see -- it looks like there's a trend here going up, but I think this is just an

artifact of the number of claims we're starting to process.

Okay. The phone calls continue to be heavy. OCAS has received over 29,000 phone calls since the program started. However, I've been told that since we've started issuing these quarterly activity reports in the mail to claimants, that has actually reduced our phone burden somewhat. The claimants, after the first round, got the idea of what was in -- what was -- what this activity report was all about and they're able to interpret it. Our phone calls have gone down somewhat.

ORAU has apparently -- there seems to be a very large number there, over 84,000 phone calls. I believe this includes the interviews that are done, as well as scheduling of interviews and close-outs, that sort of thing. So it includes some of that -- routine operations, but nonetheless, they've taken over a large burden of handling the phones. They have their own 800 number that the claimants are aware of and I think they do a pretty good job at that.

E-mail continues to be popular, over 3,900 e-mails we've received. We try to respond to those in a timely manner. Hopefully we can answer these within a day of when we receive them, sometimes a little longer depending on the nature of the question.

Okay, recent accomplishments. Physician panel -- in the area of physician panels, 40 new appointments were made on April 12th to bring our -- NIOSH has appointed 215 total physicians for the Department of Energy's activities under Subpart D.

Site profiles continue to be developed and approved. I don't want to steal my thunder in my subsequent presentation, but we have four of the major DOE sites now covered with site profiles, those being Savannah River, Hanford, Y-12 and Rocky Flats. And as of Friday, we generated and issued the Iowa Ordnance Plant site profile, which was long in coming. I'll talk a little bit more in detail about that later on today.

Quarterly dose reconstruction activity reports I alluded to a little earlier. Every quarter we send out an activity report that details the status of the claim to each claimant. We just finished the third issuance of those or third quarterly report last week, and I believe we sent out over 20,000 mailings to the claimants. I think that's been a very positive activity.

The web site, if you haven't visited it recently, I would encourage you to. It's been somewhat redesigned. The site profile page that used to be part

of the dose reconstruction page now has its own page. There's some explanatory text in there about what a profile is and what the definition of facility is that we use for those profiles, that sort of thing. There's an archive page now for previous site profiles that are -- have been revised. So even if we -- if we revise a site profile now, all versions are still maintained on the web and it can be viewed by anyone who so chooses.

The claimant status request is a new feature we've added. We've allowed now for claimants to request a status report of their claim via e-mail. If they send an e-mail to the OCAS box, they will be -- they will receive a written response from us. We try very hard to maintain claimant privacy with this process, and it was not -- it was virtually not possible to verify a claimant is who they said they were via e-mail. That's why if you send a request and we do some basic validation to make sure the person is either a claimant or an authorized representative, then we will send the e-mail -- the response directly to the claimant or the authorized rep's home address. In that case, if they haven't been the one to send in a response (sic), then there's no harm done. They'll receive a response that they didn't request. And we've been starting to get some of those in the door and we

process those in a fairly quick manner.

The claim information page is updated somewhat, and I really an excited about this update. It provides some very good statistics. There's a flow chart there that has six boxes that depict where we are -- essentially a summary of the status that I just gave; how many claims in-house, how many responses from the Department of Energy, how many interviews, how many back in the hands of claimants, how many at Department of Labor, so it's a really nice linear flow chart that depicts what the status is.

But what I really like is the feature that you can view all claim sites. If you click on the cases by covered facility, it is organized by state and you can look up where we are with every covered facility in each of those six boxes by site.

So for example, if one wanted to know where we are -- we were with the Hanford claims, you could go to Washington state, find Hanford and find out that we have 1,865 I think claims from Hanford -- 1,875 claims, 233 which have been returned to the Department of Labor with completed dose reconstructions.

It's a dynamic site. It's updated once a day, so the numbers change daily. One needs to be aware of that, so when you quote statistics you have to

be careful on what day you're quoting the statistic.

Okay, I think that concludes my formal remarks. I'd be happy to answer any questions if there are any.

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

DR. MELIUS: Yeah, I have a couple -- about three questions, to be exact. The first question concerns the backlog and how -- explain a little bit more how you're sort of triaging the requests. I get I guess a little concerned. I was a little surprised to see that one new chart you gave with the -- the group of 1,000 at a, you know, time, where they were that -- we've got a lot of requests that are very old in there. Some of the first ones that come in that aren't being handled yet, and without knowing which sites they came from and so forth, it's hard for me to, you know, project how soon you get into those. But it -- could you describe a little bit more how you're balancing between doing -- assuming you're doing batches as the site profiles get done, but what's happening to the other cases that aren't going to get -- that are old but aren't sort of covered by the site profiles or -- either within a facility or because you're not doing a site profile on that facility for a while yet.

DR. NETON: Uh-huh, where was that -- that's the one you're talking about (indicating)?

DR. MELIUS: No, no, I'm talking about the one where you broke it up by -- by thousands of claims.

DR. NETON: Oh, okay.

DR. MELIUS: That one, yeah.

DR. NETON: Okay. Both slides I guess are sort of connected. There are 4,000 claims that are staged -- what we call staged for dose reconstruction. And really that -- that's a function of where we are with our technical documentation on the programs. We have -- those four major site profiles for DOE facilities that I mentioned constitute roughly about 40 percent of our cases that we can start to do. It doesn't mean we can do them all, but at least we're eligible now. We've got a pretty good handle on the technical issues at those sites, so those are going to be in the hopper, so to speak, we like to call them.

But we also have other technical documentation that we can use. I believe at the last Board meeting I talked about these complex-wide approaches where we take a DOE complex-wide or an Atomic Weapons Employer complex-wide where we assign these very large exposures and we can move certain claims through that way. Those tend to go across many

sites. I've forgotten the statistic now, but the last time I looked, we had done dose reconstructions at 65 different sites. I think it's much more than that now, and that's primarily a function of these complex-wide documents.

But the bulk of the ones that you're going to see move forward are the ones that are covered by these -- the major site profiles. Savannah River Site, we've done a large number. Hanford, we're moving forward now. We expect Rocky Flats to start moving. Iowa should start moving. So that's sort of how we triage them.

DR. MELIUS: 'Cause if I look at this chart, it looks as if you've taken the first 11,000 or so -- I don't even know where the cutoff is -- and just sort of treated them as one group that applied at the same time and -- or just going through that process rather -- and then you're sort of triaging by when they applied for the most recent, you know, few thousand that have come in. I guess my concern is that if we get -- as you start to go through this backlog, you get -- however long that's going to take, a year or more, I don't know, it's hard to say -- but that you're going to be left over with some people that have, you know, filed claims four or five years ago and aren't being --

DR. NETON: I hear what you're saying. I agree with that, but the -- the problem is, once you have a site profile and you can do it, you know, we will do these first because those are the older claims. But however, if these can be done because we have the profile, we feel that it's in the claimants' interests not to hang onto it and wait until, you know, someone else back here can get done. So we will move a claim forward if we can --

DR. MELIUS: Uh-huh.

DR. NETON: -- given that we'll put most emphasis on moving these first.

DR. MELIUS: Yeah, I guess I would just get worried if we got six months down the road or a year down the road and we still had 500 claims left in that first 1,000 that, for whatever reasons, aren't being dealt with yet. Meanwhile we've got a lot more recent claims that you're going through. And I don't -- not saying it's an easy answer and I'm just trying to get a sense of what -- where -- where it goes and, you know, what approach might be used to help that.

DR. NETON: I understand. We're very sensitive to that and we -- we constantly -- I think I mentioned this in past Board meetings -- are moving through the claims and looking at them to see which

ones, you know, can -- can be done preferentially in the lower numbers.

DR. MELIUS: My second --

DR. NETON: Sorry, I think Dick Toohey might have an additional comment to make.

DR. TOOHEY: Dick Toohey, ORAU. I just want to remind you that we do have a small group -- it's only about four people, but we call them the supplemental dose reconstruction team, and their mission is to work on the oldest cases. They've started with claim number one and if it can be done in the absence of a completed site profile, they do it.

Also, our other efficiency process is to look at some of the easily-compensable cases. For example, lung cancer cases with positive lung counts for transuranic inhalation. Those turn out to be pretty compensable without having to do a lot of work on the dose reconstruction. And most of those, also -- apparently, at least from what I've seen -- are some of the earlier cases. So we are -- it's not a huge effort on knocking out some of the oldest cases, but there is some additional effort going on on that.

DR. NETON: Thanks, Dick.

DR. MELIUS: Another one of my questions really may be a third part of that efficiency process,

which would be in Special Exposure Cohort process. Can we have an update on that or is...

DR. NETON: I'll refer that question to --

DR. MELIUS: To Larry?

DR. NETON: -- Larry. I know. I know.

MR. ELLIOTT: We should just make that part of the progress report and say we're not making any progress.

Seriously, the rule has been revised according to public comment, which we carefully considered, and it has cleared through our Department and we're waiting on clearance from Office of Management and Budget.

DR. ZIEMER: Let me insert at this point that I have just received a letter from Secretary Tommy Thompson in reply to the letter from this Board. Did we get copies of this to distribute? We just got this. Why don't you go ahead and distribute that.

It simply says we, the Department, have completed our work on the rule and its publication awaits clearance by the Office of Management and Budget. We realize that potentially eligible classes of workers have been blocked from filing petitions to become members of the Cohort, and we look forward to publishing the rule shortly so that petitions may be

filed.

So I believe that's all we can say at this point. This is from the Secretary of Health and Human Services. You'll each get a copy of that letter and copies will be available for the public, as well.

You had a third question though?

DR. MELIUS: I had a third question. I'm not going to suggest we write a letter to OMB yet, but...

My third question goes back to the interview process, and we had a working group that dealt with some of those issues and I think we reported -- I believe it was about six months ago or so, but is -- and I guess my question is sort of where are you in some of the sort of the quality assurance steps that were being -- that we recommended and I think everyone sort of agreed on at the time that were sort of being implemented that would allow for better -- sort of -- better quality control in that process as what's sort of an ongoing evaluation of that process and -- this may be something that we put on the agenda for the next meeting or something, it's really up to you, but I think it would be nice to get an update on that.

DR. NETON: Yeah, I'm not 100 percent familiar with where they are with that right now. I know that they've drafted some procedures. Maybe I

could ask Dick Toohey to inform us -- for a sentence or two on that issue.

DR. TOOHEY: I should learn to sit closer to the microphone. The procedures have been drafted. They're in internal review. Some of them are in internal review, some we've sent over to NIOSH for review. We also have our internal QA group who completed a semi-annual -- oh, everybody hates the term "audit" so we say quality conformance assessment of our operations in February, and that report is out. And they also took a look at how the interview procedure is working and what additional procedures or controls, if any, may be needed.

DR. MELIUS: I'd just suggest that we consider sort of a -- one of the -- maybe next couple of meetings consider putting the interview -- sort of an update on that whole process on agenda on that 'cause I think in terms of our review of the individual dose reconstructions that would sort of be timely and helpful.

DR. ZIEMER: Henry Anderson and then Robert Presley.

DR. ANDERSON: Yes, I just want to commend you for -- we're sort of getting into a routine on the slides for tracking, and I think they're very helpful.

I would only add two things -- and I find this one very helpful, but what you might want to do is even make it more complex, which I know you've tried to simplify, is one along the base there it would be helpful to know what are the time frames, because 1,000, 2,000, 3,000 might have been in a four-week period or some of those, so some sense -- I like the slides that show, you know, kind of the dynamics of time, so I -- and this is somewhat time, but it's also -- at times you have a bolus come in, so 6,000 to 7,000 might really be a arbitrary split and I wouldn't want people to think that because their number is, you know, 2,001, that that's somehow -- they've been waiting a whole lot longer than somebody at 3,000, so that might help.

The other would be if you do have your staged ones, you could put the bar on top so we could have a sense -- not -- completed is obviously the finality, but get a sense of how many in fact are moving versus just sitting waiting for something else might be helpful.

The other is the phone calls. I think that would also be helpful to look at that over time or spread it out in some way so -- you'd like to be able to see that the load on NIOSH has been coming down at the same time the others are going up, where you don't

get that dynamic sense from just the totals.

The other would be to add -- I think the web site certainly has become more user-friendly providing information, and it would be helpful to see the hits on various components to see are claimants actually using it more than they were in the past. I mean you put a lot of resource into that, so you'd like to be able to show that in fact that's been effective.

DR. NETON: Thank you, very good suggestions.

MR. PRESLEY: Bob Presley. Jim, on the fourth slide, the age of outstanding requests, from 60 days to 150 days, are these outstanding requests -- are they more prevalent from one site or two or three sites, or are they pretty much scattered out all over the AWE?

DR. NETON: You know, we used to have that statistic on these slides and we took it off for this one, so now you've caught me a little short. I would say they're probably reflective of a few sites, some sites -- I can't give you the exact details. I know that at Los Alamos we have some issues with bioassay results. That's when I alluded to the database issues where we're working with them very closely to get the data into the proper form so we can get those numbers. But I honestly can't give you the statistics off the

top of my head which sites those are. I do suspect, though, that they're some sites -- you know, some selected sites that constitute the bulk of those delinquent -- what I'll call delinquent requests.

MR. PRESLEY: I'm just wondering if it would help -- if some of these sites -- if we put a letter out asking that a little bit more attention be given to helping these sites get their information in.

DR. NETON: I don't know, I guess -- I can't answer that, other than I know we coordinate very well with the Department of Energy. They're aware and, as far as I can tell, the appropriate level of resources appear to be dedicated to these efforts. It's not a resource issue, I don't think. It's really availability of the information.

DR. ZIEMER: Dr. Melius?

DR. MELIUS: Yeah, along those lines, I believe on our -- one of the agendas -- draft agendas we saw, there was a -- I think Ted Katz or someone was going to give a report that had to do with access to exposure -- you know, dose records and so forth. What was that, Larry? I'm...

MR. ELLIOTT: That was a -- we had scheduled an agenda item for this meeting to have Ted report on matters that influence dose reconstruction.

DR. MELIUS: Oh, okay.

MR. ELLIOTT: This was actually a report that we were asked to prepare for Congress on that subject matter. We had envisioned that report would be available to present to you all. We think it's very educational and informative. But unfortunately, that report is not available to speak from today. So hopefully next meeting we'll have that.

DR. MELIUS: Okay, thanks. Could -- just -- it would be helpful, along Bob's question, to -- the next time you present this is to -- little more information on the sites that -- where there is a problem and we can get a better understanding of that and not put you on the spot by trying to -- making someone remember where --

DR. NETON: We'll add that back next time.

DR. MELIUS: 'Cause if my memory's right, it appears you -- a lot of the backlog has been cleared and --

DR. NETON: Oh, yeah.

MR. ELLIOTT: We think there's a very good relationship here and we're working really hard with the DOE to be coordinated on this. And I think -- is ETEC -- is Boeing in that mix? Is that one of those sites --

DR. NETON: Yes.

MR. ELLIOTT: -- where we've got like 30 that are over 150 days --

DR. NETON: Yes.

MR. ELLIOTT: -- and the issue is is that -- we're working with them and -- the Department of Labor, Department of Energy, to make sure that they're eligible in -- claimants, first of all, and then if so, can we actually get out hands on the exposure records. So there's a little reluctance in that regard but we're working through that.

DR. NETON: I suspect there's an individual story behind every one of those.

MR. ELLIOTT: And I think -- also I would say that those that are over 150 days, there is an individual story, there's some circumstance relevant to each individual claim as to why they're that -- they're overdue that long --

DR. NETON: Yeah.

MR. ELLIOTT: -- and we're working with DOE on that.

DR. ZIEMER: Any further questions or comments for Jim Neton?

(No responses)

DR. ZIEMER: Thank you. If not, we'll

proceed on the agenda.

STATUS AND OUTREACH - DEPARTMENT OF LABOR

Next we'll have the status report from the Department of Labor. Pete Turcic is here today. Pete -- oh, hang on just a moment. Comment from Jim Neton.

DR. NETON: I'm going to steal the microphone from Pete -- we'll add back Pete's time. I forgot to mention one important thing that we're working on right now, and that is connected with recent accomplishments. We're working to get IMBA available to members of the public through our web site. We will entertain requests for IMBA outputs and runs to the OCAS inbox at this time. We do -- we are aware, though, that it's a complex program and is going to need some assistance from us, more than likely, to guide a person as to what type of input we need. And we're working to that end as we speak to develop a template for people to fill in to request, via e-mail, outputs from IMBA. So we're working very closely with Oak Ridge Associated Universities to make that happen.

In addition, we will entertain calls to their 800 number for guidance as to how to submit a request, as well. I don't -- we don't believe that it's practical to do on-line -- on telephone with IMBA runs. It's just too complicated. So we'll work with people

on the telephone to nail down what parameters they're really interested in obtaining information for, and we'll put that in writing and then we'll issue a request via e-mail or regular mail, whatever -- whatever makes sense. We'll also of course at any time entertain written requests via regular mail to our office.

Sorry for not mentioning that, but I think it's very important that I bring that up.

DR. ZIEMER: All right. Thank you. A question on that.

DR. MELIUS: I believe -- this is Mark Griffon's question -- (Inaudible) running out here, but there was I believe a commitment to try to make -- to make IMBA available to the Board members?

DR. NETON: Yes.

DR. MELIUS: Has that been resolved yet?

DR. NETON: No, not yet, but we're working very diligently to work through the licensing issues. I believe that we're close, but at this time a decision has not been made how that will work. That's the best I can say.

DR. MELIUS: How soon will we have a decision?

DR. NETON: Larry, can you help me with that?

MR. ELLIOTT: As soon as we can get it to you. We want it sooner. We realize that the Board needs IMBA, your contractor needs IMBA, and each -- each of those two entities, as well as our contractor. We are currently operating under a different user's license agreement and we have to put all of that into place. So as soon as we can work out those details -- we're full aware of the Board's time schedule for reviewing dose reconstructions. You want to get started on that, and to do that you have to have IMBA. We realize that. So we're working as diligently as we can to get it to you.

DR. ZIEMER: Thank you. Now, Pete.

MR. TURCIC: Thank you. It's a pleasure to be here to give you a status update on the DOL portion of the program.

The number of claims -- we're up to over 53,000 claims. And as you can see, the vast majority now are cancer claims.

And here's the status. This chart gives the status. It shows where -- the status of the claims in the process. As you can see, there's about 15,600 pending at NIOSH, another 2,000 -- over 2,000 that are pending action in our district offices. So those would be claims that have not received a recommended decision

yet. One thing that's affecting that number is that due to our recent efforts in enhancing our outreach, our number of claims have -- received have considerably gone up. For the last several months we've been averaging anywhere from 250 to 300, 320 claims per week. And in addition, another aspect of that is that the claims are now also -- that we're looking at, they're far -- far fewer percentage -- far less percentage are non-covered conditions. So we -- you know, the number of claims are up -- is up and so is the number of claims that are covered conditions.

Another 1,900 are -- have a recommended decision and are in the process of, you know, awaiting a final decision -- either review of the record or for a -- for a hearing -- requested hearing.

And to date we've issued over 22,000 final decisions out of the total of 39,000 -- almost 40,000 cases that we have received.

The breakdown, recommended decisions, you can see almost 13 -- over 12,500 recommended decisions to approve benefits; 19,000 to deny; final decisions, almost 12,000 to approve benefits and 16,000 to deny. Again, 16,000 -- that number is getting closer, Larry -- 16,035 that -- referred to NIOSH. We've issued payments in 10,619 and we're approaching $800 million

in benefits and some -- over $30 million in medical benefits have been paid.

Initial decisions, again we've issued recommended decisions in almost 32,000 claims or 24,000 cases. Again, there are 13,600 pending -- cases pending at NIOSH and we've issued what we call our initial decision in some 95 percent of the cases that we've received since the program became effective on July 31st, 2001.

Final decisions, final decisions in, again, 22,000 cases or almost 28,000 claims, and there are final decisions issued in over -- in about 56 percent of the cases received, you know, since the inception of the program.

Again here's a breakdown to show -- that shows the final decisions. Again, 11 -- almost 12,000 to approve benefits. Of the 16,000 to deny, as you can see, some 9,000 -- almost 9,600 were denied because of non-covered conditions; 25 -- 2,500 where employee was not covered; 700 and some the survivor was not eligible; and 2,200 was insufficient medical evidence to demonstrate a covered condition. And this number is going up, the -- now it's over 900 where the cancer was not related or had a POC of less than 50 percent.

We track our -- we have -- do a lot of

internal measurement of our processes and our -- you know, have standards for the performance. And under the Government Performance Result Act, our standards for initial processing is for a timely decision. In this year we raised it from 75 percent to 77 percent, and the two standards that we used -- if it's a DOE facility or a RECA claim, within 120 days; 180 days if it's an AWE or a subcontractor claim. And as you can see, for this fiscal year we -- we did meet our GPRA goals for last year.

For this fiscal year, which we made in -- of the decisions that were made, the initial decisions this fiscal year, 93 percent were completed in -- within those time frames and with an average of 92 days to complete that initial decision from the time we received the claim until the time the case is either referred to NIOSH or a recommended decision issued.

On final decisions, it's -- again we have -- our standard is that we want a final decision within 75 days of either receipt of a waiver of objections or a request for a review of the written record, and within 250 days if the individual requests a hearing. And this fiscal year in the final decisions issued, 99 percent of the cases met the -- those standards.

Again, on -- we have a GPRA goal that --

processing time for the probability of causation, and we have a average -- we hold our district offices to an average of 21 days, from -- 21 days from the time a dose reconstruction is received from NIOSH that they have a recommended decision issued. And as you can see, in the first quarter we met it within 99 percent of the cases with an average of nine days. And the second quarter this fiscal year, 97 percent with an average of 13 days from the time of getting a recommended decision to the claimant from the time we receive the dose reconstruction back.

The status of the NIOSH referrals -- and again, we've received 2,213 that -- with completed dose reconstructions, 189 that they weren't com-- you know, dose reconstruction was not necessary. And that could be for various reasons. Most of them were early when we had sent the CLL cases and, you know, when those came back. Of those, the breakdown, the recommended decisions, 528 to approve benefits and 1,388 to deny benefits. Final decisions, 470 final decisions to pay benefits and 691 to deny benefits.

Some Hanford-specific statistics. Again, the nature -- we've -- this is -- we had an effort in the last two months that -- with PACE to try to increase the number of claims that we have received from the

Hanford site. That has been very successful. In the last two months we've received over 275 new claims, of which 200 -- yeah, the increase in the last two months since -- since that outreach effort began, and now we're up to 3,565 claims received from individuals claiming Hanford as a work site. The breakdown, again, most of them are cancer claims and 192 beryllium sensitivity, 126 CBD and other non-covered conditions, 607. And again, that is way down, also. Most of those were early -- early cases.

The breakdown, final decisions, 153 to approve benefits, 557 to deny. Recommended, 160 and -- to approve, 785 to deny; 1,726 cases referred to NIOSH. We've issued 70 payments and over $9 million paid to individuals at the Hanford work site. Just in the last two months since our increased outreach efforts, we had an additional 16 cases approved for benefits, 32 denied in those two months, with 14 additional that have been payments issued and 159 additional cases in that time period referred to NIOSH.

And the nature -- again, 70 payments issued, 30 of them were for cancer, 40 for chronic beryllium disease and we have 100 individuals that have been awarded benefits for beryllium sensitivity and receiving medical monitoring.

The status of the NIOSH referrals from Hanford, 209 that we've received back, 205 with completed dose reconstructions. Recommended decisions in 28 cases to approve benefits, 138 to deny and 27 final decisions to approve benefits and 33 to deny.

Our outreach efforts, we've -- again, we've tried to -- been trying to greatly enhance our outreach efforts, and our goals are to identify potential claimant populations, solicit claims from non-filers. We've been tracking very closely and trying to look into various sites, more specifics of the nature of the claims. And where we're not getting the number of claims that we expected, we've been collecting a lot of facility information and to promote -- goal to promote public knowledge and awareness of the program and to provide assistance in filing claims, as necessary.

Our district office -- our district offices have been charged with coordinating the outreach efforts of the district offices, along with the resource centers in each of those areas, and to research employers at the covered facilities. And we've been focusing on trying to increase stakeholder involvement in our outreach efforts with unions, media outlets, advocacy groups and health care providers.

We had a pilot program here with PACE that,

again, has been very successful and I want to thank Randy Knowles again for -- for their efforts. It's been very successful. And we've had meetings, you know, with PACE here, public meetings. We've had a lot of media outreach. We've met with a number of the local law firms here. And based on that, our resource center has had -- just in those two months -- an additional 353 contacts have been made, people that have come in for interviews.

Some of -- on a national scope, some partners that we've been working with in our -- in our outreach efforts, the Center to Protect Workers' Rights. We have a -- an effort there where not only outreach, but the Center to Protect Workers' Rights -- we've had a difficult time, especially with some of the subcontractors, and they've -- we've put together a program and it's been very successful. They have performed well beyond what is called for in the contract and, as Knut liked to point out, under budget. So that's been a real good effort where they've -- we've been able to get employment verification completed on a number of very difficult cases that we were having problems with that, you know, the records just didn't exist. And we were able to -- they have access to some record sources that have turned out to

be very useful in that. And then we're also working with them to try to increase and develop some outreach efforts -- one of the things we were just beginning discussions on is a national effort for construction workers -- national outreach effort to reach many of the construction workers that worked at the different sites.

We're in discussions with the National Cancer Society and there's going to be links on their web site to the program to identify, you know, potential sources of -- that people may come to for assistance.

We also have an effort going on with the Cancer Treatment Centers of America. This is an effort where we're -- a number of thing-- we're cross-matching -- we're going to give them a listing of employers at the -- different sites that we have identified and they'll cross-match on their records, and anyone who may have listed that employer as an employer, then they'll send a mailing -- a letter that we give them -- to that current patient or former patient notifying them about the program and the elig-- you know, potential eligibility for benefits. So that effort is going on.

We have a strong effort with the California Beryllium Vendors. We've had a number of meetings with

-- with those folks to try to make them aware of the program. And in fact, one of our goals is to reach beryllium vendors across the country, particularly very -- we have gotten very little from subcontractors of beryllium vendors.

And a -- we have a effort going on with the National Councils of Laborers, and that's been very promising. And we're also working with them on some of their trust funds that -- in order to reimburse for payment of medical benefits and also to identify potential claimants there.

And we have an agreement with the Ohio Bureau of Workers' Compensation. This effort that -- we've had a number of joint claimants, particularly beryllium claimants up in, you know, the Toledo area and we've signed an agreement with the State of Ohio to do cross-matches of claimants, so -- also we're -- we have a process where we have reimbursed the State of Ohio for medical benefits that they may have paid for a claimant who then receives benefits under the DOL program. And that's going very well. In addition, there's a lot of exchange going on -- data exchange for -- particularly subcontractors at various sites in the state of Ohio.

And just as a -- each of our districts -- we're in a process -- we've met with each of our

districts and -- along with the affected resource centers and -- to come up with a strategic plan for the next six months in our outreach. We have Jacksonville to do. We've met with the other three districts so far and we'll be meeting with Jacksonville I think it's week after next to come up with their -- their plan. Basically what that amounts to is our Cleveland district office and the affected resource centers, the -- for the next three to six months they're going to focus on outreach to Fernald and Mound, with the rationale there being that those two sites are closing, and also the beryllium vendors. Again, we've -- the number of claims from beryllium vendors has dropped off considerably and they -- we haven't had a lot of claims from subcontractors of beryllium vendors.

Denver is going to be focusing on Rocky Flats and Los Alamos, and we're trying to do our outreach and tie it in with when the site profiles are completed and coordinate, you know, these efforts with -- with NIOSH and the site profiles.

Seattle will be focusing here in -- at Hanford and in California, and our Jacksonville office -- right now, again, we'll be meeting with them to nail down in a -- week after next, exactly what their outreach is going to be.

Additionally, we have -- on a national basis we're going to begin doing some what I refer to as educational outreach. I think that we have not done a very good job of educating people of the process so that, you know, when we get these large numbers of decisions coming back, it's -- I don't think we've done a good job of explaining to people why two people that may have worked together -- one, you know, goes through a dose reconstruction, has a certain type of cancer, is being compensated; the person they worked next to is not. So we're -- we're trying to develop some educational outreach efforts there.

The first one, we're scheduled -- we're trying to schedule is to go up to the Buffalo area to have such a meeting with the people from the -- particularly from the Bethlehem Steel facility there.

And with that, that -- open...

DR. ZIEMER: Thank you, Pete. I think you were out of the room during our earlier review of our minutes from our previous meeting, and then a question arose in the reporting of some of your statistics in our minutes. And I'm wondering if a similar confusion might not arise again. If we look at slides, for example, four and five of your presentation -- and I know that the specifics that I'm going to ask about are

given in later slides, but I think what happens is that as people look at these slides, they may get misled.

For example, a bullet on slide four says cases sent to NIOSH for dose reconstruction, 16,035. The very next bullet says payments issued, 10,619. The casual reader may be tempted to assume that there have been 10,619 NIOSH cases that have been issued payments, so perhaps in the future we could clarify -- for example, of the payments issued, what fraction of those --

MR. TURCIC: Okay.

DR. ZIEMER: -- involve NIOSH. Similarly, in the following slide, cases pending at NIOSH, 13,633; initial process completed for 95 percent of the cases received. I don't know if that 95 percent is of all of Labor's cases or those NIOSH cases.

MR. TURCIC: Okay.

DR. ZIEMER: You understand?

MR. TURCIC: Okay.

DR. ZIEMER: So a little bit of clarification, really --

MR. TURCIC: Yeah, we'll restructure --

DR. ZIEMER: -- in connecting those with your later slides which are NIOSH-specific, which give the actual numbers.

MR. TURCIC: Okay, we'll restructure that and try to make it clearer.

DR. ZIEMER: Very good. Yes, Roy and then Jim.

DR. DEHART: Roy DeHart. My question is, you had mentioned that in the process -- the legal process of going through, that there are hearings that have been occurring. Could you expand on that a bit, the justi-- not the justification, but the issue around most of those hearings?

MR. TURCIC: What -- once a claimant gets a recommended decision, one of their options is to file objections. And they can raise objections and, if they so choose, they can ask for a hearing. And then they -- at the hearing they can present their objections and to date -- we're starting to get a number of hearings that are dealing with issues in the dose reconstruction. Prior to that, most of the hearings dealt with -- objections dealt with factual information that -- or a lot of them dealt with, you know, non-covered condition, why -- or why are you saying it's -- it's not covered. Now we're starting to get quite a number of requests for hearings that are dealing with the specifics on a dose reconstruction.

Now the way that works is that DOL will have

to adjudicate factual information that goes into the dose reconstruction and the application of methodology. So someone can raise an issue that the -- in the dose reconstruction, either a factual piece of information was not covered -- then we would have to address that and either, you know, address it in the final decision or remand it back to NIOSH for -- to redo the dose reconstruction. Or they could also object to the application of methodology, saying that it's not -- wasn't consistent with other cases or whatever, you know, the objection may be.

So far, we've gotten objections that range from that certain issues were not covered in the dose reconstruction and what we would do is we then go back to NIOSH and see how that was addressed, and then in the final decision would either be to address it, you know, at that point in time or remand. But we're -- we're also -- instituted -- and maybe at the next meeting I'll have some hard, you know, data for you. We've asked our hearing representatives to identify and report issues that are coming up as, you know, that -- that -- when claimants request a hearing. You know, what -- what are the issues particular -- you know, relative to the dose reconstructions that are -- that are being raised.

DR. MELIUS: Actually first question's along those same lines and Jim Neton talked about -- I think you call them remakes or --

MR. TURCIC: Reworks.

DR. MELIUS: Reworks, okay, whatever the -- and -- confuse me, but those are cases that have gone up -- this has nothing to do with the hearings. These are cases that have gone --

MR. TURCIC: Right.

DR. MELIUS: Could you talk -- explain a little bit about the process --

MR. TURCIC: Sure.

DR. MELIUS: -- there and what kind of issues...

MR. TURCIC: Sure. We found that in -- more often than we expected, the situation may change. For example, another cancer. The individual may have been diagnosed with another cancer that was not addressed in the dose reconstruction because they didn't have that cancer diagnosed at the time the dose reconstruction was done. So that case may have to go back to have that cancer covered.

Another instance is that we -- we have sometimes -- you know, our district office may not have done a -- either a -- the form for the -- you know, for

skin cancer or smoking -- for lung cancer, and it may have to go back. There may have been errors in the -- or changes in the ICD-9 codes. So there are -- there's, you know, a number of reasons why these reworks have gone back. I don't think that to date -- and again, we are just in the process of getting the requests for the hearings on dose reconstruction cases in large numbers -- that we have remanded any on dose reconstructions. I'm not aware of any that have been remanded yet.

DR. MELIUS: One of the topics that Jim Neton mentioned was the employment history discrepancies.

MR. TURCIC: Right.

DR. MELIUS: That was the one I was sort of trying to figure out how that could occur, though it seems to me -- I mean I know one of the issues has been figuring out how the employment history matches up with the exposure records.

MR. TURCIC: Uh-huh.

DR. MELIUS: So is it related to that or is it related -- that you get new information or more information about the person's --

MR. TURCIC: It could be both.

DR. MELIUS: Okay.

MR. TURCIC: It could be that we have gotten

more information. Sometimes we don't get that information till after a final decision and the individual asks for a reopening, and so we may get information -- additional employment on a number of cases. We -- we have the process set up because oftentimes in -- in NIOSH getting the exposure records, they find additional employment that was not -- was not verified up front. Those -- they continue working it and note it so that -- but then before the case can become final, we may have to verify that employment. You know, if that additional employment was found through records, that's very easy to verify. But if the additional employment was talked about in an interview, we may have to go back and redevelop that, so there -- there may be instances there that, you know, we need to rework the case.

DR. MELIUS: Okay.

DR. ZIEMER: Wanda Munn.

MS. MUNN: Thank you very much for these good statistics. Along the same vein that was discussed a little earlier with respect to breaking numbers out, I'm particularly pleased, obviously, so see the Hanford site statistics. I'm doubly pleased to do so because one of our nationally-elected officials was quoted publicly here recently on a couple of occasions of

saying out of 35,000 cases -- claims, only one had ever been paid. So I'm pleased that you have some more firm numbers than that.

In the first Hanford site statistic, compensation figures, we had the same kind of problem that we previously mentioned --

MR. TURCIC: Yeah.

MS. MUNN: -- in that it is not clear to the casual reader or even to me, as a matter of fact --

MR. TURCIC: Uh-huh.

MS. MUNN: -- how much of this compensation is applicable to the concerns of this specific Board, so --

MR. TURCIC: Okay, yeah, we'll do -- we'll break that out specifically, yeah.

MS. MUNN: As a -- as a sub-note, if you would break that out in the future.

MR. TURCIC: Okay.

MS. MUNN: Just so we know what our specific cases --

MR. TURCIC: Okay.

MS. MUNN: -- are doing, we'd certainly appreciate it. Thank you.

MR. TURCIC: Okay, no problem.

DR. MELIUS: Another question. We're going

to spend a lot of our time -- this Board -- tomorrow dealing with setting up the individual dose, you know, review process with our -- with our contractor and so forth, and I was just wondering if you had any views on how that process sort of ties into your efforts at the, you know, Department of Labor and issues -- obviously we're not, you know, reviewing individual cases per se and -- but -- but issues may arise during that process that may affect future claims or other claims and how that gets done and I'm just curious how you view it in terms of your overall process.

MR. TURCIC: I think it's -- it's very important to our overall process, and we would like to see it as early in the process as possible. You know, it's a quality control function. I would much rather have issues identified that can be addressed, you know, early rather than waiting until -- you know, from a particular site that we may have 2,000 final decisions and then find out that we may have to reopen all 2,000 cases. So as early as possible would be, you know, our -- of benefit to us. And you know, the Board's input on things like that would be very useful when we get into these hearings on, you know, specific issues relative to the -- you know, the dose reconstruction.

DR. ZIEMER: Gen Roessler?

DR. ROESSLER: Wanda's comment, along with Pete's discussion of outreach, has prompted me to bring up something that's been on my mind for some time, and it goes back to something John Till told us when he spoke to us about outreach. It appears that Pete's program is doing a real good outreach with potential claimants. But it appears that there's a big disconnect, either misinformation or lack of up-to-date information, with others -- the Congressmen and the public and the media, perhaps. And going back to what John said, I wonder if -- I don't know if it's the Board's responsibility or somewhere we should have maybe a quarterly newsletter that's written that could be handed out to interested people. That's just a beginning thought on that.

Now I know NIOSH has the web site, which is fantastic, but how many people out there -- other than us, and maybe including us -- what percentage of people really use the web site? And is it -- is there a statement on there that's concise enough to really convey the progress that it seems like is being made on this project? It's just a thought that I think we need to pursue a little bit further.

DR. ZIEMER: I don't know if those were rhetorical questions or if you want the NIOSH staff to

answer, but certainly thought-provoking ideas.

Other comments or questions?

(No responses)

DR. ZIEMER: Pete, thank you again for --

MR. TURCIC: You're welcome.

DR. ZIEMER: -- updating us on the progress, and NIOSH.

The Chair is going to declare a ten-minute comfort break, even though it's not on your agenda. But we will take ten minutes before our next speaker comes to the podium. So please avail yourselves of the ten minutes, but come back promptly.

(Whereupon, a recess was taken.)

STATUS REPORT - DOE

DR. ZIEMER: Okay, I'd like to call the meeting back to order, please. Our next speaker will be Tom Rollow with the Department of Energy, and Tom's going to give us a status report and update on DOE's path forward. Okay, Tom.

MR. ROLLOW: Good morning. Since I talked to you folks last, I -- to this Board about -- in the fall -- last fall, I think it was in St. Louis, we've made a lot of progress. It's been real exciting. I think the main messages I want to share with you today are that we've put a maximum amount of our resources to work and

made some great progress in processing cases for the Part D portion of the program. We have a new plan which I'm going to share a little bit with you today on how we get from here to eliminating the backlog over the next two and a half years.

And just as a reminder to the audience -- I know the Board is well aware of this -- Part D is the part of the program administered by the Department of Energy. It has to do with Workers Compensation and not with a compensation payment from the Department of Labor. And it's not necessarily under the auspices of this Board, but is basically a sister program to the program run by the Department of Labor and the National Institute of Occupational Safety and Health.

I'd just like to start out here and say that first -- as a reminder, the first bullet up there, DOE provides determinations on causation by qualified physicians on our applicants, and these are determinations that affect the processing of the cases to state workers compensation. The determinations -- as you're going to see in a later slide, but the determinations that we've -- that we're now producing on a weekly basis have increased, but not nearly enough to reduce the backlog. Now we think it's a matter of resources and some legislative changes and some rule

changes, and I'll touch upon those.

Our plan to eliminate the backlog will take about two and a half years to achieve. That plan is a combination of increasing our current production, eliminating backlog. We need some Congressional help to do that, both financially and legislatively.

Last bullet on this slide, DOE is maximizing our applicants' opportunity for state workers compensation benefits. Again, as a reminder, this program helps people to apply for state work comp and does not have a compensation payment associated with it.

Just contrasting the two programs, Part D and Part B, for everyone's information, the Part D program administered by DOE is assistance with state workers compensation, it's -- covers all illnesses related to radiation and toxic exposure. If we look over on the Part B side, the Department of Labor and NIOSH-run programs have to do with radiation-induced cancers, and in some cases beryllium and silicosis, as I'm sure you're aware. And a large part of the radiation-induced cancer determination is the dose reconstructions performed by NIOSH.

Back on the left side of this screen, we use physician panel determinations. NIOSH does enter into

the picture there because NIOSH helps us recruit and actually selects and certifies the -- or qualifies the physicians that serve on these panels for the Department of Energy. Lastly, we gather radiation and other medical and employment data at the sites.

We also do gather data for the Department of Labor and NIOSH programs. In fact, Mr. Turcic -- who was up here a few minutes ago -- talked about the Department of Labor program. Almost without exception, every case that has been acted on by the Department of Labor and by NIOSH on that side of the program, we collected the data and provided that to them for those programs, both employment -- mostly employment data and also the radiation data that -- that NIOSH uses.

This is a kind of a picture of where we are, just to -- and for purposes of summary, our process can be thought of as several different boxes in a time continuum processing these cases. There's an application made here, next step is for us to interview and work with the applicant to figure out what the illnesses they're claiming, where they worked. Then we go get records from the site. Once we have the records from the site, we put together a case, and once we put together the case, it goes before the physicians panel.

This is a picture of the cases per week that

we've actually been processing and preparing cases for the physicians panel. So these are not cases completed, but these are cases prepared by the Department of Energy for the physicians panel. On the left-hand side here, these are cases processed per week, and down on the bottom is a time line.

If you notice this dotted line right here, this has to do with some financial changes that occurred in our program last fall, but it also is about the same time I think I came out to St. Louis and talked to you folks, so at that time we were preparing about -- looks like about 30 or 35 cases per week for the physicians panels, the Department of Energy. Today we're actually producing somewhat greater than 100 cases per week. We're averaging about 120 cases per week for the physicians panels.

Let's see -- this chart -- as I was drawing this diagram in the mid-air up here, this chart represents the physician panel determinations, so it's kind of the downstream end of the process. This is after the physicians have actually finished reviewing the cases and a determination has been sent back to the applicant. And again you can see that in the early part of the program we were averaging somewhere less than five cases per week. And since middle or late

January, we've actually -- are averaging up around 30 cases per week processing for the physicians panel.

The reason that these changes have taken place are -- there's several reasons for that. One of the main reasons is we did start full-time physician panels in Washington, D.C. The early concept in this program when I first took it over about a year ago was that we'd use part-time physicians. NIOSH would appoint these physicians and we would put them together part-time, working in the field, coordinating electronically to rule on these cases. We have since found that it's very efficient if we can get the physicians to meet all in one place at one time. So in early January we started bringing physicians to Washington -- one, two or three weeks at a time -- and putting them together in Washington and actually serving on a panel where they can work together in one room. And the productivity went up dramatically in our program for doing that, and we're trying to get more and more physicians interested in working that way.

Our plan to eliminate the backlog -- we have about 23,000 cases -- applications for this program. We've processed something over 1,000 -- I'll show you the numbers later in my package. But our plan to eliminate the backlog results from a four-month

comprehensive review which we finished about a month ago and has these aspects to it.

As far as the regulations go, we have actually issued a new rule about a month ago. It's out for comment -- for 30 days comment right now, but we're actually operating to it, and that new rule changes the number of physicians on a panel from three physicians to one physician. Now what that means is that one physician will look at a package in an application and rule on it. If that is in fact a positive, that application package is done and that person gets a positive determination. If that application is a negative, then it would go on to a second and to a third review to give the applicant the benefit of the doubt to make sure that -- before we give them a negative -- that two out of three physicians agree that that was a negative physicians panel finding.

The legislation component -- components of our plan involve changing the physicians' pay cap. As you may or may not be aware, the original legislation fixed the pay cap at a executive level three level, which basically comes out to be $68 an hour, and we've found that physicians doing this kind of work typically see two -- a factor of two or more times that pay per -- on a per-hour basis, and that is affecting our

ability to hire and attract physicians to work in this area.

Also we are looking for legislative changes to expand the hiring authority. Basically the -- there's some restrictions in the current statute -- when I say statute, I mean law -- in the current statute or law that restrict the physicians that NIOSH can nominate for this program, and so we're looking for some changes to the statute to expand that hiring authority.

And then also there's a requirement in there for a state memorandum of understanding with each state before we can process cases in each state. And that's really kind of a legacy or an antiquity for the program. At one time it was thought that this program might actually rule on each individual case on behalf of the state, and at that time you'd obviously have to have some kind of agreement with the state to spend their money -- their work comp money or make their work comp decisions for them.

The current program does not do that. The current program provides a positive physicians panel finding and then helps the employee make an application for state work compensation.

Those legislative fixes have been recommended

to the Congress and we're looking forward to their action on those legislative changes sometime in the next few or many months.

As far as budget goes, year -- in FY 2004 currently we have a $33 million appropriations transfer. I'll talk a little bit more about that in another slide, but we've asked Congress to allow the Department to move money from other tasks inside the Department to this task, and that request has been in to the Congress since about January and we're hoping to get action on that soon. That will allow us to apply more resources and process more cases, which I'll show you in just a minute.

In the year 2005 or FY 2005 we have a healthy budget, $43 million budget request in. And when I say healthy, as I've shared with you last fall in St. Louis, we under-estimated the level of applications in this program early on and got a slow start, and these are monies that will help us catch up in the processing.

Lastly, we've also implemented or are in the process of implementing many process changes. We've increased physicians recruiting, working closely with NIOSH to try to get more physicians attracted to working in this program. The physicians panels are our

major bottleneck in this program, and that cannot be solved just by resources. We've got to find qualified physicians to process the cases.

We're also going to put together a tiger team. The Department of Labor has agreed to work with the Department of Energy to put together a tiger team, and those of you that -- been around DOE sites for ten-plus years -- no, this is not that kind of tiger team. But put together a tiger team to help categorize and rate suggestions that have been made to date for this program and figure out which ones will give us the best bang for our buck and implement those kinds of changes. I'll touch on that in another slide here in a few minutes.

Also we are prioritizing cases -- living applicants before deceased applicants, for example. We try to process those first because those may have medical benefits which can benefit people sooner. Some of the cases involve dose reconstructions that NIOSH is performing. Previously we could have sent those to panel without a dose reconstruction and then waited some number of months or a year later to get the NIOSH dose reconstruction. It might have conflicted with the ruling of the panel, so we're going to hold back on those cases and await dose reconstruction before we

send those to panel. That provides both consistency in the panel findings, as well as allowing some of our other cases to go forward while we're waiting for the dose reconstructions.

The supply of physicians, as I mentioned, is our number one challenge or number one bottleneck in this program, and I've touched on these issues before -- the inadequate compensation issue which is outlined there. Limited hiring authority is more of a bureaucratic challenge, but if you're interested, basically the law or the statute that we're allowed to hire physicians under kind of characterizes them as part-time workers, yet this is a two and a half year program to reduce the backlog, and we need physicians that can work hard, hot and heavy for us full time for two and a half years or more, so we need some changes in the statute to allow us to do that. I don't think there's much more to say on that particular slide.

This is an interesting slide. I'll take a minute and explain some of the aspects of it so you can kind of focus on it. On the left-hand side is full time equivalent hours. And full time equivalent hours, for those of you not familiar with the term FTE, if someone is working one hour a week for you and a full time person works 40 hours a week, then you get one-

fortieth full time equivalent. Okay? So that's actually a pretty good explanation on how this chart lays out.

If you see this -- the dark blue up here, it says 167. NIOSH has appointed for the Department of Energy program to day -- when I say to date, this was like a month ago because NIOSH actually sent us 40 more physicians in the past few weeks. But NIOSH has actually appointed 167 physicians to our program here. Of those 167, 129 are currently working actively in the program. And the difference between those two numbers is just basically some docs are on vacation or for whatever reason -- they got appointed to the program but they don't have time to work on the program, so basically we have about 129 docs that work full time.

But 129, we don't get 129 FTE from them. They originally committed to NIOSH that they would work for about 16 hours per month. If they worked for 16 hours per month, you'd get this many FTE -- I guess that looks like it's about eight or nine, ten FTE there in that brown bar. What we're actually getting from them right now on average is about four hours per month, so just a couple FTE down here in this purple.

Where we need to go to accomplish our plan and to process these cases is we need 20 FTE by June of

2004, goes to 35 FTE in January of 2005, and we need 60 FTE in April, 2005 and then to the end of calendar year 2006 to make this program work. So that kind of gives you a picture of where we need to go. And this is -- these are big steps. These are giant leaps to get from this little purple bar here to those yellow bars, and it's going to take a lot of work on our part and on NIOSH's part to identify and put to work those physicians.

Physician productivity issues, there were stumbling blocks or some challenges, some obstacles in the statute and in the DOE rule that was originally produced. I've touched on this before. The rule required three physicians. We're going to one. That we have seen near-unanimity of results from these panels. It's taken us two to four weeks to coordinate these three-physician panels by telephone and e-mail, and we think going to a single physician will give us some great efficiencies there, also.

I talked about dose reconstructions, there was a possibility of double determinations or conflicting determinations with dose reconstructions. If we sent through a case today and then got a NIOSH dose reconstruction that disagreed with that case a year from now, that would have presented some

challenges for the program as to how to deal with that. Also it's much more efficient for our physicians panels to deal with a dose reconstruction if it's already performed. They can just look at it. In fact, there may even be a possibility -- we talk about it down here in the lower right-hand corner -- of some presumptive determinations and not even have to go to the panel. Say if we had a positive dose reconstruction for a certain cancer from NIOSH, why even send it to the panel; just give it some kind of blanket approval and move it on. So those are some of the things that we're studying.

There's not much more I want to say on this slide. Let me move on to the next one.

Physician panel rule, I've touched on -- provides a doubling of cases per physician. We calculate or we estimate that we'll get about a double -- a factor of two increase in our productivity going to a single physician's panel. Now you say well, gee, Tom, if it's one physician versus three, you ought to be three times faster. But it actually doesn't work out that way because there are negatives, and the negatives have to go to a second and a third physician. And if you take the number of -- the percentage of negatives that we have versus the percentages of

positives and you do some simple math, you wouldn't see a doubling, you'd see a different number. But we also think that there's more efficiencies, as I mentioned before, by a single physician working alone than having to coordinate with two or three -- with two other physicians electronically and e-mail. So we think that the -- actually going to -- change the number of physicians should give us a reduction in physician hours per application by about 58 percent.

Also it will save us money. We calculated $37 million in physician panel pay because there'll be less physician hours spent on these determinations. On the flip side, we plan to put that same $37 million back to work again both in increased pay for physicians -- if we can get that legislation through the Congress -- as well as faster rate of production. So we're going to spend that money, so I don't want anybody in the room to think we can turn that back to the Treasury. We need to put that money back to work.

The case development process, when I was drawing this diagram in thin air up here -- application, case development, physicians panel, notification to the employee -- case development process is a little bit back upstream. That process we're actually pretty comfortable with today with the

resources that we have available. We have pretty much tweaked and optimized that process, and I'll show you some numbers here in a few minutes.

Some of the issues that we have as far as ramping up, when the funds are available, to processing sufficient cases to work off the backlog in two and a half years, number one, not enough case managers, but that's simply a resource issue. We know where the case managers are. We know how to hire them. We use contractors for this work and so they're very -- it's very quick to get them on board and trained up.

Additional productivity improvement still available, we're going to bring in DOL/DOE tiger team to help us categorize -- we've gotten a lot of suggestions from different organizations that have looked at our program. I brought in an independent review from a company called the Hayes Companies last August/September time frame. I also did an internal self-assessment of the program. We identified potential improvements from those activities. The General Accounting Office, the GAO, has also made suggestions. Government Accountability Project has made some suggestions. And so this DOL/DOE tiger team will take all those suggestions, prioritize it, figure out the cost benefit, the return on the investment, and

implement the ones that make sense to implement.

Process is not standard throughout the field. We are -- this program has actually benefitted, it's actually been blessed, if you will, by having a lot of records available in the DOE system. Some of that's due to security. Stuff got classified in the past and stayed classified for many years and it made it harder to destroy. In the other cases, DOE -- the DOE program is just a pack rat and it has retained a lot of records.

In other cases, there are regulations for retaining records. For example, radiation exposure records have to be maintained for 75 years. So we're lucky that those records do exist. Because they exist in many different shapes and forms at different sites, the collection of those records, both to support NIOSH dose reconstructions as well as to support the Department of Energy's work, it looks a little bit different at each site as far as how those records are collected.

Over the years the records were treated differently at different sites. Some of them have been made electronic, digitized. Others are still stored in boxes. Some of them have people's names on them. Some of them had employee -- you know, employee numbers on

them, so you have to go correlate those to the people's names and Social Security numbers. So it's been a real challenge all around the complex of putting these records together. There's probably some optimization we can do through some standardization of collecting those records, and we'll continue to work on that.

Additional operational improvements and reprioritization of cases, I touched upon this a little bit earlier. We have -- we allowed our advisory committee -- our board, not unlike you, to expire last January, and we are in the process of reauthorizing our advisory board -- our new advisory board. This board will be focused more on the production end of the business and less on the conceptualization of the program end of the business. But we expect the first meeting -- we expect those members to be appointed sometime in the next three or four weeks, and we expect to have our first meeting -- we hope in the month of May.

I talked about applications as far as prioritizing living applicants who are eligible for medical benefits. Some applications also -- the applicants will -- may never be avail-- eligible for workers compensation benefits, like survivors who were -- had reached the age of majority before their parent

passed away, and so those kind of applications may also be reprioritized to the back of the line so that we can get the more needy cases or the more compensable cases moving forward in the process faster.

This is another picture representing the overall plan, if you will, the scope of the program. And so let me just take a minute to kind of explain this to you, kind of let our eyes study it here for a minute. On the left-hand side is cumulative cases processed, and I mentioned the word -- the number 23,000. We have about 23,000 cases -- applications today, yet this -- this chart goes up to September '07 and has numbers up above 30,000 on it. We're still getting applications in at about 100 to 150 a week for this part of the program, and so whatever plan we have over the next three or four years working off this backlog has to take that into account, those cases still coming in.

The green line here is cases processed for the physicians panels. So this is mostly my people working with the sites to get the records and put together the cases. And if you look on this chart, we're somewhere right here before this point of inflection in the chart waiting for additional resources for Congress to let us move that money from

one part of DOE to the other, and then we can put the case production past this point of inflection and put it in this -- this increase right here and process cases -- about 300-plus cases per week going up that green line.

The dotted blue line is the physicians panel process, which is much harder for us to manage, and it's not just a resource issue, but it's find physicians and work -- work smart in the physicians area so the physicians panels can process over 300 cases per week. And we anticipate that that increase is going to lag the green line by some number of months as we make these changes and get up to speed. For example, I made the rule happen a month ago. I can't make the legislation happen. That's the Congress's job. And so we have the proposal over on the Hill, but it could be well into the summer or the early fall before statute changes take place that can help this program.

This is just another picture of the plan, looking at it strictly from determinations per week of physicians panel. And so the left-hand side here is determinations per week. As I mentioned before, we're somewhere down around 30 or less than 30, so we're -- that's the solid line -- and this is our plan over the

next 12 months. If you recall when I was showing you that chart of FTE, how that stair stepped up over the -- over a 12-month period getting more and more physicians FTE time, that's what this sloping line reflects. At some point we hope to be processing physician panel determinations greater than 300 per week, and that will allow us to work off the backlog by the end of calendar year '06. And when we hit that point in calendar year '06 working off the backlog, then we're basically working in steady-state time, so that's why you see a dramatic drop-off in physicians panel determinations because we don't need as many physicians at that point in time.

Again, as I've emphasized to you in my presentation today, budget and legislation. We have worked hard on optimization up to this point. We think we've done a good job in maximizing the use of the current funds to do -- and the current physicians that we have to process as many cases as rapidly as we can. To move forward from here forward, we need budget and legislation, and I think I've touched on that adequately.

These are the numbers -- and I can come back to the Hanford numbers. I think what I'd like to do is go past Hanford and PNNL and just talk about the

national program statistics here for just -- just a minute. We can come back and talk about Hanford -- I don't want to shortchange Hanford and PNNL, but we can come back and talk to them here in a minute.

We have 23,000 applications to the program, 23,600. A couple of things to observe on this chart here. Of those 23,000, we are done, complete, with 2,140. Now we get -- we get complete in several different ways. Like Labor, we have applications that are ineligible. They applied for a disease that's not covered by the program, they applied for a facility that's not covered by the program, or they applied during a time period that's not covered by the program. And a large majority -- or a significant percentage of Labor's rejections are also in the -- in the same category. This also includes, though, physicians panel determinations -- looks like about 400 to 500, both positive and negative determinations. And then there are some situations where people withdraw -- withdrew their case for one reason or another. So we've finished 2,140 cases.

Now just to kind of focus on this for a minute, cases awaiting development, 9,600. So what -- what that says to us is we have some 12,000 -- 14,000 cases that we're currently working on, so we are

working 14,000 cases. If you were to look at this chart over time, over the last six months, that number was up in the high teens just four or five months ago. We have significantly increased the number of cases that are actually being physically worked.

If you do a little mental math here and you take these 2,000 cases here that have been completed, you take these 1,500 that are in the physicians panel process today, and you take these 1,500 that were done with that are waiting to go into the physicians process, these -- these are the total cases that my people have put together in Washington -- assembled for these physicians panels -- and that says two, three, four, five -- about 5,000 of the 23,000 cases DOE is done with their work. DOE has finished their work on those cases. All they're waiting for now is the physicians panel, and so we need to solve that problem so we can move those cases forward. But that reflects a great leap in production since I think I talked to you last fall in St. Louis.

With that, I guess I'll ask if you have any questions that I can answer for you?

DR. ZIEMER: Thank you, Tom. Let's see, who has questions? Okay, Roy.

DR. DEHART: Thank you, Tom, for the update.

I think the -- we all appreciate the new information. Particularly I was delighted to see that there's a reduction in potential conflict between Subpart B and Subpart D with regard to requirements now of having some kind of case reconstruction before you make a decision on the worker comp side of the house.

On the advisory board, if I'm not mistaken, you're asking for those participants to be volunteers, not to be reimbursed. Right?

MR. ROLLOW: That is correct.

DR. DEHART: I don't understand why you would do that when you're -- you're having problems moving forward, but this Board is not all volunteer, I might add.

MR. ROLLOW: That's information I didn't know. I'll take that back to Washington.

DR. DEHART: You may find it helpful.

MR. ROLLOW: Okay. Thank you.

DR. DEHART: One other thing. In talking with physicians, and I think you're aware that I've been actively trying to recruit the program, one of the common questions is the insurance issue. Members of this Board may not realize that malpractice insurance is not covered under this. We are not practicing medicine in reviewing those records. It's an

omission/commission administrative insurance, and also many of the doctors are hired physicians by universities, by corporations, by whoever they happen to work with and for, and their insurance wouldn't cover them if they're doing this on their own time. And what is the status of that consideration?

MR. ROLLOW: That insurance is in place, and the fact that you're one of our practicing physicians and you didn't know that tells me I have a communications problem that I'll take back to Washington and work on.

DR. DEHART: It's been about two months since I've done a case, so that may be why, but thank you anyway.

MR. ROLLOW: Yes, sir.

DR. ZIEMER: Jim, then Tony.

DR. MELIUS: Hoping that Larry will assure us that this advisory panel is not going to expire -- had us a little bit concerned there for a second, Tom.

I just wanted like first to clarify for the record one issue, I think it was the reference to what Wanda said during the previous -- when Department of Labor was presenting. The quote -- the data from Senator Cantwell was in reference to this program, Subpart D, and refers to -- I think at least as of a

few weeks ago, one person had gone through the entire program and got to the point of compensation. Now there's issues, not to belabor them, of what the intent of this program is and so forth, but that is an accurate -- accurate figure that Senator Cantwell was saying and it was something that Department of Energy, you know, testified about a few weeks ago -- at least former staff people at the Department of Energy -- do that.

One of the question I had is -- relates to some of your appropriations issues that you mentioned about cutting back staff and -- and so forth if you don't get the reprogramming. Are these staff at all involved in activities related to this program?

MR. ROLLOW: In my slides there may have been a couple of words that I didn't talk about today which talk about making some cut-backs later in the year if we don't see the appropriations. Is that what you're--

DR. MELIUS: Yeah.

MR. ROLLOW: -- talking about?

DR. MELIUS: Yeah.

MR. ROLLOW: Yes, those would be staff that work for us through the M&O contractors at the DOE sites that collect records.

DR. MELIUS: Uh-huh.

MR. ROLLOW: In other words, we're -- in the records collection area we're working at a rate that exceeds a level budget, if you will, in anticipation of seeing this $33 million reappropriation. If we don't see it, we'll have to start laying off staff in the next few months at sites.

DR. MELIUS: So that would mean that the records coming to NIOSH would be cut back also?

MR. ROLLOW: That's a good question. We have from day one, since I took over this program about a year ago, I made the decision to put my customers first, which was NIOSH and Department of Labor, and we have never wavered in that -- on that commitment. And there are many reasons for that, but one was that their program was more mature and moving faster than ours was and so right now my intentions would be to continue that commitment and to put NIOSH and Department of Labor information requests first. But as I start to run out of resources, anything can happen.

DR. ZIEMER: Tony?

MR. ROLLOW: Let me, if I could, also, just to add the -- the statement of one person has received compensation. Let me just clarify that if I could for the Board. We actually see that as light at the end of the tunnel, as a great -- great achievement. The first

person at the end of our program has received compensation from the state workers compensation program. When people say well, gee, you spent -- and they quote $70-something million, it's really more in the $50 million in setting up this program, and you try to divide that by a denominator of one, then it says okay, $50 million to get, you know, one case $15,000. That's not what actually has happened. What I just showed you here is that -- I can't make this thing go backward; there we go -- what I just showed you here was that as far as the numbers go, there's a lot of activity that's happening in the process. And not the least of which is that 14,000 cases are being worked on right now. So when you look at numerators and denominators, you need to divide by 14,000 or some much larger number than just one number in state workers comp.

We also expect many of these positives -- right now our positives are standing at 163. One can forecast that within the next four, five or six months those positives might reach 1,000. And we expect many of those to also result in financial compensation.

Now let me also be clear. We don't control the financial compensation. That is controlled by state process; it's different in every state. The

Secretary puts us in a position for maximizing the probability of that compensation by ordering current contractors not to contest a claim. But the states and state laws actually govern that.

DR. ZIEMER: I think, Tony, you're next and then Leon.

DR. ANDRADE: Right. Perhaps I missed it during the course of your presentation, but during a change in -- a reprogramming action, the money has to come from somewhere. Did you mention where that somewhere was, what it was, and given whatever its origin may be, what your own personal assessment is that the reprogramming is likely?

MR. ROLLOW: Let me make just a couple of points on that. First of all, as far as the sources go, I'm the guy running the workers comp program and I've not spent a lot of time worrying about or studying where it comes from. Now holistically, I do represent the Department of Energy, and the Department of Energy of course is very much aware and concerned of that. And also our friends on the Hill in Congress look very close at that also because there are many projects in the Department of Energy besides the workers comp arena, and many, many more considerations need to go into those decisions as to where and when you move

money.

From my standpoint, though, I do believe that the sources that were identified, a large part of them were like construction projects where the money was not used and now just needs Congressional approval to go use let's say excess or leftover money from an earlier project, use them in this project. In a couple of cases it may represent projects that will not get moving as fast this year as they -- as some may -- would like and therefore the Department says well, let's use this year's money from that project on Mr. Rollow's project and -- but I do think there's a high probability that the -- that our friends in Congress will agree that the sources, compared to the use of this money for this program, would be acceptable to them. So I do not expect that to be a stumbling block.

DR. ZIEMER: Okay, thank you. Leon?

MR. OWENS: Mr. Rollow, I've had several occasions to meet with you, talk with you, and I guess programs are measured in terms of success. And in regard to Subpart B and Subpart D, I guess we would measure them based on actual cases and claims that were paid for the individual workers and/or the survivors. And as I listened to your presentation, I think we know that there is one glaring deficiency at a lot of the

sites in regard to a willing payer. And after reading the Hayes report and reading the report by the Office of Management and Budget, I think both of those point to that as a deficiency.

I'm also aware under the former leadership at the Department there was not as much interest in addressing the willing payer issue. I know specifically at my plant, Paducah Gaseous Diffusion Plant, for those workers who do not have a covered cancer, do not fall under Subpart B, there is basically no one there, even if they receive a positive physicians panel finding.

As part of the overall programmatic changes that have been made, has the Department considered a legislative fix to the willing payer issue coming from the Department -- not just from the standpoint of processing these claims and then getting an individual to the point where they have a piece of paper that is of no value?

MR. ROLLOW: That's a good question. Let me talk globally about the program at large and then I'll just touch upon Paducah here before we finish. The willing payer question, just to frame that up for everybody's information, is a term that was coined to describe a situation where if the Department -- the

physicians panels give a positive finding to an individual, to an applicant, and that applicant applied for state workers comp, a willing payer situation would be where the Department actually controls the contractor, has a contract with the contractor where we can tell that contractor when -- when Mr. Jones applies, do not contest his claim. And that would be to put the Department in the position of being a willing payer, if you will.

There might be many payers for a claim -- insurance, state funds, other contractors -- that we don't control might pay. Willing or not, they might pay. But this situation is just the willing payer question that Mr. Owens is asking about.

There've been several estimates that have been put forth as far as what percentage of our applicants might have willing payers, and those percentages have varied from as high as 86 percent to as low as 50 percent. And so I think, Mr. Owens, your concern is that there's a -- that there's a group of people out there that may get a positive physicians panel finding that says yes, DOE harmed you, and they may not be able to get any compensation for that because of the willing payer issue.

The question is, what is the Department doing

about that. We are -- we are developing cases and moving cases forward to see how the cases react, if you will, in the state workers comp programs in each state. And we're also doing some work studying the contracts and insurance arrangements for all the contracts for the Department of Energy. That work'll take me a couple of months to do and that'll give me some good indication of where I can and cannot make orders to contractors to do not contest a claim.

As far as what's the final answer, is it 86 percent, is it 50 percent, we won't know that until we have more cases under our belt. The official position of the Department is that we will -- we're going to contract, we're going to the National Academies to go study this issue because it's not just a mechanical question of how many cases are covered. It's also a social question and it's a Congressional kind of legal -- legislative kind of question.

Congress passed a law that said use the state work comp system. The state work comp system in our country does not answer that kind of willing payer question. It's different -- it's different in every state and in different situations. And there's a lot of debate that went on on the Hill and we studied this debate, and it's -- and it's -- we have to let -- we

have to let the law -- the law has to have meaning, and so we have to -- we have to abide by the law. That's what we're doing now.

So the answer to your question is we will not be coming forth with any legislative fixes to the willing payer problem this summer because we don't know if it is a problem. We need to characterize that through the summer, through the fall. Probably will take maybe upwards of about 12 months to finish the National Academy study and have more experience under our belt.

Paducah, this will be good news for you, I think. I guess I'm concerned you hadn't heard this before, but as far as Paducah goes, all cases for Paducah that -- for exposures that occurred prior to July of 1998 when the Paducah plant was turned over to USEC would be covered by Bechtel-Jacobs. In other words, DOE would issue an order to Bechtel-Jacobs Company not to contest.

DR. ZIEMER: Okay, Larry has a comment and then -- or Leon, go ahead and follow up.

MR. OWENS: I guess my concern there, Mr. Rollow, would be that it's just not positive if Bechtel-Jacobs is going to continue to be on the site. And so at the Congressional hearing that was held by

Senator Bunning, Bechtel-Jacobs at that point in time stated that they had not been asked to be a willing payer, had no knowledge of that. So I guess -- you know, we're recompeting two contracts right now, and Bechtel's basically not going to be in position next fiscal year, so I -- you know, I'm struggling just a little bit in the event that they're not even on-site. I can't see them agreeing to serve as a payer, but...

MR. ROLLOW: Today, as you mentioned, Bechtel-Jacobs is a willing payer and will be until those contracts are placed for the Paducah and Portsmouth sites, and at that time I -- prior to that time it's the Department's intent that Bechtel-Jacobs would be ordered through the contracting officer at Oak Ridge to continue that responsibility. But that -- that legal document has not been written yet, so you're correct -- you can't count on it until it's done.

DR. ZIEMER: Larry Elliott.

MR. ELLIOTT: Tom, you mentioned your intent to establish an advisory committee. I assume and I think I'm pretty right here, that's going to be a Federal Advisory Committee Act chartered committee?

MR. ROLLOW: Right.

MR. ELLIOTT: What perspective of -- balance of perspective do you hope to bring in that committee,

and how large or how small do you see it being?

MR. ROLLOW: Well, the committee, as -- in the notice in *Federal Register*, I think it was in early January, was described I think as having representation from -- from labor, from -- I don't know the exact terms, but the insurance company, the DOE contractors, the DOE employees -- in other words, it could be both labor or it could be employee representatives -- people in the work comp industry -- I forget the exact -- the exact cross-section, and we expect it to have about 12 members. And we have already solicited and gotten a lot of recommendations into the Department of Energy, and the Secretary is in the process of making that decision to actually select the members, and then we'll send that over to the White House for the White House's endorsement. And so we expect to see that in three or four weeks.

DR. ZIEMER: Thank you. Any other comments?

(No responses)

DR. ZIEMER: Again, thank you, Tom. We appreciate the input and updating us on the DOE program.

It's now time for our lunch break. We're a little bit behind the agenda, but we have some sort of flexible time at the other end, so we'll go ahead and

take our hour-and-a-half lunch break and reconvene at 1:30.

(Whereupon, a luncheon recess was taken.)

DR. ZIEMER: Let the record show that Mark Griffon has arrived back from the Boston Marathon and he did finish the race, and that's great -- good job.

(Applause)

DR. ZIEMER: He's keeping the time a secret, so all I'll say is he finished the race, which is an accomplishment in itself.

DR. MELIUS: Finished it in time to catch his plane to get here.

SITE PROFILE STATUS, USE IN DOSE RECONSTRUCTIONS, AND ROLL-OUT

DR. ZIEMER: We're going to now return to the regular agenda, and we begin our afternoon session with report on site profile status, and Jim Neton is back on the roster. Jim?

DR. NETON: Thank you again, Dr. Ziemer. Had a nice lunch, I hope everyone can stay awake through this one. It's always tough addressing a crowd after a long lunch hour.

I'm here to talk this time about DOE site profile status, where we are, a little bit of an update on what we've accomplished since the last Board meeting

two months ago. This is a companion piece to an AWE profile discussion that I'm going to -- I'm scheduled to present tomorrow -- I think morning sometime -- so if you'll hold your questions on AWEs till tomorrow, I'd appreciate it.

The first thing I'd just like to start with is the basic definition that we've put in our site profile web page so that people are all talking about the same thing. It's a document that contains information used to understand activities and radiation protection practices at a facility, and also attempts to flesh out the source terms that were there -- what types of radionuclides were there, what quantities were there, what chemical forms were there. And if you can marry those source terms with the radiation protection practices, particularly if you had decent monitoring data, then one should be able to move dose reconstructions forward.

One thing I'd like to say -- I think at the Board conference call we had, it was discussed -- I brought up the issue at one point that the site profiles did not intend to be comprehensive evaluations of incident reports, and they aren't. There are some incident report -- incident type information in there, some of the major incidents, but they are not all

inclusive for incidents. We maintain that information in a separate site images database where we collect -- particularly the major incidents, catalog them. The site images database is searchable by keyword, that type of information. Some incidents are -- reports are very large. I mean the criticality -- Y-12 criticality incident report's very large. So I don't want you to -- give the impression that we don't include incidents in these, but they are not necessarily contained in these documents. Particularly when you're doing dose reconstructions for monitored workers, we wouldn't necessarily rely on the incident reports.

Just as a reminder, you've seen this slide before, but they are limited scope documents used as a guide, a road map to dose reconstructions, and used as a handbook. Again, if one has monitoring information -- urinalysis, TLD, film badge measurements -- one should be able to interpret, for instance, the missed dose that was there if a person was monitored. And in fact, if one looks at the internal dosimetry calculations that we do in many of these dose reconstructions, they almost presume that incidents occurred.

If one has a well-established monitoring program and you look at a bioassay point that was non-

detectable, we will assume that some sort of incident or chronic exposure occurred between those two periods and assign some sort of dose for that monitoring period.

These are dynamic documents. They are subject to revision any time we feel we have information available to us that was discovered that is new and would affect the dose reconstruction outcome for any of our claimants.

Again, they're a compilation of technical documents. There's six separate chapters. Each is a stand-alone chapter, so that when it's ready it is signed as a stand-alone document and if it can be used for a dose reconstruction -- to accomplish a dose reconstruction, it will be. We do not require that all six documents be signed and compiled for that individual chapter to be used. We call the individual chapters, if you remember, Technical Basis Documents. The compilation of all six would be called a site profile.

I want to say a little bit about the internal and external dose areas. There's been a number of questions since the last Board meeting that I've received from various sources regarding the concept of missed dose versus unmonitored dose. Those concepts

are not necessarily addressed in the site profile, but are included in our implementation guides. So if a worker were monitored routinely, for every monitoring period we would assess and attempt to assign the missed dose; that is, what dose could the worker have received and had all of his measurements show up as non-detectable.

The example I would use is if you wore a film badge and every month they exchanged the film badge and that film badge could see no less than ten millirem, for an upper limit we would assign a 121 millirem dose to that monitored worker. There'd be a distribution about it, but the upper limit would be 120 millirem.

If a person were unmonitored, it is not necessarily appropriate to assign missed dose to unmonitored workers. In fact, it shouldn't be assigned unless one can demonstrate fairly conclusively that the missed dose would conservatively estimate the person's unmonitored exposure. An example I like to use in those situations are if a person was monitored for ten years and had non-detectable dosimetry results every time for ten years, and based on that they were removed from the monitoring program because they had very low potential for exposure and they did exactly the same job for the next two years, it may be appropriate to

substitute missed dose for that unmonitored dose if we can demonstrate that that job was the same. But we have to be careful there. It's not always an automatic. It has to be done with very good justification.

I hope that clarifies it 'cause I think it's a -- they're difficult concepts to grasp. They're sort of abstract, but we do assign -- and this is covered in our implementation guides. We do assign missed dose and we are recog-- we recognize unmonitored dose. An unmonitored dose cannot necessarily be substituted with missed dose unless there's some very careful analyses done.

Looks like I got a little tab out of place here, but we have issued six site profiles for DOE sites. I don't normally think of Huntington Pilot Plant and Mallinckrodt as DOE facilities, but that's in fact that way the OWA -- Office of Worker Advocacy -- web site lists them. They're considered DOE facilities, so I've included them in this list. Many of these -- these have been done previously. I think the new ones on this list -- Rocky Flats is completed. That will allow us to start investigating 834 claims from that facility. Oak Ridge Y-12 is fairly recently completed. There's 2,088 claims from Y-12. And just

Friday we approved the Iowa Ordnance site profile, which I believe there's around 400 claims from that facility -- 500 claims from that facility. So we've made some very good progress. I think collectively, if you add these up, you get somewhere around 7,000 cases that are affected -- that are from these different sites, and that represents somewhere approaching 45 to 50 percent of our claimant population -- not 50, about 40 percent of our claimant population is covered by the current site profiles in place at DOE facilities. So we've -- I think we've made some pretty good progress.

I do want to point attention to the fact that I've said "issued" and not "completed". We do, when necessary, issue a site profile without having every single piece of information in there. We will reserve sections -- I think the Board has become familiar with this. For example, at Rocky Flats in the external dosimetry Technical Basis Documents the neutron monitoring section for certain time periods is listed as reserved. We just can't use it. It's -- we're still trying to work out the details of what the neutron exposures really were during those time periods, but in fact anyone who didn't work in those time periods and had low potential for neutron exposures, we could start evaluating those cases. So

that's the concept of pushing these out as soon as we feel that they're technically accurate, complete enough to address certain blocks of dose reconstructions. And then we continue to move forward with the completion after the fact.

They're also subject to revision. The Mallinckrodt site profile is undergoing revision one as we speak. If you remember from the St. Louis Board meeting, there were several gaps in that profile. It did not address exposures from decommissioning activities between 1959 and '61; also did not address residual contamination from '62 to 1995. So we're trying to flesh out those blocks of information so that we can move more Mallinckrodt claims through the process. I think Hanford site profile's also undergoing some limited amount of revision.

And most of these revisions tend to be additions to the information that we couldn't use before. However, occasionally a site profile will be modified from a technical perspective that may change the dose reconstructions that we have previously done with them, and of course if that happens, we are committed to going back and looking at all dose reconstructions that have been through the Department of Labor process and denied and evaluating what effect

those changes may have on the previous dose reconstructions. It's not an easy task, but we're committed to doing that.

Okay, this -- Dick Toohey likes to call these a measles chart -- really tries to depict where we are in the process. And a green circle is draft complete and in comment resolution. What this means is for these sites all of the site profile, the individual Technical Basis Documents, are complete and in draft form and have been seen by OCAS, the Office of Compensation Analysis and Support, so we're in comment resolution. We have some issues to iron out with ORAU, some technical issues -- some are substantive, some are not; it depends on the individual site. But I think it's very interesting to note that all but five of these sites are actually very near completion. So if you add that to what I just showed on the previous slide, we have a fair number of these DOE sites very nearing completion.

Once these are all done, we will have covered site profiles -- we have site profiles that will cover about 80 percent of the cases that we have in house. So that's a major success story, I think, on our part and on ORAU's part.

I know the question's going to be asked:

Well, when are all of these going to be done? And that's difficult, but I think you could understand that if we have drafts in hand and we're ironing out the details, we're not talking six months, a year. We're talking a matter of months before all of these are -- should be finalized and ready for use.

That doesn't mean, though, that there won't be small pieces of each individual Technical Basis Document that will need to have some additional work to flesh out some neutron dosimetry issue or some unmonitored period that we can't quite figure out without additional research.

I'll point out that this Iowa Ordnance Plant is now done. It can be taken off the list. Iowa Ordnance is a unique site. All the major DOE sites have these individual chapters. Iowa Ordnance is somewhat handled more like an Atomic Weapons Employer site. It's -- it had a limited operation for -- from DOE activities, and so it's covered with one -- one document rather than having these individual approved chapters.

There's additional site profiles under development. I've listed them here. ETEC is the Energy Technology Engineering Center a/k/a Rocketdyne, General Atomics -- I mean there's a number of different

facilities imbedded in -- or connected with that facility, but it's in California, 123 cases there. If one adds up these claims, that will enable another 1,400 cases to move forward.

It's not exactly 1, 400 cases, though, because some people work at multiple sites and so it's not an exact number, but it gives a fairly good approximation, within about 20 percent I think of the number of cases we could cover. Particularly at AWEs people didn't tend to jump around as much as maybe some of the DOE facilities, like the Oak Ridge reservation.

So these are under construction. Weldon Springs is a key one for us to finish to be able to move a number of Mallinkcrodt claims forward because a number of people that worked at Weldon Springs when it closed down moved to Mallinckrodt. That's one reason why you're not seeing more Mallinckrodt cases being completed. We just have not finished this site profile.

Again I know I'm going to be asked a question about time frame. I think the best I can say is we're hoping to have -- and this is a goal -- these completed by end of summer or early fall. That's our target goal for the remaining ones.

Once we get below a certain number of cases

for a site profile, we have to make a decision. Do we really want to invest the resources to generate a fairly extensive document that requires a lot of resources, or is it better just to do an individual -- what we tend to call hand-crafted dose reconstructions at those facilities. I think after these are done, we're probably getting there.

I'd just like to switch gears a little bit and talk about the site profile -- what we call site profile roll-outs and the worker input activities that we've been trying to go around and obtain. ORAU, at the last meeting I indicated, had written a draft worker outreach plan. That document is now in fact completed and it's available here for distribution. I don't know if it's been passed out to the -- okay, so you all should have a copy of that. This is a controlled document that was written by ORAU, reviewed by us and approved by us, that essentially sketches out what the intent of this program is, and I just reiterated what the bullets are here. It establishes a worker outreach group. That worker outreach group is headed up by ORAU, Bill Murray -- who many of you may know -- is the ORAU representative there. Vern McDougal is also on board. He's a subcontractor to ORAU from ATL.

They have also just recently hired -- many of you may know Mark Lewis, formerly of the Portsmouth facility. He is now actively engaged in arranging these worker reach-out meetings for us. We had a very successful, I think, meeting at Portsmouth last week. It was Mark's inaugural meeting and I'm very excited. I think that -- I see a lot of energy going into these meetings and I'm looking forward to productive input from these sessions.

They do provide an excellent input for worker -- worker input. As you recall, the site profiles -- we were -- it was indicated to us that they were -- they tended to be written in a vacuum, which we agreed, so we needed to go out to the workers, meet with the workers, get their input, let them know what these things are about, what type of information we may be missing or what they can share with us. This has been particularly productive -- I mentioned Portsmouth was a good example of that, good information-sharing.

The building trades of course also have a unique perspective on what was done and what was monitored that we need to incorporate. And in fact, we are committed to adding construction activity chapters to several of the site profiles to help flesh out those -- those gaps that we perceive to be there.

These are -- we haven't done any public briefings yet, although we may be close at one facility. Occasionally you go to these sites and it appears that the lack of information is fairly low about the programs in general, about the difference between Subpart B and D and who does what. At that point, you know, we have to make a decision. Is it worth just having a public outreach type meeting to -- for a general education session to get the information level up there.

We do take minutes at these meetings. It's not to intimidate anybody, but it's just to, you know, capture what we've done on paper, and we'll distribute them to a representative at the meeting to be distributed to the workers. We take a sign-up sheet and basically, you know, get people to input and say is that what we discussed, have we captured the relevant issues that you -- you rose (sic) at this meeting. All of this is detailed in that plan that's been circulated.

This is a listing of some of -- well, the worker input meetings that we've had so far. We've had five meetings. If you notice, we're going on our third one at Hanford on the 22nd -- that's Thursday after the Board meeting. Thursday morning we're meeting with

PACE, and I believe the Guard union representatives. Sometimes it's difficult to get everybody together in one room on the same day, and we're sensitive to that so we try to accommodate where we can. Of course we prefer to make fewer trips, but if it requires us to make multiple trips to a site, we will do that.

So we've done Hanford, we've done three meetings there. Savannah River was our first one, as you recall, on November 11th. Portsmouth we had March 24th and April 16th. And these are upcoming: INEEL is next Wednesday, I think, April 28th; Nevada Test Site is tentative for May 10th, and Pantex is scheduled for June 3rd. All these have been scheduled since Mark Lewis has come on board, so you can tell that he's ambitious to get things rolling, and we really appreciate his enthusiasm. I believe we have some tentative negotiations going on with the Mound site in May.

One thing that's come up at these meetings is that the site safety reps need some training. This came up at the Portsmouth meeting and I've heard this from other union representatives before, that there's enough claims being distributed now and the workers are going to their union representatives and asking for interpretation -- what does this mean; you know, what

is an OCAS-1 and should I sign it and what is this IREP program and IMBA? So it's happened enough times that we realize that there's a need for this training and we are in the early stages of planning a workshop for -- we're going to invite union representatives from the major sites -- hopefully health and safety type representatives -- invite them to Cincinnati. We'll fund the meeting at our expense to come there and have a one or two-day session -- we're not clear yet on how long it would take -- to essentially have a dose reconstruction workshop. Start with the regulation, go over the efficiency process, talk about IREP, IMBA, how do you read an IREP input sheet, all that kind of stuff. And hopefully to give people a baseline of knowledge that they're comfortable with with the process that we're doing.

I understand it's a complex process. It's very difficult to understand these things. I don't know that we'll ever get there where people will be totally comfortable. But to the extent that we can provide some education and input, we're committed to do it and I look forward to working with the unions -- in the very near term; I don't want this to drag on for a long time -- to come to Cincinnati and collaborate with us and to getting this information shared.

That's all of the formal remarks I had. If there's any questions, I'd be happy to answer them.

DR. ZIEMER: Okay, let's start with Gen Roessler, then Jim Melius.

DR. ROESSLER: Early on in the goals of the -- doing the site profiles, you talked about meetings with old-timers -- I don't know if that's the word that was used, but the workers and the people who were around there, if they're still available, in the '40's. And at Hanford I think that's particularly important to get that perception from the people who were really working there during the '40's and maybe during things like the green run. Have you -- what success have you had with getting people like that?

DR. NETON: I'll be honest with you, haven't done a lot in that area, but we are collecting data and information. Matter of fact, just this morning I was speaking to a fellow that's at this meeting who we're going to interview. He had a -- interesting knowledge -- level of knowledge, fascinating knowledge about what happened in the early monitoring days for construction workers -- or more specifically, what didn't happen. So we're trying to do that. We need to do more of that. But you know, we'll see how it goes. Right now we've -- we're committed to interviewing two or three

people -- I think we did one interview at Rocky Flats for a person who we had discovered had some knowledge and was getting ready to retire, but you know, our involvement there has been limited. We need to -- we need to aggressively pursue that more.

DR. MELIUS: Yeah, I have a few questions. The first is an item from last meeting -- actually several meetings ago, also, but from my understanding from last meeting was that ORAU was -- and NIOSH were developing a conflict of interest policy regarding --

DR. NETON: Right, right, I'm glad you brought that up because it was in my notes and I skipped right over it. Thank you.

ORAU has drafted a conflict of interest policy. We are -- we are still in the process of reviewing it, but I will say that the revisions that they've made to their conflict of interest plan are very similar to the concepts that are included in their dose reconstruction conflict of interest policy, so that any worker who had worked at the site -- currently works or previously worked at that site could not be a principal author of one of those Technical Basis Document chapters. That doesn't preclude, though, them from using resources, site subject matter experts as resources to help flesh out and author those chapters,

because we really frankly believe that they have to. Those people are the most knowledgeable. But the person who puts pen to paper or whatever you want to say is -- cannot be -- you know, have that conflict of interest. And for the new profiles being developed, ORAU -- even though the official policy is not approved -- is following that voluntarily at this point until we review and approve their completed conflict of interest modification.

DR. MELIUS: I don't know how to ask this. It would be helpful to see it and -- I mean you say you're following it, and yet we can't see it.

DR. NETON: I understand, Dr. Mel-- yeah, it's -- until we get the final form out, I can't -- I can't authori-- or issue it, but it's extremely close. I mean I imagine this will be within a matter of weeks that we can get this thing issued.

DR. MELIUS: Well, if we can get a -- 'cause I think it's a significant problem and frankly people are going to be skeptical until they -- they see it and see how it's being implemented.

And just a comment on what you have briefly described is I think one of the major issues is going to be transparency if there are -- you're going to access or use people with potential conflicts of

interest or whatever you want to call that as a resource, at least there ought to -- there should be some transparency to that, and I think it's really transparency for all your references for this 'cause I think that would be --

DR. NETON: I agree.

DR. MELIUS: -- very helpful and --

DR. NETON: Yeah, anyone who works on the profile as a member of the team needs to file a biographical sketch -- you know, they will have a signed biographical sketch indicating that conflict of interest and what their role was. But you're right, until we get that formal policy issued, it's -- you know, you can't tell.

MR. ELLIOTT: Can I comment here on that issue? We agree, I think, very strongly that whoever contributes to these documents needs to be so referenced. And I think you'll see this conflict of interest plan come out, as Jim has described it, that will make sure that the principal authors -- who interpret what is provided to them, what resources they have -- are not conflicted. And as soon as we have this conflict of interest plan approved, I assure you we'll give it to the Board the day it happens.

DR. MELIUS: We'll give you a day or two.

MR. ELLIOTT: I'm committed on the record, the day it happens.

DR. MELIUS: Okay, okay. Appreciate that. And I think also -- I mean references to people who are at these outreach meetings you're having, the so-called "old timers" that Gen mentioned I think would be -- are also -- I think it's helpful to the credibility of the process to see who was accessed. And as people go back and look at how this site profile that was -- you know, may have been used for their dose reconstruction, I think it really adds to the process.

DR. NETON: We are committed to putting the minutes of those meetings on our web site, as well as the attendance sheets. And I think we make it clear at the meetings that we plan on doing so, so if anyone has a problem with that, they can -- they can withdraw their name.

DR. MELIUS: You have me a little confused on another point, some of the clarifications you did at the beginning -- and this has I think some implications on what the Board's going to be doing in terms of review process. And you mentioned I think three different -- you have sort of the site profile technical document which you describe in a chapter, so forth. You have these implementation guides which I

take it -- I wasn't clear whether those were site-specific or more general.

DR. NETON: No, implementation guides are more general. Like we have an implementation guide for internal dosimetry, an implementation guide for external dosimetry. Those are more conceptual-based, how would one perform a dose reconstruction giving a set of bioassay records or a set of TLDs, how do you correct for where the organ is relative to the badge, those type of issues.

DR. MELIUS: So -- I mean those are something we as a Board have to think about how we -- do. But then the third one was this repository of incident reports and so forth?

DR. NETON: Well, it's not just incident reports. I don't -- I don't want to give you a mis-impression of that. It is what we call a Department of Energy site images database. We do a lot of data capture efforts at facilities. We have scanned I don't know how many thousands of pages of records, but they're all catalogued on our database as PDF files by site. So for instances if one wanted to look at all the records we've captured at the Savannah River Site, one could go to that section of the database and do a keyword search and pull up anything that had "incident"

or "accident" in the title and retrieve those type of documents. So it's not just purely an incident database, but the incidents are catalogued in that.

DR. MELIUS: Are they -- those referenced or indexed anywhere relative to the site profile technical document? I mean how do we -- how do somebody from the outside know what you have and -- information you have and -- and don't have and -- I'm assuming internally you --

MR. ELLIOTT: Well, these are all indexed.

DR. NETON: We can generate an index of what's in there. I mean that are put in there, but they're --

MR. ELLIOTT: And the Board certainly has access to that, as well as your contractor.

DR. MELIUS: Uh-huh.

MR. ELLIOTT: And if -- correct me if I'm wrong, Jim. If one is -- one of those are used in a dose reconstruction, that's cited in the dose reconstruction report, are we --

DR. NETON: Yeah.

MR. ELLIOTT: -- incident report was found and such and such a date cited from --

DR. NETON: Yeah, if it were used in the dose reconstruction, I mean the first ones we did were the

Y-12 criticality accident and those are referenced.

DR. MELIUS: But they're not referenced in the site profile technical document.

DR. NETON: There are some referenced in there, but it's not an exhaustive list. The problem you have with incident reports and investigations, where do you draw the line? Do you draw the line at these little episodic two or three-people incidents, or do you have to get to a critical mass of 20, ten people? We have catalogued the best way we can the ones that have reports associated with them. We also request all incident monitoring data from the Department of Energy when we issue a request for information. We also request incident information during the CATI. There's numbers of sources that bring these incidents to the forefront. However, in certain dose reconstructions where we have monitoring data, it is not necessary -- necessarily essential to have that small incident in there, for example, an internal exposure. If one assumes -- if you have two bioassay samples and we assume for dose reconstruction purposes that an incident happened the day after his last sample and what could it have been and still been non-detectable a month or two months later, that dose would be assigned to the worker in the reconstruction.

So any incident that would have been in there is covered in a fairly claimant-favorable manner. That way we don't -- we can't possibly find all -- reference to all possible internal dose incidents that occurred. If we know about them, of course we'll deal with them. But if we don't know, using the claimant-favorable approach, we will assume some type of incident happened in that period.

DR. MELIUS: Yeah, but --

DR. NETON: I don't know if that's --

DR. MELIUS: No, I understand what you're saying. I think it just -- if the individual's name is not attached to that in -- I'm trying to think as --

DR. NETON: Yeah, yeah.

DR. MELIUS: If this is like the -- you know, the base document that's supposed to sort of guide these individual dose reconstructions.

DR. NETON: Right.

DR. MELIUS: And those -- and that -- and you're using these other technical documents and -- and -- but that incident -- let's assume that it's a significant incident, whatever that means. Okay? Clearly you can't cover every single one, but there is no name attached to it. It would seem to me that you would want some system to be able to make that

association, whether it be with a building or a process or a type of job that at least would raise the suspicions or -- I mean, again, we're -- you're not necessarily going to pick up the interview process, you've got a survivor or whatever.

DR. NETON: Right. Yeah, to confuse matters even more, I can talk about a different subset of the data, which is this worker profile database that we've talked about in the past, and that is under construction, where workers' data are going in there.

Right now, by and large a large number of the claims that we are working on have monitoring data. These are -- I'm not saying we're not doing any unmonitored workers, but until we get a number of workers through that have monitoring data where we flesh out what their exposures could have been, that goes into the worker database. Then we can start moving through these workers who may have been completely unmonitored. It just can't happen until we get some more experience at certain sites. I'm not saying we're not doing any of those because there are some techniques we can use to do unmonitored workers, but -- but we need to gain some more experience with the monitored workers who have bioassay samples and TLDs to understand what happened in those areas, to

then be able to say okay, this unmonitored worker who did this exact same job or similar job has this exposure, in our estimation. I'm probably confusing --

DR. MELIUS: No, no, no -- well, probably -- I probably don't realize I'm confused -- do it -- when I'm asking these questions, but you are using this efficiency process.

DR. NETON: Yes.

DR. MELIUS: And so you have someone that has monitoring and you're -- assuming that's a fairly significant percentage of those that you're moving through now. I don't --

DR. NETON: Yes.

DR. MELIUS: You know, the site -- and so they're being excluded based on -- their -- their claim is being denied based on efficiency, yet how -- then how do you know whether or not you've missed an incident? I mean 'cause an in-- a signifi-- a significant incident, where's that --

DR. NETON: Like I say, we assume -- if someone had bioassay monitoring, let's say that the person was monitored every six months. We would assume that the person had exposure, even though they were non-detectable that whole period during their work history, and give them internal dose -- whether it

would be -- there's a judgment call from a health physi-- professional judgment call whether this was a -- potentially a chronic exposure scenario which could be more claimant-favorable or an episodic exposure scenario. I mean it depends on the case, but we assign essentially missed dose for internal exposures that would incorporate or include doses from incidents. That's what missed dose really is, from an internal monitoring perspective.

DR. MELIUS: Uh-huh.

DR. NETON: If I assume you had an incident the day after you left your last sample, then your -- and your next bioassay was non-detectable, there's no incident that could have been greater than that. That is the highest dose we could possibly come up with for that un-- for that monitored period.

DR. MELIUS: Uh-huh.

DR. NETON: Those are techniques that are -- that are often used in the program. So there is no incident that happened anywhere in that month that's going to be less dose because it happened closer to the monitoring period. Am I...

DR. MELIUS: Yeah, I've just been trying to see how the -- we, as the Board reviewing this program, captured that in our -- to make our process efficient

in terms of --

DR. NETON: Right.

DR. MELIUS: 'Cause if we're going to approach it -- if we're going to wait until we get to individual dose reconstructions, it seems to me that that could be then a lot of work for each individual dose reconstruction to make sure that the information's complete --

DR. NETON: Right, yeah.

DR. MELIUS: -- that we have for that -- that you used for that individual.

DR. NETON: I'll give you an example. About a year ago I think we gave a presentation where we said in certain cases where an organ doesn't concentrate plutonium, for example, and the person was monitored and had periodic monitoring, or maybe only one monitoring, an exit monitoring point and it was non-detectable.

DR. MELIUS: Yeah.

DR. NETON: In the efficiency process, we could assume that the person had an acute intake of plutonium on the first day of employment, and bring it down to where it was non-detectable the last day and give the person that whole integrated dose for maybe a 15 or 20-year work history. That would encompass any

possible incident that could have occurred in their work history. I can't imagine mathematically that there is a more generous assignment that one could use.

DR. MELIUS: Uh-huh.

DR. NETON: These are outlined in our implementation guides, these type of concepts. So those incorporate -- they preclude the use of incident data because you're assuming that a worst-case incident occurred at the beginning of the process.

I think when we start reviewing dose reconstructions I'm hoping this will become a little clearer, but --

MR. ELLIOTT: I know this goes back many meetings ago, but we gave a presentation -- Dave Allen gave a presentation on internal dose, bioassay analysis, and how we proposed to do that under the internal dose implementation guide. And Tim Taulbee come before you and gave a similar presentation on the external dose implementation guide. If you want to revisit those, we can certainly consider that and bring them back. They're on the web site, but we can bring those guys back in and I think illustrate again what we were proposing then and how we're actually doing it now, how we're using that -- those methods and those -- those concepts.

DR. NETON: Yeah, I would be more than happy that we'd come back and revisit the issue of how we -- internal missed dose and the efficiency process work hand-in-hand and are extremely claimant-favorable in many of these dose reconstructions.

DR. ZIEMER: Jim, are you asking about cases where -- is there any assurance that, if we do have an incident report, that it's linked to a particular individual who might have been there or involved?

DR. MELIUS: There's a way of linking it, that's --

DR. ZIEMER: Yeah --

DR. MELIUS: -- what is -- what method are they using to link to this --

DR. ZIEMER: So let's say somebody worked at Y-12 at the time of the criticality accident.

DR. MELIUS: Uh-huh.

DR. ZIEMER: Does the Y-- can you link the Y-12 report with an individual whose dose reconstruction occurs during that period?

DR. MELIUS: Yeah.

DR. ZIEMER: It's that kind of question that's being asked.

MR. ELLIOTT: Yes and no.

DR. NETON: Yeah, I mean --

MR. ELLIOTT: Yes and no.

DR. ZIEMER: You may or may not, and I think Jim is saying, for example, if it's an internal dose issue and there's bioassay data, then the fact that you made the linkage may not matter --

DR. NETON: For -- for -- to do --

DR. ZIEMER: -- that that's what caused it.

DR. NETON: Right.

DR. ZIEMER: On the other hand, if it's someone who wasn't monitored, you might have a different situation.

DR. NETON: Yeah, and that's what I was trying to say. The unmonitored workers are much more difficult. I mean I'll agree with that, and that's why we're constructing this worker database -- these data points, but we're not ignoring incidents. We're cataloguing them, but we are also performing dose reconstructions without necessarily having to link the internal exposure to an incident.

DR. ZIEMER: But if a person worked at a given site -- let's say Y-12 -- in mid-June of '58 -- that was the year, I believe. I happen to know that 'cause I was there.

DR. NETON: Right.

DR. ZIEMER: Did -- how would you link that

person's work with the incident, I guess is the...

DR. NETON: Yeah. Well, we have the entire report. We know how many people were reconstructed in that incident. It's in this database that I spoke of, the Y-12 criticality incident --

MR. ELLIOTT: I think a more illustrative example is the obverse question. Where we don't have the ability to link, what are we doing?

DR. ZIEMER: Right.

DR. NETON: Right, and that's what I'm trying to say --

MR. ELLIOTT: And we're giving the benefit of the doubt. We're not challenging them in that way. We're looking at the reasonableness of the allegation.

DR. NETON: Right, I think --

MR. ELLIOTT: And if they say an incident happened in building X where I was working, and to our best efforts we can't find that that incident was ever recorded but we can get an affidavit -- okay? -- we pursue that line.

DR. NETON: Yeah, I'm --

DR. ZIEMER: Okay.

DR. MELIUS: But the -- I guess my question is -- well, I think it's two-fold. One is how do we assure the people involved in the program, the

claimants and so forth, that these are -- you know, incidents are accessible to you, to the extent that it's possible to do this, and that in some cases there may be a reported incident that's not recorded. Other cases there -- you may not have -- again, 'cause it's a survivor's -- you know, applying, they may not have that information, yet there's some assurance that there's an attempt to find that out. And I think people's expectations -- some say that was -- would be part of the site profile 'cause the site profile is the -- what the person doing the dose reconstruction's going to use as their Bible. And so I'm trying to get a feeling for what is the other --

MR. ELLIOTT: But this goes to the practice of dose reconstruction. It doesn't go to the site profile. The site profile is a specifically-purposed document that doesn't necessarily speak to incident or accident reports.

DR. MELIUS: Uh-huh.

MR. ELLIOTT: But in the practice of dose reconstruction, we expect each dose reconstructor to ask those questions of a -- of the case and pursue that line of thought until they're satisfied.

DR. NETON: I think we need to start -- when you start getting into the dose reconstruction reviews,

it'll become more -- may become more obvious how this tends to work. The profile is a guide, it's a living document, a dynamic document. It helps the dose reconstructor with their job to be more uniform and consistent. It does not have to have every piece of data that were ever existing at that site for it to be used, and you see we oftentimes do publish them without having the entire document completed. As long as we're aware of what is missing in there and can't use it for those scenarios, I think we can use it. I mean it's okay. But one needs -- you cannot review a site profile in a vacuum without looking at its corresponding dose reconstruction that was done with it to see does that really make sense. Was a good enough job done on the dose reconstruction in collaboration with the site profile to provide a convincing argument, technically, that this is the reconstructed dose for the person.

DR. MELIUS: But I think we're also looking for how are you -- it's a concern of ours, it's a concern of yours -- is how do you maintain consistency among the cases so that the same type of information's accessed, and that's to some extent what the site profile would provide -- again, never -- not complete and so forth, and I'm sort of thinking as our process

to review these, how do we do that in an efficient way that, you know --

DR. NETON: Yeah, I --

DR. MELIUS: -- it helps the process, I mean -- obviously would do that and -- while -- but I think -- somehow I think -- you haven't convinced me yet, but I --

DR. NETON: Yeah.

DR. MELIUS: -- the site profile, including this -- you know, these incident (Inaudible), would be one way of making sure that there was some consistency. And for, you know, the claimants also to know that there'd been a comprehensive attempt to get what information's available for significant incidents and to the extent possible -- do that. And may or may not, you know, be helpful for some of the individuals -- individual dose reconstructions that you do. I'll think about it some more --

DR. ZIEMER: Let's go ahead --

DR. MELIUS: -- and be more confused and --

DR. ZIEMER: -- Robert Presley has a question.

MR. PRESLEY: Jim, do -- are y'all getting any feedback from say the -- on the site profiles that are out on the web site now, are you getting any

feedback from any type of old-timers group or what we call graybeards or anything like that? And if so, are there means to where that site profiles can be updated?

DR. NETON: We have not received a lot of feedback. I want to say that it's a handful of comments and not as many as we would have hoped, I suppose. At least -- you know, the union briefings, we do -- we do get feedback and got some valuable information. But from the write-in, there's been some -- some input. If they do provide substantive input that would change the approach to dose reconstruction, as I mentioned, we would certainly modify the site profile to incorporate that information, put that back out on our web site as a revision and then go back and view its effect on all prior dose reconstructions that were denied. We wouldn't go back and look at the one that were awarded.

MR. ELLIOTT: If I could add to that, I know that we've had one comment that resulted in our looking at the source documents for a site profile to make sure that we had a reference that was given to us by this commenter. And I think that was valuable because we did have it and we could tell them we had it.

In another case, a commenter gave us a reference which we didn't have, and so we considered it

and added it and -- added it to; I don't think it made any change to the site profile, but it was another piece of information we hadn't had before.

DR. ZIEMER: Another comment?

DR. MELIUS: Yeah, I will just be brief, but I will catch you tomorrow on your outreach plan once I figure out how to read an ORAU technical procedure -- couldn't even figure out where -- what it was at first, but -- and may have some questions tomorrow, but I'm -- one -- glad that you're doing it and so forth. I would -- and I think the idea of doing some more educational technical outreach I think is good. I would urge you to work with Department of Labor in some of -- 'cause it seems that Pete Turcic and DOL wants to do some of the same activities. And I think to the -- given the potential confusion about the different programs, I think it's helpful if everyone can go out together and do that, you know, within -- within resources and -- and so forth. But appreciate you getting this done and -- I say, I may have -- if I can understand it, I'll...

DR. NETON: I apologize for getting it late, but it was literally just signed Friday.

DR. ZIEMER: Thank you. Further comments? Mark, yes.

MR. GRIFFON: Jim, I just need a little more

clarification on the unmonitored -- unmonitored workers versus unmonitored exposures. And what I'm trying to get at here is the -- I mean I've interviewed quite a number of former workers that have -- that have said there's been various jobs, various time periods where they were coming close to their quarterly limit and were told or -- or volunteered, in a sense, or else they would be rotated out of their job, they were told to leave their badge in their locker when they worked for the next couple of weeks or else they'd be over their limit and be shipped off somewhere else. That's one example.

Another example is if you have all this bioassay monitoring data but the source term suggests that there were exposures to other radionuclides, that's something I would consider a potentially unmonitored exposure. You know, the worker was being monitored, but maybe for the wrong thing.

DR. NETON: Uh-huh.

MR. GRIFFON: So I'm wondering if you address that in your unmonitored -- in your concept of unmonitored dose, 'cause you didn't really say that when -- in your earlier statements.

DR. NETON: Right. Right. The first example that you bring up -- brought up actually came to us at

one of our worker outreach briefings. A person came up and brought up that exact issue, that even in fairly recent times workers were pulled off a job as they approached the administrative limit because -- or not pulled off, but they weren't badged and they continued to receive exposure. And in fact we're looking at that. We're going to actually write a technical bulletin on this issue where if you look at the cumulative dose for workers, cumulative frequency distribution, it goes up and then all of a sudden towards that administrative limit, it starts to go like this (indicating). And you know something happened there because the workers may even still have been on the bioassay program. So you can -- you can fit that curve and maybe extrapolate back upwards, and we're looking at ways to accommodate that.

That is not going to affect a large number of workers, but a very important segment of workers because those are the ones that are very close to maybe the compensation, you know, value, so we're looking very closely at that. That's not addressed right now, but we're looking at ways to address that and this is a good example of something that we learned at one of these worker outreach meetings.

I think we're aware of it in general.

There's articles on this, but to the extent it happened and to hear a real-world example at a specific site was very interesting to us.

The second example --

MR. GRIFFON: (Off microphone) We've heard that at a lot of sites (Inaudible).

DR. NETON: Yeah, I'm learning that. Yeah. The second example where we have bioassay programs where the source term had nuclides that weren't monitored, I think -- I think that speaks to the site profile. I mean the internal dosimetry site profile is supposed to cover and flesh out the source terms -- what radionuclides were there; were there transuranic nuclides mixed in with the uranium source term; were there other types of materials. And then that would require the health physicist to go back and reconstruct those. In fact --

MR. GRIFFON: Then this also get to the linkage that Jim was talking about. How do you place that -- the worker -- the individual that you're dose reconstructing with that source term? How do you -- you know?

DR. NETON: We know what years the source term existed and when the transuranic wastes, for instance, started coming in in the late '50's and so

if --

MR. GRIFFON: And do you --

DR. NETON: -- and the site profile would definitely address that. That's not an incident-related issue. That is just --

MR. GRIFFON: No, no, no --

DR. NETON: -- a fact -- source term-related --

MR. GRIFFON: -- but -- but for a --

DR. NETON: -- fact.

MR. GRIFFON: -- work history, especially for --

DR. NETON: Right, where the worker was, and if we didn't know, we will assume always the most claimant-favorable approach and assign the worker the worst source term that existed at the site if it's not possible to determine their exact location. That's fairly standard practice in this program.

DR. ZIEMER: Did you have an additional question, Mark? No? Okay. Question, Mark? Okay. Other comments, questions?

(No responses)

DR. ZIEMER: Jim, thank you very much. Our agenda calls for a break. We've not been back from lunch for a full hour. Does the committee feel like

they need a break yet or you want to press on?

(Pause)

DR. ZIEMER: I guess we're going to have a brief break -- five minutes.

(Whereupon, a recess was taken.)

RESEARCH ISSUES STATUS

DR. ZIEMER: Our next item on the agenda is Russ Henshaw from NIOSH. Russ is going to give us a status report on what the Board refers to as research issues. These are ongoing issues that are of interest to us in terms of -- relating to dose reconstruction and related issues. So Russ?

MR. HENSHAW: Good afternoon. Can everyone hear me okay?

I'm Russ Henshaw. I'm an epidemiologist with NIOSH's Office of Compensation Analysis and Support, and my presentation today will focus on two areas. The first is an update on research topics. And as I go through the slides you'll see that we will have projects underway within the year addressing each of the three research areas identified earlier by the Board as priority one topics.

The second part of the presentation will focus on a review of compensation results of our completed claims through the first quarter of this

year.

And Dr. Ziemer, if it's okay with you, I'd be happy to entertain questions at any time during the presentation or after --

DR. ZIEMER: Sure.

MR. HENSHAW: -- particularly in the second part when we start looking at the -- all the data. If it's unclear, please don't hesitate to ask me to clarify it.

Just to recap the Board's earlier consideration of research topics -- and here for reference purposes are the topics the Board previously identified as priorities. There are three priority one topics and two priority two topics. And I'll address each of those in the coming slides.

Well, this topic -- and that is the incorporation of occupational studies into NIOSH-IREP -- appears first on the Board's priority one list. Obviously the DOE work force itself, rather than the atomic bomb veterans -- excuse me, atomic bomb survivors -- would be the ideal source population from which to derive IREP risk coefficients. However, when the risk models were first developed for IREP, NIOSH judged that worker studies were insufficient from which to derive quantitative risk estimates, due to a number

of factors but primarily because the complexity of the factors in the study and also the often conflicting findings.

The idea, though, was to periodically revisit this issue, and we intend to do that this year. We will conduct a feasibility study within the year to review the current state of knowledge of worker studies. And if it appears warranted from that review, we would then propose to launch a more formal evaluation leading to the possible adjustment of IREP risk coefficients.

And this has been discussed often, the NIOSH-IREP lung and smoking model. And as you know, the model's a priority one topic and it conflicts now -- the model in NIOSH-IREP conflicts with the model currently in use in NCI's version of IREP which is known as NIH-IREP. NCI introduced a new lung model late last year based on a new analysis of updated Japanese cohort data.

The question was how to deal with that, whether to adopt the NCI model, not adopt it, adopt it in some revised form, what have you. Well, this year we will have SENES convene an expert panel to evaluate the new model, not to second-guess NCI's decision, but to evaluate it for its applicability in our program --

whether it fits the unique exposure characteristics of the EEOICPA-covered work force.

This approach could also be used for other model differences. For example, the bone model. The NCI model uses a slightly different latency function than we do in NIOSH-IREP.

The other priority topic -- priority one topic on the Board's list is the -- is how cancers are grouped in IREP, the grouping of rare and miscellaneous cancers, including prostate cancer. Well, again, we're going to address that this year. In fact, SENES will begin re-evaluating the risk coefficients used in IREP. In particular we are asking them to focus on the possible discrepancies in the uncertainty distributions, especially revisiting the logic and consistency in how the models were grouped in the first place and wound up into one of the 32 risk models currently used in NIOSH-IREP. Again, this project will begin this year.

There were two priority two topics on the Board's list. There really isn't much to report at this time. The age at exposure workshop concept, which has been discussed previously at Board meetings, has been shelved for the time being. But it could be revisited at a later date. The problem right now is

the lack of development of a standardized database. And frankly, lack of staff time to pursue the project.

However, age at exposure is a potentially crucial and controversial factor, so we can't let it fall off of our radar. Later, by the way, when I get into looking at the claims results, I have a slide showing the compensation rates by exposure age. It's kind of interesting.

Interaction with other work exposures was the other priority two topic, and quite frankly we've discussed this from time to time within OCAS, but we simply have not had time to properly consider it. There's nothing currently planned.

There of course are other potential research topics other than the five on the Board's priority one and two list. One of those is DDREF or dose and dose-rate effectiveness factor. And as you probably know, DDREF is a risk modifier that's used to adjust for low level radiation doses just for the non-leukemia cancers. The leukemia models employ a linear quadratic function which it's thought adjusts already for that issue.

Actually the first phase of this project is already nearing completion. The first phase was an extensive literature review that SENES has been doing -

- they began that earlier this year, and we expect to have a progress report from SENES within a few weeks. Once the report is in, we will review SENES's tentative findings and recommendations. The next phase then would likely involve convening an expert panel, but we'll wait for the written report before commenting further on that.

And then there is chronic lymphocytic leukemia. As the Board knows, there was a Congressional appropriation for research specifically on CLL. CLL is of course the only cancer specifically excluded from compensation in IREP. It's been traditionally regarded as a non-radiogenic cancer.

However, there are other cancers with very little evidence for radiogenecity and we have quantitative risk models for those cancers in IREP. For example, prostate cancer, non-Hodgkins lymphoma, and even some of the leukemia subtypes like hairy-cell leukemia that is granted some risk in NIOSH-IREP, whereas for example the United Kingdom compensation program excludes hairy-cell leukemia as well as CLL.

At any rate, our Health-Related Energy Research Branch, otherwise known as HERB, will begin a research project on CLL this year. That will include an acceleration of two leukemia studies already in

progress -- two of their own studies -- as well as a meta-analysis of other relevant studies, both published and unpublished. And they also intend to convene an expert panel, and I believe their plan is to do that this summer.

If the findings from this study warrant it, a quantitative risk model for CLL could be developed and incorporated in NIOSH-IREP.

MR. ELLIOTT: Russ, may I interrupt you just a moment?

MR. HENSHAW: Sure.

MR. ELLIOTT: I just want to make note here that each of these scientific expert panels or technical peer panels, subject matter expert review panels, whatever you want to call them, whatever the findings and recommendations are from those, we would then bring forward to this Board.

MR. HENSHAW: Right, thanks, Larry. Just following up on that, they're -- in addition to the Board's own discussion of procedures for modifying IREP, that's also spelled out in the probability of causation rule which requires us to submit proposed substantive changes to the Board for review and to then consider those -- the Board's comments, if any. Also to notify the public via the *Federal Register*, consider

those comments, et cetera. And then finally to notify the Board, the public and the Department of Labor of the expected completion date for implementing any change after we've gone through that process.

There's a provision to deviate from that -- those procedures, and again, those are the procedures in the probability of causation rule -- to deviate from those if circumstances warrant. It does not explain what those circumstances need be, but that -- that option is there. And a substantive change is defined as -- a substantive change to NIOSH-IREP is defined as any change that would substantially affect probability of causation.

Now this is maybe only marginally a research topic, but since we're doing it right now, I thought I'd report on it. As you may know, the guts operating in the background of NIOSH-IREP is a software program called Analytica 2.0. Analytica released a newer version earlier this year, Analytica 3.0, and it addresses, for our needs, some of the limitations inherent in the older software package. 2.0 was limited by capacity, and by that I mean the number of rows of dose input that IREP can effectively process, as well as the number of iterations used. You might recall that most claims are run using 2,000 iterations

in the Monte Carlo simulation process. Claims that initially fall into the 45 to 50 percent range but do not meet the compensability level of 50 percent probability of causation, we use a -- we up the number of iterations to 10,000 for a more precise estimate of probability. At any rate, IREP is currently limited to -- at 10,000 iterations, probably no more than 300 rows of dose input. What we're finding lately is that some claims can have considerably more dose input than that, up to 500 rows or even more. So 3.0 would solve that problem.

However, before changing over to it, we need to thoroughly test the software to ensure that there are no inadvertent effects on PC results, either due to rounding or some other unanticipated glitch in the software. And we are doing that. We're working cooperatively with ORAU and SENES to accomplish that. We have a test planned that actually is probably just getting underway this week, if not last week.

And finally, the research part of the presentation, I thought I'd mention the potential use of our own claims data. It's possible that an epi analysis of claims data could prove useful in the IREP risk model. I say possible because there are limitations and some very serious challenges to the

data, but it's still possible.

To begin with, the data are currently limited. The results should not be construed as being representative of all claims, not by any means. But more importantly, the dose reconstruction efficiency approach carries very serious limitations, especially when attempting to assess dose response.

Right now -- you'll see as we get into the slides, results are based on 1,325 completed claims. Of those claims, with the exception of the claims from Bethlehem Steel, a claim -- any claim that's compensable -- virtually all compensable claims use the underestimate approach. Virtually all non-compensable claims use the overestimate approach. What that means, for my purpose -- our purposes for trying to do an epidemiological analysis, is that for compensable claims the dose reconstruction stops when enough dose is found to make the claim compensable.

The converse of that, for a non-compensable claim, an extreme overestimate is used. If the extreme overestimate is still below -- would still result in a probability of causation below 50 percent, again the dose reconstruction stops. Therefore, we have few, if any, claims with complete dose reconstructions.

Again that efficiency process -- I believe

Bethlehem Steel would be the exception to that where -- it was a kind of -- I don't know whether it's a unique site, but it was a site with I believe no personal monitoring data, so the model applies I think to all the claims.

Other challenges are in comparing the data with National Cancer figures. It's difficult to do under the best of conditions. Also there are hundreds of different types of cancer, but less than three dozen cancer models in NIOSH-IREP. And finally, the claimant-friendly process further complicates an epidemiological analysis of the completed data, as in many cases we use multiple IREP models and take the model with the highest probability of causation, and that is the information that appears in our database that can be extracted for analysis.

I'd like to share the claims results with you. Again, that's through March 31st, 2004. This includes completed dose reconstructions submitted to the Department of Labor for which we have received notice from the Department of Labor of a decision. That's about two-thirds at that time -- through March 31st, about two-thirds of the dose reconstructions submitted to DOL. Thus it may not -- for that reason, it may not be predictive of future results, but also

because of the efficiency process, a more compelling reason, it would be surprising if it's predictive of future results.

Another caveat is that the results for the cancer -- specific compensa-- cancer model-specific compensation rates reflect only claims with one primary cancer. You'll see later -- I show the compensation results for two other broad groups of claim types. One is secondary cancers for which the primary is unknown. The other is multiple cancers. Those are not included in the cancer model-specific results.

Okay, just to -- what I've done here, I've taken the 32 cancer models in IREP and put them in a table. It goes across several slides. I have -- just to try to explain the table here -- I hope I'm pressing the right button for the laser pointer -- the column on the left is the cancer model in IREP, and it's arranged simply in the order that the models appear in the NIOSH-IREP pull-down menu, and that's roughly in ascending numerical order by ICD-9 code.

The middle column is the total number of cases that were processed using that model -- and again, these are only -- these are claims with only one primary cancer. And the right column, probability of causation greater than or equal to 50 percent -- equal

to or greater than 50 percent. There are the claims that were -- the portion and percentage of -- excuse me, the number and percentage of claims that were compensable.

In this case, for example, oral cavity and pharynx, there were 23 claims. Four of the 23 were compensable for a compensation rate of 17 percent. Oral cavity and pharynx, by the way, includes tumors of the lip, tongue, gums, tonsils, et cetera.

Any questions on the table format or the numbers before I go on to the next slide?

(No responses)

MR. HENSHAW: I think I'll save you the agony of having me read what exactly you can see on the slide, so...

DR. HOFFMAN: Russ, since we have members of the public here, I think it's important to point out that this is not probability of causations greater than 50 percent, but a one percent chance that the probability of causation would be greater than 50 percent, and so it's a -- it's a highly conservative estimate of the probability of causation.

MR. HENSHAW: I -- thanks, Owen. I think what Owen -- what Owen is saying is that -- I think -- don't interpret the percentage in parentheses as the

average PC or the PC result. That's simply the rate -- the compensation rate, the percentage of cases that were compensable.

DR. ZIEMER: I believe he was simply defining what probability of causation means in this case. I don't think we understood the numbers in the column to be that. Owen, you were simply defining probability of causation as it's applied by NIOSH, which is --

DR. HOFFMAN: Right, but in this case it's not a true probability of causation. It is -- after accounting for all sorts of uncertainty, if there is more than a one percent chance that the probability of causation is above 50 percent, then the claim is eligible. But that -- that qualification isn't evident here in the slide. It just says PC greater than 50 percent.

DR. ZIEMER: Yes, understood.

MR. HENSHAW: Thank you, Dr. Ziemer. I misunderstood what Owen said. I'm sorry.

Anyway, going on to the next slide, in the next five models as they appear in the IREP pull-down menu --

MR. GRIFFON: Russ, I was just going to ask one thing.

MR. HENSHAW: Sure.

MR. GRIFFON: Do we -- I think we've asked for this kind of data before and I'm not sure -- it might be more appropriate in tomorrow's discussion, but do we have a breakdown of number of claims by cancer type by site or something like that? I think -- I don't know if we --

MR. HENSHAW: Whether or not the claims were processed, you mean?

MR. GRIFFON: Yeah, just in -- in terms of our case selection process it might be important for us to see, you know, how -- how that distribution is across all the claims currently in the system.

MR. HENSHAW: I have some results. I did not include that in this presentation since I was focusing on completed claims. But roughly, if you consider all claims submitted -- sent to NIOSH from the Department of Labor, about 34 percent of the cancers are non-melanoma skin cancers; 14 percent fall into the all male genitalia model, it's mostly prostate cancer; about 12 percent --

DR. ZIEMER: Let me interrupt --

MR. GRIFFON: (Off microphone) (Inaudible) something you can --

DR. ZIEMER: Yeah, we don't need that now, and you're giving the overall. I think Mark is asking

-- for example, does some particular cancer appear to be, at least claim-wise, more prevalent at Savannah River, for example, or at Hanford -- and maybe --

MR. GRIFFON: (Off microphone) Looking at both, I think (Inaudible) --

DR. ZIEMER: Right, and maybe at some future point or next meeting we could have that, or earlier, perhaps. I think as we get into the selection process, it might be helpful information. But please proceed.

MR. HENSHAW: The simple answer then is I haven't looked at that yet, so --

DR. ZIEMER: But it could be retrieved.

MR. HENSHAW: One clarification on the all digestive model, by the way, that is all digestive except for the organs that have specific cancer models. So for example, liver cancer would go into its own model, gall bladder, et cetera. Anything that doesn't fit into that -- for example, tumor in the small intestine would go into the all digestive model.

You can see lung cancer is a very high compensation rate thus far, 91 percent of the 230 single primary lung cancer claims, only 21 were non-compensable. Some of this data is graphed a little later, as well. And the lung model, by the way, includes cancers of the trachea and bronchus.

Going on -- other respiratory, compensation rate of about 32 percent thus far. And other respiratory would include probably largely cancers of the pleura. For example, most of the mesotheliomas would fall into this category, but also the larynx and nose, except for skin cancer of the nose.

Basal cell carcinoma model, the bottom row, it's a relatively high compensation rate thus far, 44 percent.

Any questions before I move on?

(No responses)

MR. HENSHAW: The other non-melanoma skin cancer model in IREP is squamous cell, and as you can see, that is a much lower compensation rate, which basically one might speculate mirrors the fact that squamous cell carcinoma is thought to be much less radiogenic than basal cell carcinoma.

There is a separate cancer model in IREP for ovarian cancer. That's because the epidemiologic evidence is much stronger for radiogenicity for the ovaries. All other female genital organ tumors fall into the female genitalia excluding ovary model. Thus far from this dataset, none have been compensable.

That's kind of a stunning number at the bottom, all male genitalia. That is about -- well, 219

cases. None in this dataset have been compensable. And of those 219, about 95 percent were prostate cancer.

Going on, bladder cancer and then urinary organs excluding bladder, that has a relatively high compensation rate. That is -- that is a model that renal cancer would be processed in, cancer of the kidney.

Nervous system models, ICD-9 codes 191 and 192 -- 191 is for brain tumors, 192 is cancer of other organs in the nervous system, no compensable cases thus far with this data.

And similarly for thyroid cancer, 14 cases, none were compensable. This -- there are a number of surprises in these results, but I certainly was surprised when I first looked at many of these numbers. I would caution the Board, though, to bear in mind that these results almost certainly will change. With thyroid cancer -- I don't know this yet, I haven't checked into it this closely, but it's quite possible, for example, that someone did a dose reconstruction on a thyroid cancer at a very low dose, learned how to do it and then, you know, culled other low dose thyroid cancers out of the claims database and did those as part of the efficiency process. It may be that

there'll be another batch of higher dose thyroid cancers which will completely change the way the results look.

I do intend to follow this and other trends, of course, as we get ongoing in the program.

I see a fairly large number of claims fell into the lymphoma and multiple myeloma model, very few of which were compensable, two out of 90.

And finally we go to the leukemia models. There are four leukemia models in IREP. You see the first two here. The other two are on the next slide. They all have varying rates of compensation. For this dataset there were fewer than ten claims -- that is completed dose reconstructions submitted to DOL for which we've received notice -- fewer than ten claims in each of the four leukemia categories. If you lump the four -- the numbers from the four leukemia categories together, however, that's a total of 24 cases, 16 of which were compensable, for a compensation rate of 67 percent.

You kind of -- you kind of draw a line right there separating the last of the leukemia models from the next two categories and summed up the 32 cancer models, that would be a total of 1,071 claims. There are an additional 254 claims, however, that I did not

include in the cancer model-specific categories because there's really no good effective or logical way to do that.

The claims with unknown primary cancer, there were 28, 24 of which were compensable. Those are -- in this case, they're all secondary cancers with an unidentified primary. As you may know, our protocol is to run one or more of the primary cancer models depending upon the secondary cancer identified, and then take the model that produces the highest probability of causation. There were 226 claims with multiple primary cancers, 146 of those were compensable, a rate of nearly two-thirds.

Taken all together, all completed claims in this dataset, it's 1,325 claims, compensation rate is 33 percent.

I took the cancer -- cancer models with claims of at -- with -- excuse me. I took the cancer models with at least ten claims and graphed them from highest to lowest in terms of rate of compensability. And again, this is not -- the vertical axis is not probability of causation. That is the compensation rate. This recaps what you've seen in the table. The highest compensation rate was lung cancer, followed by urinary organs excluding bladder. Again that's -- I

haven't looked at this to verify it, but I'm speculating it's probably largely kidney cancer. Then the basal cell carcinoma model, 44 percent; other respiratory organs and then oral cavity and pharynx and malignant melanoma at 16 percent. And going down, squamous cell carcinoma, 6 percent; bladder, lymphoma and multiple myeloma, and so on.

There were -- there were nine cancer models with no compensable cases. There are only eight on here. Sorry, I inadvertently omitted the all male genitalia, but that should also be on this slide. Nine models with ten or more completed cases, none compensable thus far. I'm saying thus far, that's through March 31st. I mean there may very well be compensable cases in our hopper by now for some of these.

This is just a bar graph of the two groups I mentioned before, the unknown primary cases and the multiple primary cases. Again, you can see very high compensation rates.

This is a graph of compensation by years of employment. I was really struck by the way this graph turned out, a nice -- nice slope to the data.

Any questions?

DR. ANDRADE: Russ, not a question but a

quick comment. Perhaps you can validate this or not. Isn't that slope rather artificial, given the efficiency process? I mean the longer -- the longer that you have worked, either at one site or more sites, if you go through the efficiency process and assign say missed dose over the span of your career, you're going to get a linear slope.

MR. HENSHAW: I think -- yeah, that's a good point. I think it's quite possible that -- maybe largely due to the efficiency process, that this could be a proxy for estimated dose.

I did the same thing with age at diagnosis. Again, very nice linear slope. It also does not necessarily mean anything, following up on Tony's comment. It's hard to tell really what's going on with this. Of course I intend to follow it and look at it more closely as we get into this, but it's pretty to look at, anyway, for right now. But -- kind of thing if you were writing an epidemiology textbook, you know, you'd invent something like that.

This was a very interesting observation. I looked at compensation with -- I looked at lung cancer compensation by smoking status. The bar on the left is never smoked, the bar on the right are all the other categories, including former smoker. Somewhat

surprisingly, the compensation rate was actually higher for smokers.

It's hard to tell exactly what's -- I'm going to show you a slide -- the next slide breaks those numbers down by smoking category. It's hard to know exactly what's going on there. It's something we want to continue to look at as more data comes in. It probably should be noted that about -- about 100 of those 230 lung cases were from Bethlehem Steel. This may -- this may just be a function of such an overestimate -- or excuse me, such a high dose estimate used that it washes out the smoking adjustment.

Here it is by smoking category. At 86 percent is the bar on the left, and again, this is not probability of causation. That's compensation rate. You have former smoker, less than 10 cigarettes a day, 10 to 19 cigarettes a day -- you can see all of those categories are higher than non-smoker. It doesn't start to drop until you get to more than one pack a day, but even there it's a compensation rate of 75 percent. This -- you really can't make much of this number -- I think it was only two cases, one of the two were compensable. That's the more than two pack a day smoker. Then the column on the right, that question-marked number, that just -- that means smoker, but it's

unknown how many cigarettes he or she smoked per day. In the risk model it's kind of an average across the other smoking categories. Again, it was only a few cases.

Any questions?

(No responses)

MR. HENSHAW: Compensability by gender, 37 percent of claims for male workers were compensable, only four percent of the cases for female workers. I don't know for sure what the explanation is for that, but I think a good guess would be probably low dose, probably less years of employment than the males. About -- somewhat slightly less than half of the claims -- of the completed claims for females were breast cancer, by the way. I think it was like 46 percent.

Well, this takes me to the last slide, so I guess to summarize, we will have projects underway within the year addressing the three priority one topics on the Board's list. We have other research projects already underway or in planning. The completed claims results, some surprises, but again, the results are undoubtedly skewed by the dose reconstruction efficiency process and also possibly by the incomplete data. We'll continue to monitor the data for trends and anomalies and of course we will

keep the Board updated as more and more data comes in.

Thank you very much for your attention. I'd be happy to take any additional questions.

DR. ZIEMER: Thank you, Russ, for a very interesting presentation. Let's see, we've got a question here from Dr. DeHart.

DR. DEHART: Russ, when you were talking about multiple primaries -- skin cancer, primarily squamous cell and basal cell frequently are associated with primary -- multiple cancers. Is that in keeping with your data or do you exclude -- if they both -- if they're multiple cancers and the -- three of them and all three are squamous cell, how do you handle that?

MR. HENSHAW: Multiple skin cancers were not included in the skin cancer-specific results. I initially tried to include those cases, but it's -- decided it really wasn't appropriate to do that. You know, we can try to do it -- look at it that way in the future if you'd like, but the problem is, many of the skin cancer cases are not just squamous cell or not just basal cell. (Inaudible) have three or four sites, two basal cell carcinomas, one squamous cell. Then the problem, you know, arises which model do you put it in, and then if you only count it as -- you know, most of them are compensable, so do you count it as compensable

for basal cell, non-compensable for squamous cell, you know, and so on. I finally -- I looked at that really about a dozen different ways, and I just finally came to the conclusion that it would be more honest and clean to just simply exclude all multiple primaries from cancer model-specific rates.

DR. ZIEMER: Jim?

DR. MELIUS: Yeah, I have a question and a comment. One's just more out of curiosity, but when you run into sort of the limits of Analytica 2 in doing -- when you have such a complicated dose -- exposure situation, what do you do if you can't...

MR. HENSHAW: I don't think --

DR. MELIUS: I mean does it just slow it down or is it a question of you're just -- it's just unable to handle that...

MR. HENSHAW: The awareness of the problem occurred when we discovered we had claims in the hopper with rows that exceeded IREP's capacity. We have not -- we have not gotten to those yet in the dose reconstruction.

DR. MELIUS: Okay, so it's not -- hopefully you'll have the Analytic 3 that --

DR. ZIEMER: You have a comment?

DR. MELIUS: Yeah, my comment is related to

the issue of your review of the occupational studies and the other issue that you're not dealing with, though, I think it might be possible to -- at least you should consider in that is this question of interaction with other occupational exposures. If you're going to be doing anything as part of that -- part of the work that you are doing with the occupational health studies I think sort of cataloguing what information might be available and thinking -- it's just going to be hard to separate out the two issues entirely, and I just -- rather than saying you're ignoring it, I think that you're really -- I would hope that you're sort of subsuming it under the other -- other issue because there are -- particularly as we're dealing with IREP, there are ways -- different ways of thinking about the other occupational exposures, for example, that add more uncertainty to -- to your -- the model and so forth.

MR. HENSHAW: To be honest -- well, I think that's a good point and when we get to the point where we can begin a study of occupational -- a review of occupational studies, which we intend to have the literature review this year, the feasibility study, I think that's a good point. I think we can try to look at that, as well, to the extent that it's feasible to

do that, but I agree with you.

DR. ZIEMER: Henry and then Gen.

DR. ANDERSON: Just one thought that I had that would be an interesting, difficult to interpret analysis, but not unlike some you have here, would be to look at the overall distribution of the types of cancers you have, almost to a proportional ratio like you do a proportional mortality and look to see is the distribution, if you age-adjust it, is the distribution of cancers in those that you have here different than you'd expect in the general population or does there seem to be more lung cancers, fewer, is liver disproportionately represented in this group. I think that would be -- treating this as a selective cohort coming through, would be interesting to see. Are claims -- are, you know, people putting in claims because they believe a specific cancer is radiation-related, or is it just every cancer that's occurred, somebody has filed. I mean I think that would be interesting to see, as their -- prostate looked to me to be about right, the breast cancer's -- if you look at, you know, incidence not mortality -- probably is not out of line for the age groups here. But some of them seem to be a little bit more than you might expect.

MR. HENSHAW: I absolutely agree, and I intend to do that. There will be some obstacles to overcome as we do that. You know, what do you compare it to -- you know, this data -- which block of this data. You know, the way this data is modeled is not the same as the way the data's modeled in NIOSH-IREP and so on, but I agree, it's a -- it's a rich dataset to look at from that point of view and I definitely intend to do it.

DR. ZIEMER: I must have missed something there. Henry, it's not clear to me what it -- what are you suggesting be compared in that case, because these are all -- I mean this is not a normal population to start with.

DR. ANDERSON: Right, but what you do is you have 1,000 people or 1,000 cancers --

DR. ZIEMER: Right.

DR. ANDERSON: -- and you say seven percent of those were liver cancers --

DR. ZIEMER: Oh, the relative numbers of each one --

DR. ANDERSON: Right, and then you look at the general population where -- and age-standardize and say in the general population it's two percent.

DR. ZIEMER: I gotcha.

DR. ANDERSON: And therefore you may -- and then, one, looking at compensation, you may say gee, there seems to be an excess of a cancer that isn't compensated at all in this group. That would give you some leads to look into some of the epi studies to see -- 'cause these are all pretty well vetted for what type of cancer it is, other than those that are unknown.

DR. ZIEMER: Of course the underlying question then is is a population group of cancer individuals have this a priori -- should it have the same distribution?

DR. ANDERSON: Well, I mean that's -- that's part of the discussion of it, but at least you might look to see --

DR. ZIEMER: A starting point.

DR. ANDERSON: It's a starting point to see whether there are some of these. You would expect to see in this population the radiation-sensitive cancers ought to be over-represented.

DR. ZIEMER: Right.

DR. ANDERSON: And those that aren't, ought not to be.

DR. ZIEMER: Right.

DR. ANDERSON: Now if those are rare

malignancies, then percentage-wise it isn't going to be very easy to see early on, but I think that's what you'd like to look as -- more for the consistency in this database with what you know in the epi studies rather than get into quantitative measures.

DR. ZIEMER: Dr. Roessler?

DR. ROESSLER: This discussion in the last part of your presentation bothers me because even though you have qualified the interpretation, many times numbers like this are carried forward without the qualifications and I think, other than scientific curiosity, this really doesn't mean much at this point and we ought not make too much of it. As you've said, the small database, the efficiency process has certainly made this a very -- not representative population, even of the workers. And as I looked at one of your slides where you presented the numbers with regard to age, I keep wondering if because this is a claimant-friendly process, that's just the normal incidence of cancers with age and has nothing to do with the radiation exposure. My point is, let's not make -- have to be careful not to make too much of the interpretations at this point.

MR. HENSHAW: Your point is well taken. I mean absolutely. Hopefully no one will run up -- run

off and try to use this to affect regulatory decisions or anything.

DR. ZIEMER: Okay. Other comments or questions?

(No responses)

DR. ZIEMER: Thank you again, Russ. We appreciate your input to us.

We are actually approximately an hour behind schedule. At the beginning of the meeting I indicated that we might have the opportunity for public comment if we were ahead of schedule. What I will ask is if there are any who signed up for public comment who would find it very inconvenient to do their comments this evening, which is the scheduled time -- if for whatever reason, we can certainly accommodate -- yes, are you on the list, sir?

UNIDENTIFIED: (Off microphone) Yeah.

DR. ZIEMER: If you prefer to give your comment now, we'll be glad to hear --

UNIDENTIFIED: (Off microphone) (Inaudible)

DR. ZIEMER: Use the mike, please, and identify yourself for the record.

MR. COLEMAN: I'm Thad Coleman. I worked at PRTR for four or five years. That was a plutonium test recycle reactor, a very hot place. Numerous times --

let's say you're a supervisor of a building. You have 50 or 60 pipe fitters (Inaudible) work with one welder. Only one welder has the qualifications to go in and do the welding. Well, how many of those pipe fitters you going to burn out before the welder's burned out in the same place? And whenever you do burn out, the supervisor would come in -- give me your badge and pencil; he took them and went and got me another set, go back in. Well, after I took all I could, I got sick and went home.

Well, they come out to my house to see if I couldn't come back. They needed the welding done. Well, with one welder, there was no way they were going to get it done. But I had to go back in and do the welding. I was overexposed many, many times.

Another thing they did there melting lead with an acetylene torch, making shields. Well, lead is very bad. We couldn't do it in the shop 'cause it would contaminate the whole shop. They moved me outside. You still had to melt it with -- I said why don't you buy me a ventilator, a up-sucker to pull these fumes away? Oh, it costs too much. I said I'll tell you, I'll pay for it, you put it in. They wouldn't do it.

Today my lungs are full and I'd like to get

somebody to tell me what is in there. Is it lead poisoning, zinc poisoning, (Inaudible), brass poisoning or what is it? They can't tell me. They say you've got asbestosis. Well, that's one they don't pay. I would like to have them prove that mine is not -- what it is, because they can't -- I welded around the fumes and the lead-based paint and stuff for over 60 years. You get a lot of fumes in that much time. Yes, I had asbestosis 'cause I spent seven years and eight months in the south Pacific aboard ship a lot of times working around (Inaudible), but it wasn't this asbestos (Inaudible). My lungs are not asbestos today. I've got something wrong. What is it? Can you tell me?

I got a letter from a little gal said your statute of limitations expired, you don't qualify. That's a very poor excuse, if you ask me. I took it over to my doctor this morning and told him -- I had an appointment at 12:30, 12:15. I said Doctor, I just don't agree with this letter. But how are you going to overcome it? What can we do about it?

Medicare gets a bill and it costs me $449 a month for my secondary insurance. Medicare won't pay it. My insurance won't pay it. Well, then I got to pay the damned bill. We need somebody -- a coordinator in here to try to get this -- justice done. I know

this is important to do all this, but it costs a lot of money. We're suffering like hell trying to get -- stay alive, and sometimes I can't even talk, but you can't even get a doctor to go in -- I got one doctor that I think the world and all of him. He's Dr. Clipper and he's helping me a lot. But I -- I just choke up too bad to talk.

I would like to have somebody to tell me what is in there. My lungs -- they said oh, your lungs are gone. Well, now my teeth's gone. I just had them pulled out day before yesterday. Is there any place you could send me or tell me where I could go to get somebody that could give me an answer?

DR. ZIEMER: This Board probably can't answer your question, but maybe -- maybe some of the staff can direct you to who you should be in contact with. It appears to me that this is -- is this one of the workmen's compensation area ones that's --

MR. COLEMAN: Well, I don't know -- workmen's compensation, what is that, money?

DR. ZIEMER: Well --

MR. COLEMAN: I told them I don't want to be the richest man in the graveyard whenever I die.

DR. ZIEMER: I doubt if you will under workmen's comp, but let's -- let's find out and maybe

after the meeting find out if there's someone here -- certainly a doctor's diagnosis becomes a part of this, and then I don't know where in the system we plug this gentleman in, but we'll see if we can find somebody to at least assist you.

MR. COLEMAN: I would just like to get to where I can get my breath and breathe.

DR. ZIEMER: Yeah. Thank you.

MR. COLEMAN: That's all I'm after.

DR. ZIEMER: Okay. Appreciate your comments.

MR. COLEMAN: And the first thing they give me, they say fill out another form. Well, hell, I've filled out 50 of them.

DR. ZIEMER: Right.

MR. COLEMAN: And they look at me -- how many cigarettes you smoke a day? I never smoked a cigarette in my life. How much alcohol do you consume a day? I never used a drop of it. I was a healthy, very strong-willed man.

DR. ZIEMER: Okay.

MR. COLEMAN: And I thank God because I'm the only one left out of my whole group that I worked with a few years ago, and I'm the only boy that's left out of ten kids, one girl. No, all I need is somebody that knows what to do to get my breath.

DR. ZIEMER: Okay. Thank you.

MR. COLEMAN: Thank you for listening to me.

DR. ZIEMER: Are there any others that prefer to speak now?

(No responses)

DR. ZIEMER: It appears not. Fine, then we will recess until 7:00 this evening. We will reconvene in this room and all are welcome to join us at that time. This will be exclusively a public comment period. Thank you very much.

(Whereupon, a recess was taken.)

INTRODUCTION

DR. ZIEMER: Good evening, everyone. I'd like to ask you to please take your seats. We'd like to get underway right away.

Thank you all for coming tonight. This is the public comment session for the Advisory Board on Radiation and Worker Health. My name is Paul Ziemer. I serve as the Chairman of the Advisory Board, and the Board is very pleased to be here in the Richland-Hanford area tonight for this particular meeting.

Our meetings have very specific focus, but we always have an opportunity for public comment, an opportunity to learn about what's going on with respect to individual people as far as it impacts on this

program.

Before we have the actual opportunity for many of you to speak, I thought it might be of use if I took just a few minutes and familiarize you with the responsibilities of this particular Board. Our responsibilities are quite well-defined, and to some extent they are limiting in terms of what we are able to do as a Board. And I want to make you aware of what it is we do, and you can put that in the context of the larger program that many of you are already familiar with.

The program -- the workers compensation program that we're talking about here tonight is actually administered by several different entities -- the U.S. Department of Labor, U.S. Department of Health and Human Services, the Department -- Energy Department and also the Attorney General. So these various Secretaries of the various Departments, all of their agencies have a role in this process.

Independent of those agencies is this Board, called the Advisory Board on Radiation and Worker Health. The individuals on this Board largely are independent of those agencies. I say largely because actually some of the members of the Board may work for one of the subsets of an agency. That is, we have some

individuals here who are associated with some Department of Energy facilities. But in terms of our day-to-day responsibilities, we are independent of the program and serve as an oversight type of agency or really board. And I want to familiarize you with our responsibilities.

First of all, the Board itself -- its composition is defined by law. It's -- the law specifies that the Board will be comprised of up to 20 individuals. These individuals, incidentally, are appointed by the White House, by President Bush, and the White House actually determines the number because they make the appointments, so there are not actually 20 individuals, as you will see. There are a dozen of us at the moment. The White House also designates the Chair of the committee.

And the other specification in the law is that the individuals on this Board are to represent certain facets of the interested community as far as this law is concerned. And by that I'm talking about labor, I'm talking about medical, I'm talking about radiation safety or health physics types of individuals. So there are technical, medical, labor individuals. The individuals do not necessarily represent specific groups, but have that kind of

background so they can bring to the table the perspective of say labor or medicine or the technical community.

These are the members of the Board. As I indicated, I serve as Chair. We have a designated Federal official, Larry Elliott, and Larry, as I introduce each of you -- even though they have placards, you might not be able to see the placards. So Larry Elliott serves as the Executive Secretary and also heads up the dose reconstruction program or the Office of Compensation Analysis for NIOSH, which is, as you know, part of the Department of Health and Human Services.

Then we have Henry Anderson. Henry is not back from dinner yet, so -- should not have gone alphabetically, I guess.

Tony Andrade, who is with Los Alamos National Laboratory; Dr. Roy DeHart, Vanderbilt University; Richard Espinosa, Los Alamos -- you'll see in each case an indication of their particular background. Mike Gibson with Babcock & Wilcox; Mark Griffon has his own consulting firm; James Melius, New York State Labor's Health and Safety Trust Fund -- Dr. Melius; Wanda Munn, who's retired but here -- one of your local people from here in Richland; Charles Owens from U.S. Enrichment

Corporation, Paducah, Kentucky; Robert Presley is actually retired, but is still there in Oak Ridge -- retired and working again, so to speak; and Dr. Gen Roessler is retired from the University of Florida and now living in Minnesota -- in Lake Woebegone, is it? Yes, right.

The role of this Board is -- as I suggested, is specified and it's pretty well-defined. We have a role in the development of guidelines on the probability of causation. That's that calculation for the likelihood of a cancer or health effect being produced by radiation exposure. We have a role in the development of the guidelines for the dose reconstruction process, so the first two bullets simply summarize those responsibilities for reviewing the guidelines as they're developed, and those guidelines have been developed and the Board has, in a sense, done those.

We have an ongoing responsibility to assess the scientific validity and quality of the dose reconstructions that are being done. This is an ongoing process and the Board is underway and actually has its own contractor now to assist in this process.

And then there's a role for evaluating and assessing both guidelines and petitions that have to do

with what is called the Special Exposure Cohort. This is a rulemaking which is still in process and the Board has played an ongoing role in that process, as well.

So basically what you see here on this slide are the responsibilities of this Board.

The Board does not deal specifically with individual cases. We are not a Board that listens to appeals or even reviews individual cases. We may, as part of the determination of scientific validity and quality of dose reconstructions, we may as part of our audit process, look at specific dose reconstructions that have been done to assess -- and in fact we will be sampling a certain fraction of the work that is done by the Federal agency, by NIOSH, to determine the quality of that work. But we ourselves do not -- if you are a claimant, this Board will not be specifically reviewing necessarily your particular claim. And in fact, if you have claim issues, they would be referred to the agency that is responsible for processing that claim.

That completes those slides. I want to, before we start the public comment, just make a couple of additional observations. And that is that the comment period, as far as the Board is concerned, is really simply intended for us to hear from you. We're not operating in a mode -- sort of a question and

answer mode because we -- we do not have access to your specific case. Those, you know, are confidential. And so we are not in a position tonight to answer specific questions you might have. However, if you have a question on your case, if you have a particular question or concern, we certainly will make sure that it gets addressed by the agency, whether it's NIOSH or Labor or DOE, or make sure that we get you in touch with the right person to do that.

We are interested in learning about how effective this program is or where it is not effective. We're interested in hearing whatever your experiences may be that you're welcome to share whatever you wish with us because that helps us get a feel for how this program is working. So we do listen to a lot of personal experiences. Not that we can necessarily address them ourselves as a Board, but they do help us in the context of trying to assure that the Federal agencies involved do correctly and rapidly -- although the speed is not always where one would desire, but at least to be moving along on addressing the issues that individuals might have. So any commenters are free to talk about both their personal experiences as they wish, but please understand that we're somewhat limited as a Board in how we can deal with you on an individual

basis. But we do want to hear your stories and experiences, and please -- if you have issues, we will try to help make sure that they get addressed, even though we may not be able to, as a Board, address them individually with you.

PUBLIC COMMENT

Now with those preliminary comments, I have already a list of individuals who have requested to speak. And I think because of the size of the room and the configuration -- although we have already set up a mike near the back, I think it would be better if those who wish to address the group would come up here to the podium where you can be seen better. And also if you're a little nervous, it gives you something to lean on, so that always helps, too.

Oh, I do need to announce two things. One is that for our public record we do like to have a record of all who are in attendance, so there's a sign-up sheet if you haven't already done this. It's in the back and Cori, who's waving her hand back there, is the keeper of the records and she will point you to the right place to record your attendance with us tonight. And then if you have -- if you do wish to speak and haven't already done so, we ask that you sign up there. And this just helps us keep the flow going and make

sure that we get everyone who wishes to speak.

So I'm going to return to my seat now and I'll get the record there and we'll get underway. And please excuse me if I don't pronounce the names right. I can feel for you, mine gets pronounced incorrectly at least half the time, also. It looks like Gai Oglesbee. Is Gai here? Gai's with National Nuclear Victims for Justice from here in Richland. Gai, could you -- would you be willing to use the mike near the front so we can...

MS. OGLESBEE: (Off microphone) Oh, okay. That one up there?

DR. ZIEMER: Yes, please.

MS. OGLESBEE: Okay. I'm from this area and I work with a lot of people across the nation to try to help all I can because I am very experienced and knowledgeable by now after many decades. My own daughter is a claimant, as well, who suffers with beryllium exposure and the effects of cancer, so it's pretty disheartening sometimes, so -- I've had cancer and her father has had cancer. We all worked at Hanford. There's nine people in my family that have -- are battling with cancer right now.

Before I get started -- this is always a show-stopper because you can't see it -- I know you

can't, but this is what radiation exposure looks like, people. And I'll give your Chair a copy of it. A friend of mine did this after traveling to -- they're Russian farmers is what they are, by the Caspian Sea. And I know people that have mutations just like this in this country.

Then this is -- I want to get this in, too, and again I'll give your Chair a copy. This is (Inaudible) that was found on Hanford by individuals appointed by the CDC that says dose reconstruction cannot be done here at Hanford. That is very emphatic information that's not being paid attention to.

Then there is a survey done already of Hanford that lists what some of the construction workers and people are exposed to at Hanford. So there has been a survey done here -- many of them -- and I have copies of them if -- and I'll probably try to send them along.

So let me begin here by saying in my case the agency employees are traditional agency defendants with conflicts of interest with a point of view that is so confrontational I have decided the incidents and quarrels must stop. I didn't enter this to be put-upon and I've -- it's cost me a lot of money to get where I'm at right now in time and energy and my own

finances, and I live on a fixed income. So I was an unmonitored employee, especially after I disclosed the events that happened to me at Hanford B plant (Inaudible). There are many in this room who know my story. I support them and they support me.

Because the escalation of my historical issues a high-ranking government official, the former Secretary of Energy, Hazel Leary (sic), came to (Inaudible) by April 17th, 1996, which was indeed her obligation anyway, and she knew that. Secretary Leary (sic) decisively enforced her initiatives. Consequently, her subordinates were disciplined for their adversarial role against me. Because of this error of adjustment, I processed through -- there is a contract -- I -- as I processed through, I should say, there is a contract in place that forbids the Hanford contractors and the USDOE from violating the terms of agreement. If one agreement's violated, the rest are still intact, so this became a problem for me with some of the agencies and agents that I had done business with before in my past.

In a private meeting before I testified before the USDOE Assistant Secretary Environmental Health and Safety, which was Dr. David Michaels, I was encouraged to apply for EEOICPA provisions after being

informed that my history would not affect my right to apply. USDOE contractor Oak Ridge Associated Universities disqualified themselves already due to their recognition of conflicts of interest about a year and a half ago. The USHHS subsidiary, CDC-NIOSH, employees seem to be unable to get a grasp on the concept of conflicts of interest where I'm concerned.

Because of my background, knowledge and experiences, I know for a fact that health physicist evaluations are not considered expert in any illegal (sic) adjudication process I am aware of. My expert witness is a high-profile Ph.D. peer who heads a team of ten international experts. The preparation of my expert witness evidence cost $24,000, and that was done several years ago.

NIOSH insists that the expert witness do not outrank their scientists and methodology. Well, perhaps the time will finally come when we test the NIOSH employees and the USDOAC employees -- employee Admiral Rollow's perspectives in Federal court. Consequently, for lack of better -- a better phrase that is powerful enough to -- definition enough to use, Dr. John Howard, Director of NIOSH, and I are in a pissing contest -- excuse me, but that's what it is -- regarding what he feels in his right -- is his right to

dismiss my generic dose reconstruction. I am informed that the only evidence NIOSH would accept is imaginary USDOE contractor HEHF X-rays. Obviously I have failed to explain historical circumstances over and over again to the NIOSH agents. I should not have to explain in the manner that these agents have required. I am wholly aware that I am not finished with my medical monitoring, as that is an ongoing reality that I must manage for the rest of my life, but Dr. Howard insists that I shall obey his agency code command and sign his waiver, or else.

The Interactive Radio-Epidemiologic Program, IREP, that was created by Dr. F. Owen Hoffman, is challenged as an unreliable methodology. The generic causation has already been deemed unreliable for individual causation purpose by peers -- peer experts and also by the Ninth Circuit Court of Appeals, who explain in their decision that Dr. Hoffman's theory is not all that is needed to reconstruct the dose of radiation-exposed workers and vic-- or victims, whatever you want to call them.

My point is, because I am the only person in the world who can release any of my original personnel records regarding my case issues, I cannot be absolutely sure that the records that are being

processed by the agency employees are the same records I submitted. It appears NIOSH and USDOE employees are relying on slush files -- what's been deemed slush files provided by unassuming USDOE record-keepers. The $500 box of records I compiled have been lost, rediscovered, lost, rediscovered, recopied, re-established, lost again and rediscovered in the USDOE mail room, according to the witnesses. Because of this rhetoric, the originals I submitted in early August, 2001 were ordered returned to me, so I have the original copies of what I originally sent.

I have custody of high-profile expert witness testimony. That is a court record which is included in my files I released for this EEOIC purpose. The experts verify that I am irreparably damaged by ionizing radiation and components. I have filed a claim with the USDOL and the USDOE. This was originally supposed to be presented to just the Advisory Board, these quotes. I'm very alarmed by some of them. Resigned -- this is Secretary Robert Card testimony that was sworn before the Senate committee March 30th, 2004. In that -- in a quote that was very alarming to many of the survivors, the quote said additionally given, the medical benefits are available in most state workers compensation systems for living

applicants. We are moving applications filed by living applicants ahead of those filed by survivors. Finally given that the statute requires us to provide all available information, including a dose reconstruction from relevant Part B applications, we are setting aside these Part D applications where Part B dose reconstructions are pending.

Now Senator Grassley, as you know, is very heavy into this situation. And I also have made some quotes because I was challenged today by Mr. -- or Admiral Rollow, and I want to read -- these aren't my statements -- sworn statements. These are Senator Grassley's sworn statements. It says (Reading) Nothing can make up for the illnesses these workers developed because they were exposed to toxic substances without their knowledge or consent.

That's me. Today they wear their battle scars in the form of illnesses and disease and -- diseases, the least of our -- our government can do is try to compensate them, compensate them quickly and compensate them before they die, but that -- but that is a problem. The program is moving like molasses. Thousands of workers or their survivors are in limbo while their requests for help sit in offices here in Washington. We need reform with -- with accountability

and results.

Now he goes on to talk about the Science and Engineering Associates known as SEA, which is a USDOE contractor. This company's employees are the ones processing the compensation claims of sick workers. What we found should make Congress think twice before forking over more money to the Energy Department, especially without any guarantees that things will get better. Mr. Chairman, I want to note that the Navy and SEA don't want these numbers to come out. They stamp the words business confidential and priority in big red letters all over their invoices. Sometimes people in government contractors who feed from Uncle Sam's trough forget who they are working for. They're working for the taxpayers, not themselves, and they should not be trying to hide the way they're using taxpayer money.

The Energy Department's seeking $33 million in FY '04 appropriations transfer, plus $43 million for its FY '05 request, totaling $73.3 million or $77 million. The Department of Energy's plan to eliminate the entire backlog of applications will be 2006, commonly referred to as a path forward plan.

Let's see -- SEA is charging exorbitant amounts of money for questionable results. An aide position at SEA bills the government at a rate of 36.9

or $36.09 an hour that comes up to $72,180 a year. That's a lot of money for someone who makes copies, sends FAXes and puts files in filing cabinets. Then they get their 40 percent an hour benefits. And people who do the bulk of the case preparation work at SEA are the nurses who examine compensation claims and get them ready for the physicians and make a decision. Now how is it that when I have an expert witness and a ten-team international team of witnesses that a nurse -- and I don't really -- I don't want to offend the nursing profession, but I don't see where that is a reliable source. Sorry, they don't know what we know and what anybody else knows, but that's the way it works. And they're making $90.51 an hour for nurses' work and about $181,000 a year. The highest-paid SEA official on the project is Richard Cutshaw, the program manager. SEA is billing $264 an hour for the -- his time. Let me be clear so there's no confusion. I said $264 (sic) cents per hour. That comes up to $401 -- $200 -- $401,280 a year. Mr. Cutshaw costs the taxpayer more than the salaries of Energy Secretary Abraham and Labor Secretary combined. He costs more money than the Vice President, and SEA charges just a bit more for his work than the salary of George -- President George W. Bush. Mr. Cutshaw's counterpart at the Labor Department would

be a GS 14 director or district director who costs about $135,000, including fringes. Only in the government contract can people make so much money and perform so poorly. If this were the private sector, these people would not be -- would get canned and be out on the street. Now we know how much the Labor Department folks are getting paid. We don't know how much SEA employees are getting paid. We only know how much the company is billing the taxpayers for their work.

And in excerpt quotes, USDOE Admiral Rollow explains that I have misunderstood all the issues and that if I repeat any of the conversation we had this afternoon that I can be charged with slander. I would say, Admiral Rollow, that you don't know where I've been or what's going on and you need to find out because your -- your people are handling my case right now, and you assured me that they were.

Can Admiral Rollow handle a job after making a statement such as this? Is everybody wrong and Admiral Rollow right? It is Senator Grassley's sworn statement and other of his associates investigative findings, it wasn't mine. I have before me several sworn statements regarding the conduct of the USD employees that are before me to ponder. I'm not quite

ready to talk about those yet, but they're pretty disturbing, I can tell you that, that involves me.

My daughter Carol is also an EEOICPA claimant who battles with the health effects caused by cancer and respiratory problems after being exposed to the harmful toxins at Hanford and Rocky Flats. In 1993 Carol was notified by the USDOE she was exposed to beryllium because a coworker died after developing the disease. Gai Oglesbee, Subtitle B and D claimant, National Nuclear Victims for Justice. And I will give your Chair a copy of what I have here, and I have many more -- any many more records I want to send you. I have over 75,000 records accumulated.

DR. ZIEMER: Thank you very much. Our next speaker will be Thad Coleman, and Thad -- oh, that's the individual who -- I think Thad already addressed us this morning -- or this afternoon. Thank you.

Louisa -- is it Jahnke? Louisa Jahnke.

UNIDENTIFIED: (Off microphone) (Inaudible)

DR. ZIEMER: I'm sorry?

UNIDENTIFIED: (Off microphone) (Inaudible)

DR. ZIEMER: You want to use this mike here? Oh, okay. Thank you. Did you have someone else you wanted to speak in your behalf or --

UNIDENTIFIED: (Off microphone) (Inaudible)

DR. ZIEMER: Okay, thank you. E. R. Samser, Samson, Samser -- E. R. -- you might have to correct me on the name, sir, when you get up there. He's from -- Samson from Kennewick.

MR. SAMSON: Well, there's quite a few people here tonight I know, but anyway, I've worked around here many a year and everything, but I'm not going to talk about that.

I am so thrilled that this group that's here now has give us more information in one day than we've had in four years here. Now that's pretty pathetic, really. That's the thing that's disturbing me. They've got a lot of money they're spending and nobody's telling us nothing. And I mean it's bad when you call Seattle and they say well, can I get -- I want to see where my list is of my -- on my plan that -- as I wrote to you guys about, and they say well, we'll have to see if the examiner's got time to work with you. I've seen the examiner one time in two months. The rest of the time, he never comes on.

Here we are trying to find out what's going on. I think I have a pretty good claim, you know. I worked all over the -- every area out there and everything. My nose is half gone and everything, but I don't -- I don't let that bother me. What I want to do

is -- we got a little group of people here that a lot of their husbands has all passed on and whatever, on a fixed income. I want some of them people. I'm not worried about me, I'll make it. But some of these people that needs the money and everything, you know, especially on the medical end of it. So I'm going to close by just telling you that. I think we need some more help like you give us today would help a bunch of things around here. Catch you later.

DR. ZIEMER: Thank you for your comments.

(Applause)

DR. ZIEMER: Again, I'm having a little trouble reading the writing. It's -- the last name appears to be M-o-u. Is it -- could be a Charles W. Moore, maybe?

MR. MOORE: (Off microphone) That's me.

DR. ZIEMER: Is it Moore?

MR. MOORE: (Off microphone) I'm not a Ph.D. there and I wrote that.

DR. ZIEMER: Well, you must be a medical doctor. It looks like a prescription to me.

MR. MOORE: (Off microphone) No, I'm not (Inaudible).

DR. ZIEMER: Anyway, it's Charles Moore then, is it, from Yakima?

MR. MOORE: Correct, from Yakima. I worked 23 years on the Hanford project. After 23 years I was fired because I have asbestosis. I've never received any compensation whatsoever about that, but that's not why I came here to talk to you. I come to talk about reconstruction of the dosage, and I have a whole bunch of documentation that I want to give the panel. I have one here that's got my name on it. It's a five -- four-page document about my personal exposure, but it's not what I come to talk to you about, nor will I read it.

But I have a document here that I received under public disclosure showing my dose rates from -- oh, boy, I had cataracts removed the other day and it changed my eyesight a little bit -- from 1950 to 1972, and it kind of lays out what I've received. And then I went through my documentation and here's a document here that says mine was withdrawn. Here's another document that shows that I received a lot of radiation in a year that is not on the first documentation. They forgot to put it on there. And here's another document exactly the same.

So I don't want to talk too long. I just want to say that there is no way we can reconstruct dose radiation from years ago because they didn't keep

track, nor did they give a damn -- excuse my expression.

Here's another document from Battelle, says that my documents has been changed, altered. This is kind of one of my favorite ones. It says that I had contamination on my nose in dash five building. I took a shower, changed clothes, and I left the building and the alarm went off. It wasn't on the tip of my nose; I had alpha particles in my nose. That's kind of a good example of what we had to contend with out there.

Here's another document that says that -- primary the same thing. It is not on the computer sheet with the dates. Another document, deleted. And here's a nice little document. Remember your weekly radiation dosage that you signed the bottom of each week? A lot of you remember those, don't you? Well, this is not my signature. Somebody forged my signature on this one. So how can we reconstruct something if the left hand doesn't know what the right one's doing?

Here's another one about the same as the other one. So I just wanted to give the panel these documents to go through and look at and tell me if they can figure dose radiation from what we received out there. And I thank all of you, and have a good day.

(Applause)

DR. ZIEMER: Okay. Thank you, Charles. Next we have Randy Knowles. Randy's with PACE and -- here in Richland. Randy Knowles.

MR. KNOWLES: (Off microphone) I had intended to speak on behalf of Mr. and Mrs. Williamson, but (on microphone) their son's here and I think it's more appropriate that you hear from him --

DR. ZIEMER: That would be fine.

MR. KNOWLES: -- instead of me.

MR. WILLIAMSON: My name's Jim Williamson. I was just writing notes as I heard my name called, so you have to understand I'm not really ready because I didn't know I was going to speak tonight. But I'm speaking on behalf of my mom and my family and my dad's name was John Williamson and some of you know him as Jack. He was hired in 1987 -- 1967 and he worked for 25 years. He retired in 1993, and that same year he was diagnosed with cancer; 1996, a few years later, he also had part of his nose cut off, like the gentleman said earlier with him. And two years after that, he was screened for asbestosis and it was confirmed he had that. And in '99 he was diagnosed with myelodysplastic syndrome and finally myelomonocytic leukemia in August of '99. And I remember -- I mean I vividly remember -- I have four kids and I remember this day with my dad

more than I remember my kids being born, but I remember the doctor looking at my dad and saying John, you have a disease -- a rare disease that has no cure. You have one year to live. I mean it was just a -- I replay that many times in my life.

Again, here's where I'm not quite sure... But anyway, my mom had LNI claim and it was from the State of Washington and it was -- they won the claim with the State of Washington and it was one of the few or maybe the only ones with the Hanford cancer-related cases that has won in the State of Washington, but in -- for the Federal, for some reason, it's -- it's not working, for some -- we just don't understand if -- if it's one of those cases that the state is paying and they're supposed to have some kind of process where the cases that are -- that are easy to process and everything's already done, and I -- and I don't even know how many years ago it was, three, four years ago, my mom's still trying to deal with this and it keeps getting backed up or they call her and they're doing a phone interview and my mom doesn't -- my mom's here so I can't say anything bad about my mom, but she doesn't have -- she doesn't have a clue on those kind of questions or the way they're asking the questions. So I teach school and I take off school and I go over and

I try to help my mom with the questions and it's just -- it's kind of unfair -- it's very unfair, and I feel for the -- all of you that are in here that are going through that, that are dealing with this stretched out and stretched out. Again, I -- I don't know what it is, four years, five years -- seems like a long, long time that we're dealing with this process.

So again, I just -- if it -- to me, if it happened at the State of Washington and they've already gone through and they say yes, it's -- he died of cancer and I -- and then how come at the Federal level it's -- I don't know, we need to check it out a little bit longer and spend another four years. Anyway, it's -- sorry for being unorganized, but I didn't know I was going to be speaking tonight.

(Applause)

DR. ZIEMER: Okay. Thank you very much, Jim. Next we have Ken Staley. Ken Staley, is it? Ken?

MR. STALEY: (Off microphone) Here or up in front?

DR. ZIEMER: We'd prefer in the front, if you're willing.

MR. STALEY: (Off microphone) (Inaudible).

I think maybe I'll talk into this. My name is Ken Staley. I come back here in 1946. I come out

here in the '40's early when they were building Hanford. Uncle Sam knocked on the door and I got hurt in the south Pacific. I come back in '46 and started working at Hanford and there isn't an area out there that I haven't been in.

And I think probably that I've looked around the room here and seen a lot of people that I know have worked there, but it's very obvious to me that when we first started working out there, you were allowed 300 millirems a week. You were allowed 50 a day or 300 a week. My contention is, no one explained where that 50 went and you were able to pick it up the next Monday, or the next -- the next week.

I understand from my son-in-law now they're allowed only 100 a week. Am I getting to everybody? Well, I'll tell you what. The people have moaned and groaned about these down-winders. I happened to have worked in that 108-B building, the P-10 project. I have four children by my first marriage, '47, '49, '51 and the one born in '53. It so happens that not only me, but my friend of mine's daughter was born the same time in '53 that the down-winders are hollering about this stuff that went up the stack, that beautiful yellow smoke. She's been in a wheelchair over 30 years with MS. Her girlfriend, born the same time, over the

same period of time, is in the ground. I have asked several people, did I contribute that to them.

And this building, this 108-B building that I'm talking about, this other electrician is in the ground, and I went in there. I said Art, what in the world have they got these scales in here for? Well, he said, Boat, he -- my name is Boat, Steamboat. He said they weigh this heavy air before they let it go. I said what the hell they let it go for -- excuse the French. Once in a while I speak French. He said but they weigh it so they know how much they've got.

Now I know -- I go around the room and I know a lot of these people go around 240 to shortcut over to the coast. They see this beautiful orange-yellow smoke go up the stacks in the 200 areas. What is it? I'll tell you what it is -- contamination off the slugs that they've taken the stuff off them. Where does it go? Out in the prairie. Now they're worried about the deer and the rest of them having it. Well, I wouldn't eat a deer from out there anyway, but my contention is this. This gentleman that's sitting back here that I worked with for years, if you've noticed his beautiful nose -- 1973 he had a speck go up his nose; it took them five hours to get it out. They went in with chemotherapy and burnt on him. It come back on the lobe about a

year later. If you look at his beautiful face, it's going to cost $40,000 to get it rebuilt. There hasn't been one iota finances to help this gentleman out -- none -- whether the Medicare or the -- what will take care of it, but they're not getting off their duff here to help anybody that has been irradiated with this stuff.

I've got beautiful arms here. It's not from the sun. It's from different things that you get into out there. I've never smoked in my life. I have to admit I put them on -- swinging graveyard in the bars once in a while. But security was so tight at the time that this happened in the '50's and the early -- late '40's that five of us had a glass of -- one pitcher of beer down at the old Rec Hall down here, and I happened to be the last one in. This is telling you how tight security used to be. I was the last one in with this little glass sitting there and I said gosh, that's for saving it for me. You better be good 'cause we were about to drink it. I sat down and said see those two fellas sitting at the bar up there? I said yeah. He said that one guy's been shooting his mouth off of what he's been doing out there. And I hadn't finished that glass of beer and he grabbed him bar and he said he's fired, come on.

Now this is how tight security is and nobody -- and I'm sure around here a lot of them know what I'm talking about, but I know there's a woman didn't want to get up here, used to be my neighbor, and we were interviewed from the State Radiation Department, three of us, Ray Samson, myself and Louise Jahnke. She has pictures of her husband. For the last five years he was dying of radiation poisoning. She don't want to speak.

We were interviewed three years ago by *Seattle Times* -- three years ago, Bobby Pittman, Ray Samson and myself. Bobby Pittman had radiation so bad when he come out of that danger zone, they field-stripped him, scrubbed him and buried the truck. Now I know a lot of you people working out there know what I'm talking about, burying radiated equipment. Before my friend Bobby Pittman died, he was on chemotherapy three times a week. Now if you think that's fun, try it.

I'm not going to get up here and preach because I preach Fridays. I don't know religion preaches Fridays, so I'm going to get down. But I do want you people to know that they're very, very slow in compensating these widows and some of these other people out here, and it's very obvious that somebody is

filling their pocket up other than taking care of these widows. I have a unit of about 12 or 20 people -- I think it's real close to 20 people -- that we are talking about, widows. I'm looking at a few of them around here. What they're living on? I had one of the people say -- I had to loan this woman $100 so she could eat for the rest of the month. Is that fair because her husband died of this stuff? Not really, fellas.

I've heard this early morning session where they were talking about Paducah, this wave and -- I think I heard, in the whole course this morning, Hanford mentioned only twice. What are they waiting for? These men and women come in here to understand what kind of stuff has been going on out there, and these people at NOSHA (sic) down there or whatever they call it, I don't think any of them -- I don't believe any of them have ever been across that 300 area line toward the radiation and know what they want.

I have a claim number. I have been denied. I had a sample taken out of my arms that are so beautiful, but they took it in the wrong place. It come back benign. My case number's 2398. I've heard nothing but it has been denied. So it kind of makes you wonder, and the woman down there was a little bit

impudent with me. I said don't worry about it, they still make lawyers, and that's a heck of a way to be.

I'm not going to preach anymore because I know there's other people got better stories than mine, and I thank you.

DR. ZIEMER: Thank you, Ken.

(Applause)

DR. ZIEMER: Next I have Michael Henning. Is it Michael Henning? Michael Henning is -- I think that's Henning. Anyone with a name similar to that? Okay, perhaps is not here.

Richard Miller, Government Accountability Project.

MR. MILLER: (Off microphone) Why don't I pass for now, Dr. Ziemer?

DR. ZIEMER: Okay. Donna Beecroft. Donna?

MS. BEECROFT: I wanted to make a comment on dose reconstruction. In January of 1943 we moved here. My dad was one of the first people to be a reactor operator out at Hanford.

In those early years you probably know that the rods -- the nuclear rods were changed by hand, so whenever the reactor slammed, Dad would go in and put on these white gloves and white suit and go in and take these rods out and they were disposed of. The gloves

came off and went into a big bin and the white suit went into a big bin, and all of the beautiful equipment like pliers and wrenches also went into a bin and everything was buried.

One time one of Dad's coworkers tried to sneak a wrench home in his lunch box and was fired immediately. And my dad was not a person ever to take anything that didn't belong to him, but he thought that was so severe because I don't think in those days they understood anything that they were up against. This was -- this was fun, it was wonderful, it was exciting and we loved living here.

We didn't come and ask for this money. I was approached and asked if we would apply for it, and I feel like we have not been treated well and we never asked for it. My dad worked -- when the reactors went down, sometimes Dad worked three shifts in a row, and they were -- they had a limit, and I don't know if it was seven minutes or 12 that they were supposed to be inside the reactor, and the -- but -- and then Dad would come out -- seven minutes, and Dad would come out and take off his gloves and his suit and put it in the bin that gets thrown away and put on a new suit and new gloves, and go back in again. And he wasn't supposed to do that, but they did it over and over because when

that reactor went down, you didn't say well, my time is up. You know, you kept on working, and they kept on working and a shift -- back-to-back shift.

It's the first time Dad ever heard of a TV dinner. They had these dinners and they'd just heat them right up and it -- it was fun, it was exciting. He liked it. And he didn't know that he was getting sick, and some of his friends died. The first one was Jack Spadey and another one was Earl Sealey, and I happen to know them because -- I mean I knew them personally, and so -- and I'm sure a lot of others did, too.

Anyway, now when I -- I call, they tell me well, we are looking at -- this is ten months -- ten months Dad's been in dose reconstruction. We're in dose reconstruction, but I'm wondering, you know, how in the world are you doing dose reconstruction when Dr. Charles Moore who spoke to you, his record's from 1950 to 1976, and do you think they did a better job in record-keeping back in 1940? Let's see, 1943, that's when Dad started working, before they even had robots to change those rods. He was changing them with his hands. And you say you're going to do -- Dad knew what he was doing was illegal. He wasn't supposed to be taking that -- he'd -- he'd go on the geiger counter,

it'd tick -- when it ticked so hard that he couldn't make it quit ticking by showering and scrubbing and soaping, when he didn't quit ticking, then he didn't go back in anymore. But he came home like that.

Now I don't want you to think we're a pitiful little family, because we're not. And we are proud of what my dad did and we're proud of him. We're proud of Hanford. We love it and we've enjoyed our lives here. It cost us to be here, but it's worth it. But this wasn't just Dad.

When he comes up with bladder cancer, he had years of chemotherapy, changed his personality, it's taken a toll. I have three brothers and all three of them have thyroid problems and have had to have -- one of them's had the thyroid removed, maybe two. My only sister had breast cancer. My mom died of cancer. I seem to be the only one who made it just great, but anyway, the dose reconstruction, that's my point.

I don't think it's honest or fair to say you're going to do dose reconstruction. You can't do dose reconstruction. They didn't keep those records, and you know they didn't write down when the dosimeter had a higher number than was legal. They didn't write that down. They wrote down something that was legal. And why is it that DOE has recognized that it's

impossible to do dose reconstructions at other sites, but not at Hanford? I don't think it's fair.

We didn't ask for the money. I was not -- I was contacted. I didn't come and ask for it. But now that it was offered, and it's been what, nearly three years or -- over -- well, and -- and as far as I know, there isn't anything's been done on it, and it seems like it's a dead end. And I appreciate the opportunity to speak to you.

(Applause)

DR. ZIEMER: Okay, did Michael Henning come back to the room? Yes.

MR. HENNING: My name is Mike Henning. I've worked out there since 1978 and --

UNIDENTIFIED: (Inaudible)

MR. HENNING: My name's Mike Henning. I've worked out there since 1978. I've worked pretty much every building that's there. I was working as a QC inspector, inspecting pipes they broke and everything else, and going in the tank farms and doing that sort of stuff. And I have had my reconstruction done. I filed it in 2001, December 2001, and they came back and said that I had so many rem and that it was less than the 50 percent required.

Well, they didn't say what the 50 percent

required was, where it had to be five rad or 50 rem or whatever it was supposed to be. They didn't never tell us -- tell me in the letter or anyplace else that I know of what that criteria is. And where do they come up with this criteria, pull it out of their hat? I don't know. They don't tell you that, either, where they got these criteria for making these -- for rejecting you or whatever. And I -- I've had lymphoma cancer five or six years ago -- six years ago, and it hasn't come back again, but I don't know whether it will.

You have people ask you whether or not you're clear from the cancer. Well, I was clear before I got it, so I don't know.

So I just -- I think they need to inform people a little better about what criteria they're using and where they got their criteria and give -- like I said, they said I didn't meet 50 percent. Well, what was 50 percent? I don't know. So thank you very much. Oh, and I am glad you guys are here.

(Applause)

DR. ZIEMER: Thank your very much. Your comments are noted. The issue of communicating is one that we hear fairly regularly and it's something that is certainly being worked on.

Let me ask if there are any other individuals here who did -- who did wish to speak but did not get an opportunity to sign up on the sign-up sheet?

Sir? Please. We have a little time, so we can take additional...

UNIDENTIFIED: (Off microphone) (Inaudible) gentleman says he signed up and he hasn't been asked to speak yet.

DR. ZIEMER: Am I missing a -- I may be missing a sheet. Please go ahead, sir, and we'll -- we have time, we'll get you next.

UNIDENTIFIED: Well, I want you to know I'm only 86 years old. I came here to Hanford in 1944.

DR. ZIEMER: And give us your name, for the record, please.

MR. SHATELL: Charles W. Shatell.

DR. ZIEMER: Thank you.

MR. SHATELL: And I came here with the DuPont Company, but as far as radiation work is concerned, I wasn't involved in any until 1948, and from 1948 I worked for the Jones Company and -- or the contract under Jones, and we did radiation work for all the reactors. And so finally with -- well, I ended up with cancer. And in 1978 we used 400 men -- 400 exposure -- radiation exposures of 400 men in 100-N when we were

changing all the valves out. And of course now everybody thinks this film you've got on your badge was -- tell you how much radiation you took, and that is not so 'cause most of the times that we worked in 100-N on all those valves, it was beams from material that was in these valves. And a lot of -- well, I guess that when the fuel elements had a rupture and then those -- those partly -- is -- gets into the valves and you get a beam from them, and that's what you get most of your radiation from was the beams from ruptured fuel elements and whatever. And I don't know how many times I've talked to people since I've been in this cancer business, and they think this film badge on here tells you how much you get. Well, that's not so.

Well, anyhow, in 1978 we did all this work out here at 100-N. And as I say, we used 400 -- the exposure of 400 men. And right at the last of the valves, we run into cobalt 60. I don't know whether -- how many of you know about cobalt 60 or not, but anyhow, we had a rupture -- fuel element, evidently -- and we had a valve that read 550 R, which is pretty -- pretty rough. And that day that we run into this valve that read 550 R, everybody left. And you couldn't blame them. All the engineers and everybody that we -- was taking over the thing, they all left. They didn't

want anything to do with 550 R.

So we -- when we took the contract from Jones to do these valves, we anticipated that we might run into some high reading radiation, and so we built boxes -- lead-lined boxes, even up to the point of three-quarters of an inch thick of lead -- that when we cut a valve out we could put it in that and then you could handle it. But this cobalt 60 -- and I didn't know that they was even using cobalt 60 as a fuel element, but I guess they were. So we run into this valve that was reading 550 R and so what do you do? You can't even get close to it.

So the plumbers and the fitters are the ones that had jurisdiction over these valves. We had decided that we would take 300 MR per week. That was it. And anybody caught going over that amount on their own, like putting their things in their hip pocket or whatever, they would get fined $1,500, so most of them -- nobody ever went over it that I know of.

And so I know that I was one of the -- I was the general foreman over the group and any time we had something that was reading 550 R, I wanted to be damned sure that somebody didn't do something wrong, so I went with them all the time whenever we had something that was -- reading that hot. And so I happened to be -- I

happened to be one of the people that did one of the operations that -- we decided how we were going to do it and got it all set up to take this valve out. And we got young -- agile young fellas. The boy that could go by the valve and put a choker on it in three seconds -- he had three seconds. In three seconds you would get 300 MR. He had to do it in three seconds, so he did it. And I know I was up above with a electric hoist with a hook hanging down and he hooked the choker onto the -- onto the electric hoist.

So anyhow, then the welder that cut the bolts, he had a cut torch with a six-foot handle and he was able to take his 300 in one minute, and he cut the four bolts -- cut the nuts, the bolts off, then they dropped out.

In the meantime, we had this valve hoisted up, pulled the pipe apart and whatever and we hoisted the thing up. And the job that I did was nothing. I put a plastic bag over the valve as it come up through the floor. And -- because if that particle that read 550 R dropped out on the floor, you'd been in a hell of a shape, so that's what I did. And I put that -- that plastic bag on the valve, and it come right up by me and I had three seconds to do it, and I did it.

And so two years later, that's when I found

out when I had a four plus four cancer in my prostate, and it was really -- I'd never had any cancer before or anything like this. I've been a pretty healthy guy all the way down the line, so anyhow, when this new urologist come in, he got a bunch of new equipment and he -- he found this -- with the biopsies, he found this cancer on my prostate and it was four plus four. Now I don't know whether -- how many of you know what four plus four means. They told me that five plus five would kill you, so it was -- pretty hot thing.

So anyhow, now I signed up for this deal for the Hanford setup, and when I signed up for it of course they needed all this information. The Jones Company that I was -- worked with, every day that anybody worked on any of our radiation, we had a log book that was fixed up every day and wrote down exactly what everybody did, how much radiation they took and location and everything. The reason we did that was because we got sued two or three times for people saying they did this and did that -- just like your down-winders or whatever now that stuff drops into you out of the sky. But anyhow, those log books, when I left there we had a whole filing cabinet full of them. And Jones Company, when they left out there, they give them to DOE and brought them down here to DOE. If they

could get those log books, that'd solve a lot of problems for these people as to what they did, where they did it and how much radiation they took and the whole works. So -- but they tell me they can't find them, so I don't know.

But anyhow, I signed up with this thing and I've been going through all the -- the -- for the NIOSH and the whole works, and in 2002 I spent $10,000 on my cancer. Now the shots that they gave me -- I know that gal from DOE says what? The shot I took every four months was $2,400 a shot, and it didn't take too long to get up to $10,000 bucks when you do that. But it did the work. It got my cancer way down, PSA was way down. But I still got -- the doctor said oh, hell, your PSA is down, you don't need any more shots. I said no, I want a biopsy to make sure. So we had a biopsy and find out sure enough, I still got a little bit of cancer left. So we're thinking the $2,400 shots -- it was $2,360 when we started but $2,400 now, and (Inaudible). I can't under-- this nurse says did you ever have gold pumped into you, and I said no, I never did. She said well, you just did. At that time the shots was $2,360.

So anyhow -- so now I've went through all your NIOSH and I've went through telephone interviews

and I've went through the whole works, and finally I'm back to the deal now where they want to know actually how much money I spent, so maybe they're getting ready to pay me, I don't know. But I asked that -- the girl that is the first gal under -- oh, the head of the DOE -- she wrote me a letter and told me about (Inaudible) four plus four cancer, and she knew it was high, and she put her phone number on there, so I figured if anybody puts their phone number down, they expect you to call them. So I did and I called her and I said well, what I want to know is when are you going to start paying us some money so we can get -- get this thing back in shape again. And she said well, that's a different story. She said we put in for that program every month into the White House, and Mr. Bush turns her down every time. He said they've got insurance, let their insurance take care of it. Sure, I've got insurance. But my insurance now is up to $530 bucks a month and it's going to go higher. You can bet your life on it. And each time I get a letter from the insurance company that says -- and they turn their -- turn me down, but they said we're taking it under advisement. So finally they come and pay it. But with $530 a month, that's getting up around $6,000 a year. And so I think it's time that NIOSH or whoever's doing

it would be start recognizing the fact that the insurance companies can't be expected to pay for the whole thing.

And then another thing, that other $40,000 that they had there was -- I don't know what that was for, for a person. And every time I talk to anybody, how's your cancer doing? So it -- that $40,000 was to take care of whatever happened to you, I suppose. But I think -- I think that radiation, as far as Hanford was concerned, we did a lot of it. And all the records was kept and everything and I'll say one thing for the DOE. When we had suggestions, they did them. We told them how to clean the radiation down and before we'd go in, and for a higher radiation they would clean the place up first, and that was good. And they got us blankets with -- lead-lined blankets to where we could stop these -- the beams from hitting you. So I'll say one thing for them, they were -- they were cooperative with us on the thing.

But since you have a group here of these people, I think there's one thing I would -- I'd just like to add before I quit. Quite a number of years ago it came out in the paper that anybody that had leukemia, radiation didn't -- was -- didn't have a thing to do with leukemia. And it was -- and it was

believed. People believed it. So this boy, that HEHF doctor here, I don't know what his name was because he wouldn't tell us, but we've -- from the plumbers and fitters, we decided that we were going to -- wasn't going to take 5,000 MR a year, we was only going to go -- take 3,000. And so we had an awful time getting it through, but they -- our international president said no, you're going to take 5,000. I said well, come on out and take it, if that's the way you want.

So anyhow, they -- we talked to a nurse. She's dead now, God help her. She would come and take blood samples of our people that was -- we were going down in the -- like at 100-N, down in those holes, and they get 300 MR in about eight minutes. So we would take a blood sample of the boys that went down in those holes and this doctor that came along, he brought his microscope out and he would take this plate and make a plate of the blood sample. They would go in and do their job at high radiation and eight minutes, and come out and we took another blood sample right after they come out and he made a plate for it. And after looking at -- a lot of people never looked in a microscope before, but I have, and we looked at it -- at the plates. And this doctor said you see that? When you've got leukemia that's what your blood looks like.

So it was pretty much proven that radiation upset your blood system, too. So what we did, too, we went a week after that and took another blood sample of the same people and their blood was back to normal again. So that's were we came up with the 300 MR. That's all we took.

So I just hope some time or other that they start paying us to get back even again because -- oh, one other thing. I just got a letter from them. I complained to them about -- that they didn't have any doctors or people that interview us from the Hanford project, so they sent me a list of the people from -- they said all you've got to do is just put a circle around the ones you want to talk to, so that's what they did. And this one guy I talked to, he had never -- he didn't even know what a tube reactor was. He'd worked in labs all his life, you know. And so as I say, they cooperate with you pretty well. But it's been quite a few years since -- since this thing's been going on and I hope I outlive the cancer. I don't know whether I will or not, but -- but anyhow, I'm still taking the shots. And these shots that they give you -- any of the women in here that's over 50 years old know what I'm talking about -- you have hot flashes. Yeah, you do, you have hot flashes. And I mean -- so I

told the doctor, I said God, those hot flashes -- he said oh, hell, I got a pill for that, so he give me some pills for it. And also this thing that you're taking, you take this shot and you -- these hot flashes you have, your skin just burns up, you know, and -- but you get red spots and green spots in front of your eyes. That's what -- that goes with those shots. So you -- so I'll tell you, it's -- it's quite a -- it's quite a thing to go through that, and I just hope that -- that they get their act together. They say they're up in the million dollars now that they've give to people in -- in the Hanford project. I hope they --

DR. ZIEMER: We had those discussions. Thank you. Thank you.

(Applause)

DR. ZIEMER: I think they cover everything but hot flashes, actually. Just -- thank you very much for your comments.

The other gentleman that -- is over here, yes.

MR. DAVID: My name is John David. I'm a sheet metal worker. I'm fortunate enough right now to represent the sheet metal workers here in this area, sheet metal workers Local 66. And I think it's pretty evident to anybody that's had an opportunity to hear

people speak here that this record -- dose reconstruction just absolutely, totally does not work.

Now I can remember working out there where this gentleman worked, and I can remember working with that gentleman right there, and he's a sheet metal worker and his father was a sheet metal worker. And whether you're a sheet metal worker or a pipe fitter or whatever you did out there, you took a whole lot of dose. And it's pretty amazing to me that -- and I can remember people called timekeepers, and that's all their job was, they kept track of our dose. Now where all these books went is pretty amazing to me because they've got stacks of books everywhere out here and they've got every record in the world. And I'll guarantee you if I did something wrong out there, they could find every record on me they -- and they could probably replicate it in -- just like that. But when it comes to finding out for these people's medical issues, they can't find squat. Now there ain't nothing -- you can't call it anything other than unadulterated bullshit.

(Applause)

MR. DAVID: Thank you. And these people need to be taken care of. Now I don't -- you guys can travel all around the country, and I want to thank you

for coming here, I want you to know that, and every one of us here want to thank you for that. But bottom line, you've got to give these people what they have coming, plain and simple. And they've put all this paperwork together. They've done everything they're supposed to do, and they're just waiting for somebody to do what they're supposed to do.

And this gentleman here, Mr. Elliott, I've had the opportunity to see him and his people come through here, and his people that are sitting over here, I've seen them and I've seen them here multiple times. But hey, the rubber's got to meet the road sooner or later. And people are not going to continue to accept from you that hey, we're working on it, because working on it just don't cut it. And so all these people that are saying that they're trying to do something, what are they trying to do?

Now I'm no genius. Okay? I went to two years of community college and I went to an apprenticeship, and I'm proud to tell you that. But I can figure out that this site needs to be a special cohort site, and I don't know how long it's going to take your Advisory Board or the NIOSH or whoever else it is to come up with that.

Now these people around the country, these

other sites, they've got that. And you're just going to continually just talk to them and talk to them and talk to them -- okay? -- and they're not going to get anything and these people are dying, and that's horrific.

Now I had the opportunity to work out there for 14 years. I don't have anything wrong with me, I don't think. Okay? So you -- you got -- you just got to bite the bullet and accept that and create this -- make this a special cohort site. You can't beat around the bush any more than you already have. You determined now that you had your dose reconstruction project complete in October of 2003. You can't prove to anybody that you're getting anything done.

I'd also like to say that I happen to have the opportunity to represent a gentleman that's had his head opened up twice. Well, he's not eligible. He can only go through the State of Washington LNI program. Well, the last time it was, here last October, he got his head opened up, that was $250,000 to our health care plan. That's the second time it's happened. Both times, fortunately, the tumors are benign. He's not eligible, and he's going to get some more of these tumors 'cause he's got to go in every six months and he's got to get checked. He's 50 years old. He's got

to have malignant tumors before he can get any money? A quarter of a million dollars.

This gentleman over here says he's told that hey, our health care plans will provide it -- provide for us, and our health care insurance premiums are going through the roof, which the government has a responsibility to address this.

I also had an opportunity to work with a gentleman that he came here at the last time Mr. Elliott and his group of people were here, and he was so serious about this that he told Mr. Elliott that you could go exhume my dad's body right now, I'll give you permission. My sister and I will do that. Because there's no records of my father ever being contaminated, and I will guarantee you you will find plutonium in his system today. Now that's a pretty serious thing when somebody would be willing to allow their parent to be exhumed. And there's probably other cases just like that.

Now I also would like to say and I'd like to thank Eunice Godfrey and the people that are over in that office that are trying to help these people of this community, because they have one of the most thankless jobs that I could ever imagine having. And they do a fantastic job of working with what they have.

But you people and the people that are supposed to be helping these people have got to do something to actually come up with something. And so this gentleman over here doesn't have to tell you about the horrific medical expenses he's experienced and 86 years old, which I'll go out on a limb and say it's pretty amazing to me that he can afford that. And go back and tell whoever it is you've got to tell wherever you've got to tell, because apparently they're not here, that this can no longer go on any longer.

And again and lastly, I'd like to thank you. I know that everywhere you go you're probably hearing the same story. I don't know if you get paid for what you do or whatever, but whatever you're getting paid, you're probably -- you're earning every penny of it. But you're going to continue to get this until you finally and -- give these people what they're asking for, and that's simply just what they're supposed to get. This program was created in 2000, said hey, come on, sign up. And it's unacceptable to anybody that here four years later we have these minuscule numbers that we get a chance to read in the papers that we've compensated people for. Comparative to the amount of people that have applied for this program, it's -- I don't think that you could -- anybody could really say

that it's done its job so far.

So again and lastly, thank you for coming and please take this message back. Not for me, not for you, for all these people and for all these people that aren't here tonight that -- they have died and their survivors are trying to get this compensation, and thank you.

(Applause)

DR. ZIEMER: Thank you very much. Another gentleman approaching the mike -- give us your name, sir, and...

MR. MITCHELL: My name is J. L. Mitchell and I worked out at the project for 33 and a half years. I worked in all the areas and all buildings with various types of material. In fact, the night that the plant blew up, I was the one that ran the sample and I was told that the samp-- we didn't have that much americium in the project. And we pulled another sample and in between the two, then she went -- the plant went. And I got contaminated and so did the rest of the crew that was there. We really got a shot of americium.

I also worked with the thorium and beryllium and all of that over the period of time that I was in the plant. And I -- we always wore badges, but the badge only reads when it's coming directly to you. If

you have the badge pinned here and you turn this-a-way, well, your body's getting the reading instead of the badge. So it's not a -- really a true reading there, and I was never satisfied with -- they put the air sample up and then they'd take it down the next day and they let it set 24 hours while it decayed before they'd take the reading. But in the meanwhile, we was in the lab all the time getting it all the time and we never had no decay period. So there's really not a accurate reading that -- I don't think, because if we had been, it wouldn't be as many people is sick -- that are sick from the -- the things that they went through out there and they taken. And so I'm here to just let them know. And as I read in the *Reader's Digest*, the article about McCluskey was really not accurate because they left out some things and I don't know who dictated to the writer, but I'm the man that ran the sample and I'm the one to know what happened. And I just want people to know that that write-up wasn't really like it was supposed to be because it was too much left out. I don't know if it was covered over or left out, but it really wasn't accurate. And I'm here because I would like to get compensated for my sickness and for the suffering and I put myself through. And if it's any ways possible that I could get some help with this

reconstruction because I've been contacted by attorneys from a southern state -- and I won't call the state -- about my sickness and they wanted to know was anybody doing anything for me. And they asked me about the asbestos and I didn't even know about it, and they said they was in the area and took X-rays and I had something in my lungs and they figured it was asbestos, and this is what they was writing me about and they wanted to get an answer from me. Well, I don't know what it is, so what can I tell them? So I'm just kind of between a rock and a hard place, but they keep calling me and talking to me about it and they said if -- if they don't do something about it pretty quick and they was going to take over -- they was going to take over the -- for my -- and be my attorney, and without me even knowing what was going on. So I would, you know, just like to know, is it other people outside the state that know more about things than we do right here in the tri-city area?

And I realize I been in Arkansas taking care of my mother for about five years and I really haven't kept up with everything because I wasn't here. And if I had gotten any mail there and she got ahold to it, ain't no telling what would have happened because she's suffering with Alzheimer's. But really something

really needs to be done because it's a lot of people out -- out here that worked out in that area and we got a lot of radiation that we shouldn't have gotten. But we got it and so what we going to do about it? And thank you.

(Applause)

DR. ZIEMER: I have one more individual that signed up. It's Hank Hartley. Hank Hartley?

MR. HARTLEY: Good evening. My name is Hank Hartley. I did have the pleasure of serving on the Hanford Health Effects subcommittee with Dr. Henry Anderson for about six years. For about six and a half years I have managed the Hanford building trades medical screening program, and I wanted to touch on I guess four subjects. I'll start out with Charlie.

I worked for Charlie many years ago, the pipe fitter general foreman who came up here a little while ago and talked. I was one of those young guys that used to run down there and attach the chokers, and Charlie would tell them to be careful of the shine. Well, I didn't know what shine was, so we went over to 100-H one day to get some valves out and Charlie said see that wall over there? I said yeah. He says you got to run like a son of a gun and get over there -- and I did. And then we ran in and put the chokers on

and got it out.

Anyway, the only thing I've ever really had is a little bit of skin cancer, which the doctors burn off about every three months or so. A little acid fell on my shoulder in the Purex building -- PNO galley -- and I had a cancer removed from it. It was about 30 years ago I got that on me. But anyway, so much for that.

What Charlie was talking about is these guys (Inaudible) shine. I have seen a lot of fellows that are not even nearly Charlie's age that are gone -- of all -- of all crafts, of all unions, of all workers of all types, production and construction.

The other subject I wanted to talk about was this dose reconstruction. So many times in the past I wanted to know what my dose rate was or how much did I get, and they never could really quite tell me. Now hopefully -- I'm hoping that today they can establish some way or some means of being able to tell us what our dose assessment was. I don't know how they're going to do that. Maybe if they have people that did receive doses and you worked near them or in the same building as them, maybe they can do it, I don't know. I hope that they have means and methods of doing it.

The other thing I was going to talk about was

-- so many talk about -- people talk about the down-winders. Well, you know, I had my doubts a little bit, too, a long time ago. But time passed and I've listened to a lot of people talk, especially Gail at the meetings I attended, and Ken Staley and Mr. Samson. And anyway, I've been married a few times, but I married a lady that used to live out in the Waluke Slopes. She got 47 acres out there. I told her to sell the property. I don't even want to live near that. But what happened out there, during the green run there were people out there, innocent people living out there just doing their thing, and there are areas out there that has been documented where people absolutely died for no real reason. And I'm talking about like Ritzville, Connell, all the little outlying lands that are down wind from Hanford.

Well, anyway, I didn't much believe a lot of these stories until you actually, like in my case, get married to someone and they talk about it. And there were a lot of strange things that took place out there with animals, vegetables, women drinking milk when they were -- I don't know, six, seven, eight years old and developing breast cancer. And those women that couldn't tolerate milk from a cow drank goat's milk, which was even worse. And I attended a meeting on that

up in Spokane, and that was documented about the green run that got on the grass and the cows ate it and the animals got it up.

Anyway, there was a fella that lived out near Eltopia, he was a Navy SEAL, and he has kept records of -- of deaths of people in and around the area that are hard to explain, and mostly they were cancers. And a lot of them didn't have cancer in their family, but they lived out in the blocks, we call it, down wind from Hanford, and they had pretty bad cancers.

Then there was this -- another individual who -- he's about my age, I would say. He lived out on his grandfather's farm when he was very young, and the grandparents used to go out into the wheat stubble and find weather balloons. And these weather balloons were released about the same time as the green run and they would come over and fall down into the wheat stubble. Well, the folks would go out there and pick up the balloon. It'd have a little note that says if found, please return to your Federal government and tell us where and when and what and how. They did.

They thought they were doing their duty to their country, and they were. But by the same token, they were sort of being -- I call it experimented on, you know, what through this release through the

balloons and the green run stuff that went over the top of them. Well, most of those people died of a strange -- brain stem cancers and things like that. A lot of those people died from it.

And I read about it where so many times it's written off, saying oh, well, you know, they had to have it somewhere. Or there's people that live other places that get it; you know, you can't blame it on Hanford. But why so many people in such a small little area? I mean that becomes the question, to me; why so many deformed animals in that area, vegetables, things like that. It makes you wonder.

Now from my wife's property, which I don't own, you walk up to the top of the hill and what are you looking at? 100-N, 100-H, all the places that Charlie told me to look out for when we were working out there as a pipe fitter. So I just wanted to touch on that, that the whole thing is related not only from the workers at Hanford, but from the people that live down wind from Hanford, and they suffered serious consequences.

There were cases that I have noticed, having been a construction worker, Hanford's Health Effects and the building trades medical screening, where there were sometimes -- all the people on one side of a

block, for example, in Ritzville, would die, but the people on the other side didn't. Something to do with the prevailing wind -- I mean who knows? I'm not a scientist. But I wholly concur with David -- John David who just got up from sheet metal, and I sincerely hope that some good things come of these meetings. And I just want to tie it all together, Hanford, down-winders, all the people that have suffered one way or another because -- perhaps because of a lack of knowledge.

So many people are afraid to come to EEOICPA. I refer a lot of people here from the medical screening. They're afraid that they can't remember the details or who they worked for or when or where or what. But there are ways -- I want to let the public know, there are ways of finding out where you worked and who you worked for. It takes a little research, pension records, Social Security, affidavits from other people that worked around you.

Now Charlie -- speaking of Charlie, there are many people who could use Charlie as a person who could sign an affidavit for them, and I have signed myself four or five affidavits for widows whom I worked with their husbands in various areas. And now that I saw Charlie again tonight, it brought it to mind. He might

be able to help with a lot of these other people who are looking desperately for someone they worked for. They come to me and they say gee, Hank, everybody I worked with is dead. You know, he was right. They have been dying at a rapid rate, and they're at that age where they do naturally die at this time because a lot of them are World War II vets. My father is dead. He worked out there. A lot of those guys have passed on and they're not around to do affidavits and say that yes, I worked with this individual at 100-K, 100-D, HHR, whatever, they were there. But I think Charlie would be a good person who still has good faculties and he could sign affidavits and help people to prove where they worked, and that's one of the bugaboos that the people are worried about.

I tell them, regardless of your fear, call the resource center in Kennewick. Those ladies down there will help you. They will help you with the paperwork. They're very good at what they do. They're personable. I've had many, many, many individuals come back to my office and tell me how personable those ladies were, how good they were, how they -- how helpful they were and how resourceful they were. I mean they really work hard. And personally, my hat is off to Judy Goudy, Teresa Hammer, who are the

caseworkers there, and Eunice Godfrey, their manager. I mean they -- those ladies have really done a great job and I'm here to give them a hand.

(Applause)

MR. HARTLEY: I guess that's all I had to say. This is kind of impromptu. I was kind of nervous coming up here. Usually I can talk a little bit longer, but I'll try and let Charlie be the longer talker. Thank you.

(Applause)

DR. ZIEMER: Thanks, Hank. We are running short of time, but there was another individual -- yes, sir, if you would approach the mike and give your name. Use the mike so our recorder can pick it up here. Thanks.

MR. YATES: Yes, I'm Roy Yates and I'm an electrician out at Hanford. And I did have colon cancer and it was stopped, you know -- or caught before it spread throughout my body, but I did have to take nine months of chemo. And right now I have on stage of osteoporosis. You know, they detected it in my back and hip and the doctors, you know, point for a man to have it at my age of 56, you know, it had to be the chemo that affected the thyroid and -- but I'd like to add a few notes here that -- I worked at Purex and at

the plutonium finishing plant and while I worked at Purex, you know, I witnessed, you know, a lot of inconsistencies, such as, you know, we had commingling, and that was throughout the 300-- or 200 areas and -- and that the rad workers would routinely check, you know, the code site, you know, for any contamination. And during one check they up and found hot spots on our chairs in our shop -- one of our chairs. And these are the same chairs we sat in, you know, with our coming and going-home clothes. And after that there, a couple of our more rowdiest electricians, you know, complained to DOE and at Purex we got that commingling stopped, which made, you know, management kind of upset, but -- this was for taking breaks and stuff. It was fast to get surveyed out of a zone and -- and not change out of your whites.

And at the same -- as time went on, we ended up finding contamination on our whites after not being in anywhere where we should have got contamination, and it came to be that we were getting hot coveralls back from the laundry and -- so that was another episode that -- all the stuff is probably -- no records kept of it, you know, and Rockwell mission, you know, to its managers, was do what it took to keep the plant running.

And I was told as electrician at times to, you know, do things that I thought was unsafe electrically just to keep, you know, different components running. And consulting with a radiation technician that I worked with, both at Purex and then moved on to the dash -- you know, plutonium finishing plant, enlighted (sic) me with activities about their equipment. They had monitors that, you know, they turned off because they'd cause nuisance alarms, and then they had inaccurate monitoring of records of other monitors. Then they had -- these monitors also consisted of aluminum parts, and when they had them in the corrosive environments of -- of areas of Purex, they -- they tend to fail that way. And I witnessed this working on the equipment in those areas myself that components were badly corroded. And so we were exposed to another element right there with all the, you know, toxics (sic) of the corrosions that went on.

And I guess -- like I said, I just -- I knew this meeting was -- somebody told me this meeting was coming up, but I didn't know about it until, you know, just -- just this -- you know, earlier this evening, so that's about as prepared as -- I did get my -- I did record, you know, my -- my cancer, you know, into the ONOSH (sic), you know, reporting. And I got my -- my

report back that said I was denied because I didn't have, you know, the percentage it required. But I still feel like under, you know, other testimonies and -- and what I'm stating here that -- that we were getting shines and other stuff that -- like I'd get that shine, too, because we went to, you know, the canyon where we had to work on the crane and the component you were working on is what they would, you know, kind of, you know, time kept what you were facing. But in back of you, you had the crane hook that was putting off a lot more dosage and a lot of your monit-- or a lot of your timekeepers didn't account for that, and that was coming from your back. So there was other -- oh, various activities of this nature that I feel like I didn't -- you know, what's on my records, you know, probably didn't account for everything that I was exposed to.

DR. ZIEMER: Thank you.

(Applause)

DR. ZIEMER: Thank you very much. Let's see, Richard Miller, are you wanting to speak today yet or --

MR. MILLER: (Off microphone) (Inaudible)

DR. ZIEMER: Okay. There will be an opportunity again tomorrow for public comment.

Let me ask one final time, are there any other individuals -- I know we've gone past our time -- was advertised as going to 8:30, but -- you have another lady? Thank you very much.

UNIDENTIFIED: (Inaudible)

DR. ZIEMER: Okay, right. Well, let's give this lady a chance and then you'll have the opportunity...

MS. VAN DYKE: Hi, my name is Catherine Van Dyke and I am not a public speaker so you'll have to excuse me, but I've been feeling led throughout the whole meeting tonight to get up here and share. I was a quality control inspector out at Hanford for ten years, and I quit to come home and take care of my little boy and be an at-home mom. When I come home from being employed out there, I worked at several different areas out there, I had ongoing health problems and was in communication with the journeyman that I worked side-by-side with all those years who has a cousin disease compared to what they were finding or treating or still are currently treating me for.

He has scleroderma, which is a connective tissue problem. They've been treating me with lupus, but I've never really been textbook for anything. I went and applied for the former Hanford checkup and I

am beryllium sensitized, which really took me by surprise after many years of ongoing testing and putting us in a financial situation of many medications and many different testing. I am currently going to National Jewish once a year. I go next month for lung biopsies. I did have high lymphocytes showing and everything. But my main concern this evening is to mention to you -- and I do have a claim with you guys. It has been approved as far as the beryllium sensitivity goes for ongoing testing.

But I'd also like to have you take a look at the fact of all my other health problems from all the other things that I've been exposed with. I just cannot seem to find a physician or someone to place it all together as all the multiple problems that I have. I am 45 years old and I am permanently disabled, and it has been a real struggle for me. And I thank you for coming and -- and I just want to make you aware of where I'm coming from. Thank you.

DR. ZIEMER: Thank you.

(Applause)

DR. ZIEMER: Now this -- this is --

MS. JAHNKE: Louisa Jahnke.

DR. ZIEMER: Right, Louisa.

MS. JAHNKE: My husband worked out here for

40 years. He came -- he came out of the Marines, went to work for Hanford. I have documented where he -- which building he worked in, every building he worked in and what he done. He was exposed to asbestos, beryllium, and I have papers on where there was two accidents out there that he was in in radiation. And this is the way he ended up, completely paralyzed.

I have letters from five doctors that said they did not know what was wrong with him. They couldn't diagnose beryllium or -- or anything that he had. And if you men would look at this picture, I had to change his diapers every hour. It was rough. Just think if your wife had to do that for four years. But I loved him, so I did it. And I just can't get no place on these people. They won't do nothing for me, and I'm still paying the hospital bills. Can you imagine that? I'm still paying them. Social Security don't go very far, so I sure wish you would do something about this. I thank you.

And I want to tell you something. My kids were all born and raised here. My youngest son, they found beryllium in his lungs. He never worked out there. He went to Seattle to Dr. Dakari, probably some of you know him, and Dr. -- the doctor came down here to Hanford. They found beryllium in his lungs from

Bill carrying it home on his shoes, washing the clothing all together. That's what the doctor said. Can you imagine that? So I wish you would take care of at least one of these. I appreciate it. Thank you.

DR. ZIEMER: Thank you.

MS. JAHNKE: I made it.

(Applause)

DR. ZIEMER: Thank you very much, all who participated and all who attended this evening. The Board will be meeting again tomorrow. I should emphasize to you, our meetings are completely open, not just the public period. They may be a little boring at times, they may be exciting, but you are welcome to all the meetings tomorrow. There's a lot of information, as one of the earlier gentlemen pointed out, our various presenters providing the Board with information to help us 'cause we are learning, too. And so you're welcome to join us again tomorrow.

Our session begins -- what time does our session begin? The formal part of the session will begin at 8:30 and we continue through the day tomorrow. There will be a public comment period in late morning tomorrow, as well.

Again, thank you and good night.

(Meeting adjourned 8:50 p.m.)

C E R T I F I C A T E

STATE OF GEORGIA)
)
COUNTY OF FULTON)

I, STEVEN RAY GREEN, being a Certified Merit Court Reporter in and for the State of Georgia, do hereby certify that the foregoing transcript was reduced to typewriting by me personally or under my direct supervision, and is a true, complete, and correct transcript of the aforesaid proceedings reported by me.

I further certify that I am not related to, employed by, counsel to, or attorney for any parties, attorneys, or counsel involved herein; nor am I financially interested in this matter.

WITNESS MY HAND AND OFFICIAL SEAL this _____ day of May, 2004.

_____
STEVEN RAY GREEN, CVR-CM
GA CCR No. A-2102