

THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING I

DAY ONE

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Hyatt Regency Hotel, Tampa, Florida, on August 17, 2005.

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August 17, 2005

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

(By Group, in Alphabetical Order)

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P R O C E E D I N G S

(1:05 p.m.)

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ADMIRAL ZIMBLE: Ladies and gentlemen, it's 1:05 and I -- I don't want to set a precedent of having delays in either the beginning of meetings or in the progress of this Board. So I welcome -- I welcome you all to this inaugural meeting of the Veterans' Advisory Board of -- for Dose Reconstruction. And we'll start off the agenda as soon as I can find it -- okay. I would ask that as you enter, make sure you've registered so we know who has attended. And if anybody wants to subsequently speak, to provide some testimony, that -- that opportunity will be available starting at 7:00 tonight, and we'll stay until we've heard everybody. So -- but that also requires registration. Let me ask Mr. Faircloth, who's our Designated Federal Official and who is Chief of Staff at the Defense Threat Reduction Agency, to say a few words.

OPENING REMARKS

MR. WILLIAM R. FAIRCLOTH, DESIGNATED FEDERAL OFFICIAL

MR. FAIRCLOTH: Thank you, Dr. Zimble. In

1 fact, I think you covered about half the things
2 I wanted to do, so I just need to be short, be
3 brief and get on so that we can get on with
4 this important program.

5 I'd like to echo the welcome and the good
6 afternoon. Welcome to the veterans and the
7 families who are here, and I'm confident more
8 will be showing up later on. I am the
9 Designated Federal Official, which means I'm
10 the rule keeper. I make sure that we're
11 following the Federal Advisory Committee Act
12 regulations and that we do start on time and
13 end on time, and that we cover what we need to
14 cover.

15 I think we have a fantastic Board here. This
16 level of expertise I've rarely seen assembled
17 to assist in looking at our processes. The
18 members were selected to provide expertise in
19 historical dose reconstruction, radiation
20 health matters, risk communications, radiation
21 epidemiology, medicine, quality management,
22 decision analysis and ethics, and I am
23 confident they are going to assist both the
24 Department of Veterans Affairs and the Defense
25 Threat Reduction Agency in improving the way we

1 are serving the veterans in this program.
2 Today's meeting is a significant milestone. I
3 hope you've had an opportunity to pick up some
4 of the handouts that are outside in the back
5 door. It should cover the briefings that are
6 going to be provided, the agenda, and -- and
7 also highlight the open comment periods. So we
8 do have an ambitious agenda ahead of us and I
9 look forward to working with the Board and
10 listening to the veterans' comments and
11 concerns in the public period. And at this
12 time I am pleased to turn the Board over to --
13 and the meeting and the proceedings to Retired
14 Navy Vice Admiral James A. Zimble, M.D., former
15 Surgeon General of the United States Navy. Dr.
16 Zimble.

17 INTRODUCTION OF THE VBDR MEMBERS AND

18 CHAIRMAN'S WELCOMING REMARKS

19 ADMIRAL JAMES ZIMBLE, CHAIR

20 **ADMIRAL ZIMBLE:** Thank you very much, Mr.
21 Faircloth. First of all, again, this is our
22 inaugural meeting, so we will be going over
23 some initial items that need to be -- need to
24 be documented for the record. The handouts
25 include the charter for the Board and what our

1 Board is all about, and I would just like to
2 reiterate that what this Board has been
3 designed to do is, first of all, maintain
4 independence. We do not represent the
5 government. We represent basically -- we want
6 to represent our customers. We want to
7 represent those people who -- who we -- we need
8 to attend to.

9 We're going to be looking at oversight. We
10 want to look at the processes of dose
11 reconstruction, the processes of filing claims
12 with the VA. Those are our mandates, of
13 assuring that we do that with quality and that
14 we assure that we are able to properly
15 communicate. And by communication, I mean two-
16 way communication. This Board is ready and
17 prepared to do a lot of listening. We really
18 need to hear from the atomic veterans that --
19 that have been involved in the atmospheric
20 testing of -- and who have been involved in the
21 occupation of Hiroshima and Nagasaki. Those
22 are our requirements.

23 We have a terrific Board. I am -- I feel very,
24 very comfortable chairing this Board because
25 I've got a lot of expert help to allow this

1 Board to do what it needs to do. And I would
2 like to ask each of the Board members who are
3 present -- and we do have a quorum -- to
4 introduce themselves. You'll see that their
5 bios are available as handouts, but I would
6 like each one of them to introduce themselves
7 and say a little bit about themselves. We can
8 start with Mr. Pamperin.

9 **MR. PAMPERIN:** Good afternoon. My name's Tom
10 Pamperin. I am Assistant Director for Policy
11 of the Compensation and Pension Service of the
12 Department of Veterans Affairs. I've worked
13 for the Agency for 33 years as a claims
14 examiner, rating specialist and management
15 official in the field, as well as in central
16 office. I've been in Washington for 11 years
17 and am principally responsible for our
18 regulations and development of policy.

19 **MR. FAIRCLOTH:** Tom -- can -- can you hear that
20 in the back, Melanie?

21 **MS. HEISTER:** Yes.

22 **MR. FAIRCLOTH:** Okay, thanks.

23 **MR. VOILLEQUÉ:** I'm Paul Voillequé. I'm a
24 health physicist. I have a fair amount of
25 experience in dose reconstruction and other

1 aspects of radiation and radioactivity, both in
2 facilities and in the environment.

3 **DR. ZEMAN:** Good afternoon. My name is Gary
4 Zeman. I'm a retired Navy officer, served 20
5 years as a Medical Service Corps radiation
6 health officer. Since retiring from the Navy
7 I've worked as a radiation protection officer
8 at AT&T Bell Labs in New Jersey, and for the
9 last seven years at Lawrence Berkeley National
10 Laboratory in Berkeley, California.

11 **COLONEL TAYLOR:** Good afternoon. I'm Edwin
12 Taylor. I'm a retired Army Colonel. I come to
13 the Board with experience in three specific
14 areas. One is combat experience, which is kind
15 of a leveling thing when we're dealing with
16 servicemen; experience in atomic matters that
17 are fairly extensive in contacts with others,
18 certainly not as extensive as a lot of people
19 we'll deal with; and thirdly, over 23 years
20 since I've retired, almost full-time activities
21 with a myriad of veterans' organizations in the
22 southeast United States, and particularly in
23 Florida. I welcome this opportunity more than
24 you can imagine. Thank you.

25 **ADMIRAL ZIMBLE:** Dr. Reimann?

1 **DR. REIMANN:** Yeah, my name is Curt Reimann.
2 I've been associated with the National
3 Institute of Standards and Technology in one
4 form or another since 1962, as a chemical
5 researcher and a science manager in some areas
6 relevant to this study here in -- in radiation
7 and -- and precision measurement and so on.
8 And in my later career I had responsibility for
9 establishing a national award in quality and --
10 and that would be my particular interest in --
11 in working with this Board. I very much look
12 forward to it. Thank you.

13 **MR. GROVES:** My name is Kenneth Groves and I am
14 a retired Navy enlisted man and commissioned
15 officer. I served 26 years in a number of
16 functions. My -- one of my jobs in the latter
17 part of my career was Director of the Navy's
18 Nuclear Weapons Radiological Controls Program
19 office. When I retired from the Navy I went to
20 work for Los Alamos National Lab, was involved
21 in radiological dose reconstruction and any
22 number of other radiation health-related
23 activities. I've also retired from the
24 University of California, office of the
25 President. I'm looking forward to serving on

1 this Board and doing what we can to deal with
2 the issues that we have responsibility for.
3 Thank you.

4 **DR. BOICE:** My name is John Boice and I'm a
5 radiation epidemiologist and spent my entire
6 career studying populations exposed to ionizing
7 radiation and evaluating late effects. I'm
8 Professor of Medicine at Vanderbilt University,
9 and also Scientific Director of the
10 International Epidemiology Institute. I
11 represent the United States as an advisor to
12 the United Nations on their Scientific
13 Committee on the effects of atomic radiation,
14 and serve on quite a number of international
15 and national radiation committees.
16 Another interesting aside is that my entire
17 life I've had a military I.D. card. And my
18 father was career Army and served in World War
19 II and the Korean War, and my brother was
20 career Navy. And I spent 28 years as a
21 commissioned officer in the Public Health
22 Service and retired after 28 years where I
23 served at the National Cancer Institute and was
24 the Chief of the Radiation Epidemiology Branch.
25 **MR. BECK:** My name is Harold Beck. I spent

1 over 30 years with the Atomic Energy
2 Commission, which later became part of the
3 Department of Energy, at a laboratory in New
4 York called the Environmental Measurements
5 Laboratory. Originally it was called the
6 Health and Safety Laboratory and it was the
7 laboratory that did most of the monitoring of
8 fallout throughout the world during the '50s
9 and '60s. So much of my career has been spent
10 studying fallout and I've been involved in most
11 of the major dose reconstruction efforts for
12 fallout.

13 Since I retired I've been serving as a private
14 consultant. Again, still working on fallout
15 things, but I've also -- was a member of the
16 National Academy's committee which reviewed the
17 dose reconstruction program which resulted in a
18 recommendation which resulted in this Board
19 being formed, so I've had a lot of experience
20 in this area.

21 **DR. BLAKE:** Thank you -- thank you, Harold. My
22 name is Paul Blake. I'm the Nuclear Test
23 Personnel Review Program manager at the Defense
24 Threat Reduction Agency. Up till about eight
25 months ago I was active duty, a Naval officer.

1 Some of my positions included being the
2 specialty leader for the Navy in the radiation
3 health community. Eight months ago I retired
4 and I became civil service, and that's what I
5 am now at the Defense Threat Reduction Agency.

6 **ADMIRAL ZIMBLE:** All right. We have one more
7 Board member who is present, but she's present
8 long distance electronically. Dr. Vaughan --

9 **DR. VAUGHAN:** Yes.

10 **ADMIRAL ZIMBLE:** -- would you please say a few
11 words?

12 **DR. VAUGHAN:** Yes, my name is Dr. Elaine
13 Vaughan. I'm a psychologist and professor at
14 the University of California Irvine. I'm very
15 honored to have been appointed to this Board.
16 My areas of expertise and research have been in
17 risk communication, issues of trust, the use of
18 medical scientific evidence to make decisions.
19 I've worked with many different communities on
20 cancer risk issues and helping our experts to
21 understand public perspectives on cancer risk
22 issues and the interpretation of uncertainties.
23 So I'm hoping my expertise will add something
24 to this Board.

25 **ADMIRAL ZIMBLE:** All right. Thank you very

1 much. And there is a -- there are three
2 members who will not be able to attend this
3 Board meeting. They'll be apprised fully of
4 the proceedings of this meeting later. That's
5 Dr. Blanck, Dr. Lathrop and Dr. McCurdy. Those
6 individuals had commitments that preclude their
7 being here today, but they will certainly be
8 participating in the deliberations of the
9 Board.

10 In addition to that, Dr. Swenson will be -- Dr.
11 Kristin Swenson will be with us tomorrow for
12 the second day of the meeting.

13 I would -- I would remind anyone who has
14 questions or comments to be sure that you
15 identify yourself and speak into the mike
16 that's in the center of the room. And we will
17 have several presentations here. I'm sure that
18 following the presentations that anyone has
19 specific questions directed towards those
20 presentations will be -- certainly their --
21 their questions or comments will be welcome.
22 Please, if you have cell phones, one of the
23 biggest plagues to audio engineers are ringing
24 or vibrating cell phones during the course of
25 these proceedings. So please, if you have a

1 cell phone, turn it off. I just remembered and
2 turned mine off.

3 PERSPECTIVES ON DOSE RECONSTRUCTION PROGRAMS BY CHAIRMAN
4 OF PRESIDENT'S ADVISORY BOARD ON RADIATION AND
5 WORKER HEALTH

6 DR. PAUL ZIEMER, ABRWH CHAIR

7 **ADMIRAL ZIMBLE:** With that, I'd like to get on
8 with the agenda. And the first speaker is Dr.
9 Paul Ziemer. Dr. Paul Ziemer is Chairman of
10 our mirror image board. The board -- he's
11 Chairman of the President's Advisory Board on
12 Radiation and Worker Health and is looking to
13 those individuals that have been working with
14 the Department of Labor, Department of Energy,
15 et cetera. And he's been in the business for
16 some time now, and we -- we hope to learn from
17 his example, and we certainly appreciate -- Dr.
18 Ziemer, we appreciate your attendance here
19 today.

20 **DR. ZIEMER:** Thank you very much, and it
21 certainly is a pleasure for me to be here. I'm
22 very impressed by the Board that has been put
23 together for this program. I should tell you
24 by way of background, my own career area is
25 that of health physics or radiation protection.

1 I really began my career at the Oak Ridge
2 National Laboratory, but then moved on to
3 Purdue University where I became a professor of
4 health physics, have taught many students over
5 the years in areas of radiation protection and
6 health physics. I did have the opportunity in
7 the early '90s to spend a few years in the D.C.
8 area as -- in the previous Bush administration
9 as Assistant Secretary of Energy for
10 Environment Safety and Health.

11 But you know, as a college professor -- did I
12 just pick up 15 minutes to add to my --

13 **ADMIRAL ZIMBLE:** Actually -- if you have
14 tenure.

15 **DR. ZIEMER:** You recognize a professor is
16 someone who speaks in other people's sleep, and
17 it is right after lunch. But nonetheless, I do
18 welcome the opportunity to address this Board
19 today and share a little bit about perhaps the
20 similarities and the differences between how
21 our boards may operate.

22 I must point out that what I say today
23 represents really my own personal views. I
24 cannot speak for our board on anything where
25 they haven't taken action. That will happen to

1 you, too, sir.

2 **ADMIRAL ZIMBLE:** Yes.

3 **DR. ZIEMER:** But -- so I don't speak for the
4 board other than where I present some factual
5 public information to you about our board and
6 its activities. But insofar as I offer
7 comments and opinions, they are mine alone.
8 As you may know, there are currently four
9 radiation-related compensation programs that
10 are in place today. I've listed those here. I
11 don't need to read all the names. Certainly
12 you're familiar, I think, with them -- at least
13 by title -- and you're involved in at least
14 part of this list. And of course the one I'm
15 involved in is the last one on the list, the
16 Energy Employees Occupational Illness
17 Compensation Program Act, or EEOICPA, as we
18 call it.

19 You may recognize the third one on the list,
20 Radiation Exposure Compensation Act. That's
21 the one that also includes the down-winders in
22 their program.

23 So what I want to do, though, I'm going to
24 focus on our program and your program, and
25 particularly the roles of our advisory boards,

1 and perhaps give some comments that you might
2 find to be useful as you think about going
3 forward from this point. So let me begin by
4 familiarizing you very briefly with our program
5 and what we do.

6 In October of 2000 the United States Congress
7 passed the Energy Employees Occupational
8 Illness Compensation Program Act, and on
9 December 7th in the year 2000 the President
10 issued an Executive Order which assigned
11 several of the policy-making technical roles
12 under this Act to the U.S. Department of Health
13 and Human Services, the U.S. Department of
14 Labor, the U.S. Department of Energy. This law
15 became effective in July of 2001 and so we've
16 been in operation pretty much after that, and
17 more effectively since January 2002.

18 This law is really intended to provide, as the
19 law says, timely, uniform and adequate
20 compensation of covered employees or survivors
21 who've suffered from illness incurred in the
22 performance of duty for the Department of
23 Energy and certain of its contractors and
24 subcontractors. In fact there are about
25 650,000 nuclear weapons production workers who

1 have been employed by the DOE or its principal
2 contractors since the inception of these
3 programs in the early 1940s. In addition, as
4 many as 100,000 workers may have been employed
5 in the production of weapons in the first
6 decade of those programs and are the ones
7 referred to under this atomic weapons employee
8 program.

9 EEOICPA mandated Federal compensation of
10 \$150,000 in lump sum payments for the provision
11 of medical coverage -- and the provision of
12 medical coverage for surviving employees or
13 workers who've incurred cancer, beryllium
14 disease or silicosis resulting from service to
15 the United States in the nuclear weapons
16 programs.

17 Now in addition to the responsibilities
18 assigned to the Federal agencies in this
19 particular law, the law also called on the
20 President to appoint an Advisory Board on
21 Radiation and Worker Health, and accordingly
22 the President appointed the Board under
23 Executive Order 13179, and designated certain
24 responsibilities to this advisory board.

25 Under the Act, the Department of Health and

1 Human Services was given very specific
2 responsibilities, including the promulgation of
3 two regulations central to the adjudication of
4 the cancer claims. The first of these rules,
5 which is 42 CFR Part 81, establishes guidelines
6 for determination of whether or not an
7 individual with cancer is at least as likely as
8 not to have sustained the cancer from exposure
9 to ionizing radiation. The second rule is 42
10 CFR Part 82, establishes methods by which
11 Health and Human Services, and particularly
12 NIOSH, will estimate doses of radiation
13 incurred to the individuals employed in this
14 program.

15 In relation to those responsibilities, our
16 advisory board was given some very specific
17 responsibilities. The first of these deals
18 with the development of those two guidelines,
19 and our board was charged with providing input
20 to the development of these two guidelines, and
21 specific comments that would assist the
22 Department of Health and Human Services in the
23 promulgation of those particular guidelines.
24 So this is a very specific responsibility of
25 the board, and actually was basically the first

1 thing we did when we got underway was get
2 involved in the development of those two
3 regulations.

4 In addition to that, this board has been given
5 responsibility to provide advice to the
6 Secretary of Health and Human Services on the
7 scientific validity and quality of the dose
8 reconstruction efforts. And thirdly, provide
9 advice on whether there's a class of employees
10 for whom it's not feasible to estimate dose and
11 whether there's a likelihood that they have
12 received doses that would nonetheless endanger
13 their health. In this case these are
14 individuals referred to as part of a Special
15 Exposure Cohort and for whom compensation would
16 be provided without the need for a dose
17 reconstruction.

18 These three items are the full charge to our
19 board; the advice on the promulgation of the
20 two regulations, the responsibility on
21 reviewing scientific validity, and the issues
22 related to the determination of Special
23 Exposure Cohorts.

24 Now I've looked at the charge to your veterans'
25 board, and I'd like to make some comparisons

1 and some observations in this regard.
2 There's the first one of your responsibilities,
3 conduct period random audits of dose
4 reconstructions and decisions on claims. And
5 we have what I would call an analogous
6 responsibility. Our is advise the Secretary of
7 Health and Human Services on the scientific
8 validity and quality of dose reconstruction
9 efforts.

10 Now it's interesting to consider how one would
11 go about doing these things. How does one
12 establish scientific validity and quality?
13 Well, in -- in your case, this is done
14 obviously by a random selection process, but
15 you may in fact end up having to determine yet
16 how you will indeed do this.

17 Our board has decided to audit two and a half
18 percent of the total cases. Now this is
19 somewhat arbitrary. It's based in part on what
20 we thought we could reasonably do and get a
21 sufficient number to establish perhaps trends
22 that we might see, but a number that was doable
23 by an advisory board. And you could work the
24 numbers. Obviously the total's going to depend
25 on the number of claims, and we only audit

1 completed claims, claims that have been final
2 and gone to closure and a decision made. And
3 decision on our claims actually is made by the
4 Department of Labor. So what we audit is not
5 Labor's decision, but NIOSH's dose
6 reconstruction. We do not audit the decision
7 as a decision. We audit the dose
8 reconstruction itself.

9 Now we say that we select our cases at random,
10 and we do this through a random number process.
11 But we also input on that from time to time.
12 We may specify parameters as part of the random
13 selection process in order to ensure that we
14 sample from a full spectrum of types of cases.
15 This would include cases from a variety of
16 facilities. For example, if for some reason
17 the random number process didn't give us any
18 cases say from the Hanford site -- which is one
19 of the major sites -- we would say wait, we
20 need to look at some Hanford cases. So we
21 would go back and ask that, at random, some
22 certain number of Hanford cases be selected.
23 We also want to make sure that we are looking
24 at a variety of cancer types, which therefore
25 represent a number of types of individual

1 claimants. And we may add other parameters to
2 that, depend-- for example, we don't want to
3 look at only external exposures. And so we --
4 we impose, if necessary, additional constraints
5 on the random selection process.

6 I might also tell you that we do not -- if we
7 find -- if we have findings on discrepancies or
8 problems with -- with a claim that we look at,
9 this is not part of a review process for
10 individual claims. We are looking for patterns
11 of findings, so we go back to our agency,
12 NIOSH, and present our findings in terms of a
13 roll-up. And we tend to take the claims --
14 well, currently we are taking 20 at a time, and
15 we will roll up the results and say we have
16 found these kinds of issues and this kind of
17 pattern. Whether or not the output affects an
18 individual claim is strictly up to NIOSH. They
19 may go back and say, you know, based on these
20 findings, we want to review a particular claim
21 and they could go back to Labor and ask for it
22 to be brought back and reviewed.

23 But we are simply looking at the process as an
24 auditor would and say here is a kind of
25 finding. We're looking for patterns of

1 procedural deficiencies, calculational
2 deficiencies or other kinds of deficiencies
3 that might be in the system and need to be
4 looked at. And insofar as those arise, then
5 the con-- or the -- the agency may have to go
6 back and look at other cases of that type. But
7 we -- we definitely do not look at this as a
8 method for reviewing individual claims and
9 asking for claims necessarily to be reversed.
10 Here's another comparison. Your Board has a
11 responsibility to assist the VA and DTRA in
12 communicating to veterans information on
13 mission, procedures and evidentiary
14 requirements of dose reconstruction. We have
15 been given no similar duty in terms of
16 communicating to our constituents. In fact,
17 that would appear to be a -- a sort of vacuum
18 in our case, because as we proceed we do indeed
19 find that often the agencies -- NIOSH, Labor,
20 Health and Human Services -- could be doing a
21 better job of how they interact with the
22 stakeholders, the constituents. So although we
23 have no specific charge of this type, our board
24 is not bashful about giving its opinion --
25 sometimes its individual opinions of board

1 members that don't carry any weight beyond --
2 in other words, do not necessarily represent
3 board consensus, but nonetheless, the agencies
4 do hear the comments. And we have found that
5 in a number of cases they have in fact changed
6 procedures and approaches to how they deal with
7 the claimants as a result of such comments. So
8 although we don't have the duty and
9 responsibility, it -- it sort of arises
10 naturally in the course of things.
11 But I would add that I believe it's a good
12 thing that it's spelled out for you that you
13 have this responsibility of looking at how you
14 are communicating with those who are your
15 constituents in a very real way.
16 You have kind of -- what I might call a catch-
17 all phrase in your list of duties, "carry out
18 other activities". We -- we don't have
19 anything really quite like that. The only
20 thing I put in here is we -- we do advise the
21 Secretary on the development of guidelines, but
22 that's very much more specific, those two
23 Federal regulations that I mentioned earlier.
24 Yours seems to be much more broad and far-
25 reaching, although it appears to me that there

1 is a requirement that it be specified by the
2 agencies in order for you to do it. I'm not
3 quite sure how you will interpret that, but
4 that says "as specified jointly," so there is
5 this -- it looks like the possibility of
6 expanding the role if the agencies so desire.
7 We -- we really have no equivalent counterpart
8 in our list of duties. I don't know if that's
9 a good thing or a bad thing.

10 You also have a charge to make recommendations
11 on modifications to the mission and procedures
12 of the program, as you may consider
13 appropriate. This is something that would
14 presumably arise out of the audits.

15 We have no similar explicit duty or
16 responsibility, although it would appear to be
17 implied in the nature of the review process.
18 By nature of the review where you are having
19 findings and, in essence, suggesting how the
20 findings might be addressed, or asking that the
21 findings be addressed, in essence that, I
22 think, could lead to appropriate modifications
23 in procedures. Certainly procedures is one of
24 the things we review as part of the audits and
25 -- and I'll mention a little more in a couple

1 of minutes about that, but very specifically,
2 in order to audit you have to look at how the
3 dose reconstructions were done, and that leads
4 you directly into reviews of procedures done by
5 the agency or by its contractor.

6 I might mention for those who are not as
7 familiar, the dose reconstructions under the
8 responsibility of NIOSH, National Institute for
9 Occupational Safety and Health -- NIOSH has a
10 principal contractor that assists in that
11 responsibility. It's Oak Ridge Associated
12 Universities, and the dose reconstructions are
13 primarily carried out by the contractor under a
14 set of procedures and guidelines that have been
15 developed with NIOSH's approval. So we very
16 much look at those procedures in terms of how
17 they impact on the determination of the dose
18 reconstructions.

19 Now let me say a little bit about the
20 composition of our two boards. Our advisory
21 board, under -- under the law, consists of no
22 more than 20 members appointed by the
23 President, who also designates the Chair. But
24 you'll note our actual membership is 12. We
25 actually had 13 -- one of our members died this

1 past year and has not yet been replaced, but
2 we've never had more than that, and it appears
3 that the White House does not intend to fill
4 this whole quota of 20. We have not really
5 objected to that. I think there's -- I think
6 there's a general feeling amongst the board
7 members that when you get somewhat larger it
8 gets to be a little unwieldy. You have also
9 more and more difficulty getting 20 people
10 together in one place at one time, so there's
11 some practical issues there. But in any event,
12 we are operating currently with 12, plus our
13 Designated Federal Official.

14 Our mandate says that the members shall include
15 affected workers and their representatives, and
16 representatives of the scientific and medical
17 communities. Your charge I noticed is a little
18 more specific in identifying specific areas of
19 expertise and numbers of individuals. I should
20 tell you that as I look at your board and
21 compared to ours, your -- your board has a much
22 higher percentage of technical individuals than
23 ours. We have a fair representation from -- of
24 individuals representing the various aspects of
25 labor, therefore the worker population, non-

1 technical individuals. Our percentage on that
2 is about 30 percent non-technical individuals.
3 I'll make some additional comments on what that
4 leads to here in a moment.

5 I've been asked to relate a little bit about
6 our frequency of meetings. Technically our
7 frequency is determined by NIOSH and the
8 Centers for Disease Control and based on agency
9 needs. It is not done uniquely by NIOSH. It's
10 done really with the concurrence of the board
11 as we look at the workload and what is coming
12 up and what the needs are. And since January
13 2001 our board has met 31 times, and we meet
14 again next week. That will be our 32nd
15 meeting. I say since January 2001, but
16 actually most of this started since 2002 when
17 we really got underway, so in about three and a
18 half years, we've met 31 times, so you can do
19 the math. We're meeting quite frequently.
20 These are two- and three-day sessions in
21 various locations. We -- we tend to meet in
22 locations where there are facilities, either
23 national laboratories or atomic worker
24 facilities. For example, we meet next week in
25 St. Louis where there's a large contingent of

1 claimants from Mallinckrodt Chemical where much
2 of the early uranium work was done.
3 All of our meetings, like yours, are open to
4 the public. There's some exceptions where
5 certain confidential material is being
6 discussed, but this is pretty rare. If for
7 some reason a particular case is being
8 discussed -- and this is not typical for our
9 board -- and in some cases where we are dealing
10 with the board's contractor in terms of
11 contract cost issues, we may meet in something
12 equivalent to an executive session where the
13 public is excluded. But normally we're meeting
14 in public. We have transcripts maintained. We
15 use actually the same court transcriber that
16 you're using, Ray Green, who has done an
17 excellent job for our board.

18 Here's the status of the program. This -- this
19 information is about a month old. I don't have
20 the numbers through July, so this is basically
21 through June. These are the numbers that have
22 come to NIOSH from the Department of Labor.
23 The cases initially go to the Department of
24 Labor. They determine the eligibility of the
25 individuals in terms of workplace requirements,

1 and then the cases go to NIOSH for dose
2 reconstruction. Over 18,000 cases so far, and
3 if you'll look at the bottom of this slide,
4 you'll see that nearly half of those have
5 already been completed. The final dose
6 reconstructions sent to Department of Labor --
7 and I'm sure the number now is over 9,000, but
8 close to 9,000 a month ago -- nearly half the
9 cases the dose reconstructions had been
10 completed.

11 Of the others uncompleted, a large number of
12 those are in pre-assignment development stages.
13 That means they're being developed to proceed
14 on to individual dose reconstructors who carry
15 out the dose reconstruction for NIOSH. There
16 are a number of draft reports at any one time
17 that claimants have where the claimant is given
18 the results before -- to find out if they have
19 any final objections to the dose
20 reconstruction. At any one time there are a
21 number -- several hundred of those out to
22 claimants, and then they come back for final
23 adjudication.

24 In addition now we have Special Exposure Cohort
25 petitions. Under the one regulation that was

1 promulgated, groups of employees can petition
2 for this status. Under Special Exposure Cohort
3 status, the need for dose reconstruction is
4 waived. Typically this is only granted if, for
5 example, there is insufficient information to
6 do a dose reconstruction. This -- in cases
7 that have been finalized and where final
8 decisions have made, the bottom of this slide,
9 these are cases where there's almost a complete
10 absence of dose information or of source
11 information for groups of employees, making it
12 nearly impossible to do reasonable dose
13 reconstructions.

14 In those cases the board is required to make a
15 recommendation. NIOSH makes a separate
16 recommendation. These go to the Secretary of
17 Health and Human Services, who makes the final
18 recommendation which goes to Congress.
19 Congress has 30 days after that to deny the
20 recommendation. Otherwise, it goes forward.
21 So this is a process that in each case requires
22 either action or lack thereof by Congress in
23 order to be finalized.

24 To date we've -- there've been 37 petitions
25 received. A number of these were

1 administratively closed. They did not meet the
2 requirements for Special Exposure Cohort.
3 There are a number of active petitions as the
4 moment, and several have been finalized. On
5 all of these there's a requirement for the
6 board to make a specific recommendation of its
7 own separate from NIOSH.
8 I've summarized here what the board has done to
9 date. You -- I've already talked about
10 reviewing the regulation, the rule-makings.
11 We've been involved in these Special Exposure
12 Cohort petitions that have been completed.
13 We've established methodology for doing our
14 dose reconstruction reviews. We've established
15 methodology for reviewing what are called site
16 profiles or Technical Basis Documents. Many of
17 our facilities -- the dose reconstructions are
18 very dependent on site profiles. Site
19 profiles, for example, may contain information
20 on how dosimetry was done at that particular
21 site -- let's say Savannah River. We need to
22 know what the sensitivities of their film
23 badges were, what their limit of detection,
24 those kinds of things are contained in the site
25 profile -- areas where workers may have been

1 exposed to certain nuclides, those kinds of
2 things are identified -- to help dose
3 reconstructors do their job. And so in order
4 to review the dose reconstructions, we also
5 review the site profiles.

6 Now what we found was the board members, as a
7 group, did not have either the time or
8 expertise to do these jobs. And we do have a
9 number of technical members on the board, but
10 as you might guess -- and particularly with the
11 groups we're working with, the various
12 laboratories and weapons facilities -- there
13 are all kinds of detail differences in these
14 facilities and one health physicist or another
15 may not have the expertise to review the
16 material. And we have a number, as I said, of
17 non-technical people on our board. So to
18 assist the board in this job, the board now has
19 its own contractor.

20 We have contracted with Sandy Cohen &
21 Associates, SC&A, for assistance in reviewing
22 the dose reconstructions and to do our audits.
23 This group then provides reports to the board
24 on their findings.

25 Now their findings do not necessarily represent

1 the board's views. The board may disagree with
2 their findings, because think about this: If
3 we can't review NIOSH's scientific information,
4 how can we review our contractor's scientific
5 information. What we really end up with is
6 another set of eyes looking at this and raising
7 some issues. And then we have to decide -- if
8 there's disagreement between our contractor and
9 NIOSH, then we send them back to the table and
10 say we want to hear why there are these
11 differences. And if one side or the other
12 believes that the other is correct, one side or
13 the other may yield, as it were, and say yes,
14 that's a good point; I agree with you and we --
15 we go forward. If they end up disagreeing, and
16 this is often the case, then it comes down to
17 the board saying okay, we will go with one or
18 the other. There are often valid scientific
19 disagreements, as you might expect.

20 Our contractor has four specific tasks. We are
21 probably going to expand this very shortly to
22 five, but they are tasked to assist us in doing
23 the site profile reviews; the individual dose
24 reconstruction reviews, task order four;
25 procedure reviews, task order three; and then

1 they have a tracking system which is a separate
2 task order, simply keeping track of what has
3 been reviewed and what the outcomes are and
4 where it is in resolution process. We are
5 probably going to add a task order that will
6 specifically involve our contractor in
7 assisting us in reviewing the Special Exposure
8 Cohort petitions.

9 Now I'm going to close with just some musings,
10 as it were, on independent advisory boards. I
11 know that the question is often asked, is it
12 worth the expense. In fact, I can tell you
13 that there are members of our public who
14 believe that the advisory board is a bunch of
15 overpaid people who like to travel around the
16 country a lot and live in hotels, thinking that
17 we are getting rich off of this. Actually our
18 folks are Designated Federal -- or not
19 designated, we are Special Federal Employees,
20 as you are. I suppose we're getting the same
21 underpaid government consulting rates as you
22 are. If you're getting more, we want to find
23 out about it, actually.

24 But -- but in fact, the benefit to the programs
25 for really an incremental additional cost I

1 think is tremendous because it gives an
2 independent view -- a public independent view
3 of what's going on. There's -- there's no one
4 on our board and no one on your board that's
5 beholden to the agencies. You know, we do
6 respect them and we give due credit to their
7 work. But if we disagree with them, we feel
8 free to tell them so and why. I hope that is
9 true here, as well. And this increases public
10 confidence in the process.

11 You may in fact disagree with what is being
12 done, or may say here's a better way to do it.
13 Whether it's communication, dose reconstruction
14 or whatever it is, the fact that there's an
15 alternative path should not be threatening to
16 the agencies. They should welcome this and say
17 yes, let's think about it. Maybe or maybe not
18 it's a great idea, but -- and you'll get public
19 input, too, and you need to hear that.

20 There are then opportunities to introduce
21 alternate scientific and practical issues and
22 views, and this comes out in the process, I
23 think. The increased transparency brings I
24 think improved accountability of the agencies.
25 It's just inherent in the process. When you

1 have an independent group looking over your
2 shoulder, that increases accountability.
3 And then I think the fact that the meetings are
4 public and you have public comment periods does
5 give the opportunities for the views of our
6 various interest groups, our stakeholders, to
7 surface, to be considered openly and to be
8 shared with the larger community, and this is
9 very important.

10 And so my bottom line is, I think the
11 establishment of this Board is a very positive
12 addition to the dose reconstruction program of
13 the Department of Defense. This Board can play
14 a very significant role in the future
15 directions of the compensation programs for our
16 military veterans. Your role is a good one,
17 one that has potential to be of great help to
18 the program. I wish you well as you proceed.
19 You have the talent. You have the resources
20 and the ability to do it. And I just wish you
21 the best.

22 **ADMIRAL ZIMBLE:** Thank you very much. Dr.
23 Ziemer, I want to thank you very much for
24 providing us a good -- as a -- acting in the
25 role of professor and providing us a terrific

1 tutorial for getting this Board started. I
2 would just ask, are there any questions or
3 comments from the Board members before we
4 proceed? Right --

5 **DR. BOICE:** John --

6 **ADMIRAL ZIMBLE:** -- Dr. Boice.

7 **DR. BOICE:** John Boice. Paul, I was interested
8 in your comments about was it -- is it worth
9 it, because I thought you were going to say not
10 is it worth it to have an advisory board, but
11 is it worth it to have the cost of a dose
12 reconstruction program. And so I was sort of
13 curious, sort of being new to this. It seems
14 like it's an enormous cost to go through dose
15 reconstruction. Is -- how does that compare to
16 the actual compensation?

17 **DR. ZIEMER:** I would suggest that you run the
18 numbers, and you will be astounded if you take
19 your -- is yours \$150,000 or -- what's your --
20 what's your compen-- your -- your compensation
21 thing is much more complex than ours. Let me
22 take ours. Ours is \$150,000. If you -- if you
23 take the numbers and you take our current
24 20,000 cases, run the numbers, you'll see what
25 the total could be. That's a big number, much,

1 much greater than the cost of doing the dose
2 reconstructions. You know, I don't know where
3 we'll end up in terms of total numbers, but we
4 hear that quite frequently that -- the idea
5 that we're spending more to operate these
6 programs than it would cost just to pay
7 everybody off, but it simply is not the case.
8 I -- I don't know what the potential here in
9 the veterans' program is, but I think if you
10 run the numbers -- certainly if it ever is the
11 case where it's costing more to administer than
12 it would cost otherwise, then I think the board
13 would have an obligation to say something about
14 that, too.

15 **ADMIRAL ZIMBLE:** Right, I think that's an
16 outstanding question. I'm glad we have it for
17 the record, and one of the things we really do
18 need to do is a cost-benefit analysis of the
19 process. Thank you.

20 Any other questions, comments? Okay. Paul,
21 one more. Gary?

22 **DR. ZEMAN:** Yes, thank you for an excellent
23 presentation. I'm Gary Zeman. One of the
24 accomplishments of the board was developing
25 methodologies for reviewing and assess dose

1 reconstructions. I wonder, did the board
2 develop these or did the subcontractor develop
3 these methodologies?

4 **DR. ZIEMER:** We actually charged the
5 subcontractor to develop a methodology for
6 reviewing the procedures, tell us how you will
7 review them. They came back to the board with
8 a proposal on how they would review the
9 procedures. The board reviewed this, did some
10 tweaking, and then based on what was finally
11 approved, they went back and did the review of
12 the procedures.
13 Now what we find, I might add -- if I can take
14 one additional minute -- is that procedures
15 evolve as -- as the main contractor got
16 experience in doing dose reconstructions, they
17 developed additional procedures and variations
18 and new procedures. So it's always a moving
19 target, so you can approve a set of procedures,
20 but then you find that they're not using those
21 anymore, there's a -- some new, better ones.
22 So it's an ongoing thing. But the board -- the
23 contractor does the legwork on it and then
24 comes back to us with their proposals and
25 findings.

1 **DR. ZEMAN:** Is that methodology something that
2 could be shared with this Board then? Is that
3 -- is --

4 **DR. ZIEMER:** The methodology is not a secret.
5 Everything we do is open and certainly
6 shareable. How much it applies, I don't know,
7 in terms of the similarities in procedures, but
8 certainly it could be shared.

9 **DR. REIMANN:** I want to ask --

10 **ADMIRAL ZIMBLE:** Okay, Dr. Reimann.

11 **DR. REIMANN:** Yeah. Paul, what can you say
12 about the exposure scenarios for the workers
13 compared to the atomic veterans? Do you have
14 any perspective on the -- on the level of
15 complexity and --

16 **DR. ZIEMER:** I honestly don't know enough about
17 yours to comment. My intuitive feeling is that
18 yours may be a little bit more similar to each
19 other. I can tell you that -- and maybe not, I
20 -- okay. We -- we have -- in -- in ours, every
21 facility is unique, and what you -- well,
22 there's some that are similar if they're doing
23 similar operations and you can apply one to
24 another. For example, at Bethlehem Steel in
25 New York, in the absence of certain data we --

1 we were able to apply the air sampling approach
2 of another facility and air sampling quality --
3 or air quality of another facility doing a
4 similar operation and apply it. So we do have
5 some that are similar. But -- but if you look
6 over the DOE complex, the national labs, you
7 find not only a great variation, but within a
8 facility a lot of very different -- very
9 different operations, different nuclides and so
10 on. So you -- you can't -- you cannot simply
11 have a one-size-fits-all. You have to have a
12 lot of unique scenarios, depending on what
13 you're talking about.

14 **ADMIRAL ZIMBLE:** Yeah, I think we have -- we
15 have exactly the same situation. Every --
16 every one of the 200-plus shots and the
17 occupation of Nagasaki and Hiroshima were all
18 different -- weather circumstances, activity of
19 the troops, et cetera. So they're all unique
20 and they do require a good analysis of the --

21 **COLONEL TAYLOR:** Before he leaves --

22 **ADMIRAL ZIMBLE:** Sir.

23 **COLONEL TAYLOR:** Before you leave the stand,
24 Dr. Ziemer, I attended your last meeting at St.
25 Louis and I was most impressed. It was a

1 completely new area for me. I just had not
2 realized the concept in what you were doing.
3 The one thing that still occurs to me between
4 the two is the role and the effect that are
5 played by the labor unions and by the companies
6 that in some case you deal with. And I realize
7 there are a number of variables there. And for
8 example, in the labor unions, in your judgment,
9 would you consider that an asset to what you're
10 doing, or how do you assess what they -- what
11 their role is in representing the workers?

12 **DR. ZIEMER:** The labor unions are obviously
13 advocates for the workers.

14 **COLONEL TAYLOR:** Certainly.

15 **DR. ZIEMER:** My -- my view is that it's -- they
16 are doing what they need to do. We have
17 learned a lot from listening to workers who
18 have the stories about what really goes on in
19 the workplace, as opposed to what officially
20 appears in documents. Often there are great
21 differences. And we've tried to take that into
22 consideration where we could, where workers
23 will say well, this is what the official report
24 says, but this is what really happened. And if
25 we can confirm that -- and usually you have to

1 have -- you know, if you're hearing -- hearing
2 the same story from multiple workers
3 independently, then you begin to say okay, this
4 may be a possibility.

5 But the labor unions have been helpful in
6 making sure that the workers -- the affected
7 workers are made aware of the program -- I mean
8 this is the responsibility of the Department of
9 Labor, but really is very dependent on the
10 active work of the labor unions in making their
11 constituents aware of the program, making sure
12 workers have the opportunity to input.

13 There -- there certainly may be adversarial
14 aspects to it where the workers see things very
15 differently from management, or from the
16 technical community where the health physicists
17 may say this was -- this process -- procedure
18 was adequate and the worker says well, it
19 didn't seem to me like it was and here's why.

20 **COLONEL TAYLOR:** Thank you.

21 **DR. ZIEMER:** And the truth is not always on one
22 side or the other, and --

23 **COLONEL TAYLOR:** Thank you.

24 **DR. ZIEMER:** -- so I -- I -- you know, that's
25 kind of a fuzzy answer, but you understand --

1 **ADMIRAL ZIMBLE:** Well --

2 **DR. ZIEMER:** -- the input is important.

3 **ADMIRAL ZIMBLE:** Right. Although we don't have
4 unions involved --

5 **COLONEL TAYLOR:** We've got a lot of --

6 **ADMIRAL ZIMBLE:** -- we have the equivalent of
7 various veterans' organizations that can be
8 extremely helpful in helping with the area of
9 communications --

10 **DR. ZIEMER:** Right.

11 **ADMIRAL ZIMBLE:** -- and we --

12 **COLONEL TAYLOR:** Right.

13 **ADMIRAL ZIMBLE:** -- we hope to be able to
14 employ them.

15 **DR. ZIEMER:** Right.

16 **COLONEL TAYLOR:** That's exactly why I brought
17 it up.

18 **ADMIRAL ZIMBLE:** Thank you again, Dr. Ziemer.

19 CURRENT STATUS OF NTPR DOSE RECONSTRUCTION PROGRAM FOR
20 VETERANS

21 DR. PAUL BLAKE

22 **ADMIRAL ZIMBLE:** All right, now we're going to
23 hear from Dr. Blake, who's going to give us the
24 first of his presentations on the status of the
25 NTPR program.

1 **DR. BLAKE:** Dr. Ziemer, thank you very much.
2 That was fairly illuminating and I would
3 mention there's certainly lessons learned
4 between the two programs. In fact, next week
5 we have two physicists coming to our program
6 from the NIOSH program, and hopefully the two
7 groups can learn from each other in
8 collaboration.

9 Today I'd like to talk about the current status
10 of the program that I'm in charge of. It's the
11 Nuclear Test Personnel Review program.

12 **ADMIRAL ZIMBLE:** I don't think they can hear in
13 the back.

14 **DR. BLAKE:** Okay.

15 **ADMIRAL ZIMBLE:** Ask if they can hear in the
16 back.

17 **DR. BLAKE:** You can hear me okay? All right.
18 I'll do my best to speak up.

19 With regards to what I'd like to cover today,
20 the briefing outline, I'll first go over an
21 overview of our program, look at historical
22 events, talk about some recent events, a
23 discussion of radiogenic diseases, and then
24 briefly the road ahead. And hopefully I'll
25 cover that in 40 minutes, with a few minutes to

1 spare.

2 The Defense Threat Reduction Agency, the agency
3 that I work for, performs a vital national
4 security mission. And that is we reduce the
5 threat of weapons of mass destruction. We are
6 the go-to agency within the Department of
7 Defense for that -- for that role.

8 We are also a defense combat support agency,
9 with more than 2,000 personnel coming primarily
10 from the military services. We have
11 approximately -- when you look on the active
12 duty side, 40 percent Army, 40 percent Air
13 Force, and from the Navy side only about 15
14 percent and the Marine Corps a little smaller.
15 We have, in addition, Federal civil service
16 employees. We have employees that come to us
17 from non-governmental organizations such as the
18 national labs, and we have some people that
19 come to us from corporate America.

20 The roots of DTRA can be traced back to the
21 Manhattan Project. After the conclusion of
22 World War II, the nuclear weapons development
23 was passed from the military to the Atomic
24 Energy Commission. The concept was to put it
25 in civilian hands. That Atomic Energy

1 Commission became what we call today the
2 Department of Energy. However, the military
3 still had an urgent need to understand the
4 effects of nuclear weapons, and consequently
5 the tests that went on, even though they were
6 run by the Atomic Energy Commission, the
7 military participated in them.

8 From 1945 to 1962 the Atomic Energy Commission
9 conducted some 235 above-ground, atmospheric
10 nuclear weapons tests. This testing occurred
11 primarily in Nevada and the Pacific, with over
12 200,000 Department of Defense military and
13 civilian personnel involved.

14 In March of 1977, 15 years after the last
15 above-ground test, the Veterans Administration
16 Regional Office in Boise, Idaho received a
17 claim for disability benefits from a retired
18 Army sergeant, Paul R. Cooper. Sergeant Cooper
19 was a patient at the VA hospital in Salt Lake
20 City, and he had attributed his acute
21 myelocytic leukemia, also known as AML, to
22 radiation exposure he received when he was a
23 participant in Shot Smoky of Operation
24 PLUMBBOB. The VA initially denied Cooper's
25 claim, but later reversed its decision.

1 This claim was not totally surprising. With
2 the advent -- with the discovery of X-rays,
3 within a few years scientists were noticing
4 acute radiation effects on the human body. But
5 the non-acute effects, the first time they were
6 noted in the peer review literature from the
7 atomic weapons testing, particularly Hiroshima
8 and Nagasaki survivors, was in 1972. So our
9 sentinel event in our program came about in
10 1977.

11 This decision by the VA initiated a series of
12 events that ultimately involved the Department
13 of Defense, the Department of Energy, the
14 National Academy of Sciences, the Department of
15 Health and Human Services, and the White House.
16 This led to questions about possible radiation
17 doses received by participants, and possible
18 long-term health effects resulting from those
19 doses. To help answer those questions, in 1978
20 the Department of Defense established the
21 Nuclear Test Personnel Review program.

22 What is the mission of the NTPR? Well, we
23 provide veterans, the Department of Veterans
24 Affairs and the Department of Justice with
25 confirmation of participation in those tests

1 and other radiation areas, and also radiation
2 dose, when applicable, to the military and DoD
3 civilian personnel who, one, participated in
4 U.S. atmospheric nuclear testing from 1945 to
5 1962; two, served with the American occupation
6 forces of Hiroshima and Nagasaki from August,
7 1945 to July, 1946; and finally, a group that
8 was interred as prisoners of war near Hiroshima
9 and Nagasaki at the end of World War II.

10 What are our program objectives? I think they
11 can be summarized in three areas. First and
12 foremost, veteran assistance. We provide
13 timely, complete and relevant support to
14 individual participants, to the organizations
15 responsible for administrating veterans'
16 benefits, and also supporting scientific
17 research in those areas relevant to our
18 program.

19 Secondly, we provide dose assessment, providing
20 accurate dosimetry result-- we provide accurate
21 dosimetry based on film badge information and
22 apply dose reconstruction methodologies when
23 film badge data is not sufficient for the
24 population supported by the NTPR.

25 And finally we maintain a database on over

1 400,000 veterans that were involved -- and
2 civilian personnel involved in these tests.
3 We're to establish and maintain a credible,
4 comprehensive and accessible repository of
5 personnel, historical, and radiological
6 information for all populations supported by
7 the NTPR.

8 With our program requirements, Congress passes
9 laws. And in fact, if you look at the laws
10 that directly impact our program, it's somewhat
11 subjective, but I -- I look at it from the
12 viewpoint of 19 public laws. It includes laws
13 such as the Freedom of Information Act, the
14 Privacy Act, and a number of other laws that
15 I'll discuss later. We, as Federal agencies,
16 then take those laws and say how do we
17 implement them. And when we explain how we
18 implement them, we can put that in the Code of
19 Federal Regulations.

20 The three Federal agencies involved here have
21 written, in the Code of Federal Regulations,
22 how they're going to implement those public
23 laws. The first group, the Department of
24 Justice, under Title 28 Code of Federal
25 Regulations Part 79, describe how they do their

1 part. Similarly, the Department of Veterans
2 Affairs, in Title 38, Part 3 of the Code of
3 Federal Regulations, describe their procedures.
4 And finally, in my own Department of Defense,
5 Title 32, Part 218, we provide the guidance for
6 the determination and reporting of nuclear
7 radiation dose for DoD participants in the
8 atmospheric test program.

9 What is the environment that we operate in?
10 Well, if you look at that slide, it's fairly
11 complex. It includes obviously the individual
12 veterans. We deal with interagency decisions
13 and work with other groups closely. We also
14 spend a lot of time from a historical
15 perspective, researching data in archives, in
16 some case, data that's been classified. We
17 need to get it declassified and into the open,
18 public arena.

19 We also sponsor scientific developments,
20 procedures and reviews. We interact with
21 Congress, providing requests for information,
22 testimony upon request. We get involved and
23 asked for input on legislative issues. We're
24 involved from a legal viewpoint. There is
25 business parts of the program. Similar to what

1 we heard before, the Department of Defense uses
2 contractors in how we actually perform part of
3 this process. And finally there's an
4 oversight, review and scrutiny of what we do
5 through the Government Accountability Office,
6 the National Academy of Sciences, and now this
7 Advisory Board.

8 What is our team made up of on the NTPR side?
9 Well, I describe it as an integrated product
10 team. That is a combination of both the
11 government and the contract side. On the
12 government side, right now we currently have
13 three board-certified health physicists running
14 the team. It's myself, civil service; an
15 active duty Naval officer; and another
16 individu-- another civilian personnel in the
17 program. On the contract side we have 25
18 support and 14 scientists and engineers. We're
19 primarily located in northern Virginia. We at
20 the Defense Threat Reduction Agency are located
21 in Fort Belvoir, which is a little bit south of
22 Washington, D.C.

23 Our contractors primarily sit in Reston and
24 McLean, Virginia. However, some of the
25 scientific work can be sent out, and we have

1 individuals helping us on dose reconstructions
2 currently located in Idaho Falls, Idaho and San
3 Diego, California. In addition we have two
4 contractors on site out at St. Louis, Missouri.
5 At St. Louis there exists a government facility
6 known as the National Personnel Records Center.
7 And for active duty people, when we separate or
8 retire from the service, our service jackets
9 and our medical records are sent to that
10 facility, so that is one of the common places
11 we go to get our data on verification.
12 The program was smaller in the past, but as
13 I'll discuss, the program has expanded in the
14 last year or two based on a National Academy of
15 Science review that was published in 2003.
16 In early 1977, due in part to Sergeant Cooper's
17 VA case, the Centers for Disease Control and
18 Prevention, now known as CDC, initiated an
19 initial epidemiological investigation into an
20 abnormal incidence of leukemia among
21 participants in Shot SMOKY. They basically saw
22 a leukemia cluster that was unusual.
23 At the same time, interagency meetings between
24 the Department of Defense, Department of
25 Energy, the VA and the U.S. Public Health

1 Service were initiated to address this problem.
2 By 1978 Congress began to hold hearings on this
3 topic.

4 As I mentioned before, in 1978 DoD directed the
5 Defense Nuclear Agency, the predecessor
6 organization to my agency, to stand up the NTRP
7 program. At that date NTRP established a toll-
8 free 800 call-in program, and the phone
9 number's actually 800-462-3683. That number is
10 still in existence today. We typically receive
11 perhaps a half a dozen phone calls on a daily
12 basis from different people that are interested
13 in the program trying to obtain information.
14 This is in addition to many letters that come
15 in on a weekly basis.

16 At that same time the VA authorized physical
17 examinations for the first time for nuclear
18 test participants.

19 If we look a little farther down on historical
20 events, in 1981 Congress passed what many
21 considered the first law in this area, Public
22 Law 97-72, which provided health care to
23 atmospheric nuclear test participants and the
24 occupation forces of Hiroshima/Nagasaki.

25 In 1984 Congress passed what I would consider a

1 more extensive law, Public Law 98-542, the
2 Veterans' Dioxin and Radiation Exposure
3 Compensation Standards Act. Three main points
4 I'd like to point out in that law.
5 One was it directed the VA to establish
6 radiation compensation standards. Secondly, it
7 directed the VA to establish an environmental
8 hazards advisory committee. And thirdly, it
9 directed my own predecessor organization to
10 prescribe guidelines for reporting internal and
11 external radiation doses. And in fact, those
12 guidelines were published, as I mentioned
13 before, in the Code of Federal Regulations.
14 Congress has continued to be legislatively
15 active in responding to nuclear test
16 participants' concerns.
17 Similarly, DoD's NTPR program has been active
18 in addressing veterans' concerns. NTPR has
19 sponsored or cosponsored over eight National
20 Academy of Science studies involving human
21 radiation effects. The most recent study that
22 we cosponsored, along with the Nuclear
23 Regulatory Commission, the Environmental
24 Protection Agency, the Department of Energy and
25 the Department of Homeland Security, was this

1 Biological Effects of Ionizing Radiation Part
2 VII that was just published in 2005.

3 Veterans have also actively participated in
4 some of these studies. For instance, one
5 group, the National Association of Atomic
6 Veterans, contributed medical survey
7 information in the National Academy of
8 Sciences/Institute of Medicine CROSSROADS
9 mortality study in 1996.

10 My program, the NTPR, has published over 68
11 historical technical reports. These, when they
12 were published, were distributed to a number of
13 libraries and other Federal institutions across
14 the country. I'm in the process of putting the
15 remainder number of these documents on the
16 internet. We have a specific site, an NTPR
17 link to our DTRA web site where all these
18 documents will be publicly available.

19 In addition, there was a -- among those 68
20 documents, 41 were a volume history of test
21 series, and the remainder are technical
22 reports.

23 The NTPR has also declassified over 1,000
24 publications containing information pertinent
25 to the personnel aspects of the U.S.

1 atmospheric nuclear tests. This information
2 currently resides at our own library in Reston,
3 Virginia. And the public is certainly welcome
4 to come. We'd ask just for a phone call to
5 make sure that we're available for you.

6 It also exists at the National Technical
7 Information Service in northern Virginia; and
8 finally, the Department of Energy's Nuclear
9 Test Archive in Nevada.

10 As I mentioned before, in the early days and
11 later on with nuclear weapons tests, the Atomic
12 Energy Commission led that effort where
13 Department of Defense contributed. Well, when
14 we looked to combine all those records, they
15 have now been combined out at Las Vegas, Nevada
16 at the DOE's Nuclear Test Archive. That's
17 jointly funded by both the Department of Energy
18 and the Department of Defense.

19 Since its inception the NTPR program has
20 received over 80,000 phone calls on its toll-
21 free telephone line, and released over 210,000
22 correspondence actions on former -- on
23 Department of Defense letterhead back to a
24 number of personnel and agencies.

25 Moving on to recent events, the Green Book, as

1 it's known, was a National Academy of Science
2 study published in May of 2003. This study had
3 a major impact on my program. In implementing
4 the eight NAS recommendations, we've been
5 challenged. I'd like to briefly discuss those
6 eight recommendations.

7 The first one was to establish an independent
8 advisory board for external review and
9 oversight, and Congress got involved and passed
10 a public law, and that's one reason we're here
11 today.

12 On the second item, re-evaluate methods used to
13 estimate doses and their uncertainties to
14 establish more credible upper bounds. That --
15 that has proved technically challenging. We've
16 tried to implement many of these concepts in
17 our policy and guidance manual, but it's still
18 an ongoing action.

19 Number three, develop and maintain a
20 comprehensive manual of standard operating
21 procedures. I believe we've moved fairly
22 effectively into that arena, but there still
23 remains to be work done there.

24 Four, develop and implement a state-of-the-art
25 quality assurance/quality control program.

1 I'll discuss a little later today, but we went
2 through an ISO-9001 certification process to
3 answer that recommendation.

4 Recommendation number five was to apply benefit
5 of the doubt consistently. We have tried to
6 put that in -- in place through our policies
7 and guidance manual, and I believe at this time
8 we have done that. But we look forward, for
9 instance, to this Board's review on how we are
10 implementing that.

11 Number six, improve interaction and
12 communication with the atomic veterans. That's
13 an ongoing action. We have been working on
14 getting the inf-- our information much more
15 publicly available. Yesterday I spoke at one
16 of the veterans' groups that was holding a
17 meeting here. We're updating our information
18 sheets, but one of the functions the Board can
19 help is in that interaction and communications.

20 Number seven, establish more effective
21 approaches to communicate the meaning of
22 radiation risk to veterans. Provide
23 information to veterans on the significance of
24 their doses and in relation to their diseases.
25 That's also an ongoing action.

1 And finally, number eight, advise atomic
2 veterans and their survivors when methods of
3 calculating doses have changed so they can ask
4 for updated dose assessments. That occurred
5 initially after the National Academy of Science
6 study when the VA went through the records and
7 sent back to us a number of dose
8 reconstructions to -- to perform once again.
9 We notified the veterans what was going on, the
10 veterans affected, and we're in the process of
11 still redoing some of those dose
12 reconstructions under the new methodologies
13 proposed through the National Academy of
14 Sciences.

15 So in summary, the impact of the
16 recommendations. When that study came out, we
17 basically shut down for a number of months to
18 reorganize ourselves and redo our procedures.
19 That shut-down occurred between May and October
20 of 2003, so we didn't get back on line until
21 about November of 2003 on doing dose
22 reconstructions.

23 In addition, over that last quarter of 2003 the
24 Department of Veterans Affairs returned over
25 1,000 dose reconstruction cases to us.

1 Our challenge is, this has created a backlog.
2 The National Academy of Science
3 recommendations, as I'll describe a little
4 later, have forced us to lengthen our process
5 in performing this. There is a lot more
6 interaction with veterans. And one of the
7 challenges I currently have is how do I reduce
8 this backlog.

9 Two ways that procedure was lengthened I'd like
10 to summarize. One was to include a lot more
11 communication with the veteran. We introduced
12 a new step. It was known as the Scenario of
13 Participation and Radiation Exposure, which we
14 call the SPARE. There we go back and forth and
15 communicate with the veteran, first with a
16 questionnaire. And based on that input and
17 some telephone calls, we work up the SPARE of
18 where the veteran was during -- when the
19 radiation exposure event occurred. Could he
20 have been in -- he or she have been in --
21 inhaled certain radionuclides, ingested certain
22 radionuclides, where he could have been --
23 received external/internal radiation. We get
24 all that input. We send it back to the
25 veteran. The veteran signs off on it. It

1 comes back and then we move into the next step.
2 The next step is this final Radiation Dose
3 Assessment. This is the dose reconstruction
4 process, and that's even become a more
5 extensive product. I often look at some of the
6 RDAs that were released now and they look the -
7 - almost the equivalent of certain master's
8 thesis topics -- certain master's theses.
9 What has happened to the timeline? Here I
10 present perhaps our most challenging case, when
11 we do dose reconstructions for a non-
12 presumptive case. And you can see the initial
13 processing's fairly quick. Historical research
14 takes a little period of time, but the dose
15 assessment, primarily the SPARE, is probably
16 where we're sucking up the most -- the maximum
17 period of time in actually doing these. And
18 what we're looking at, are there any ways we
19 can develop a more efficient process. But the
20 bottom line when you look at this typical
21 process -- some are obviously shorter, some are
22 longer -- is a process of about 204 days to do
23 this dose reconstruction.
24 Based on that backlog we've come up with a plan
25 on how we need to get it back to where we were

1 before the Green Book was published. And
2 currently our -- what we have promised to the
3 Under Secretary of the Department of Veterans
4 Affairs is that we hope to -- hope and are
5 aiming to get the backlog back to where we were
6 before by September of 2006. This is based on
7 expectations on what the typical incoming,
8 outgoing and gradual drawdown of our backlog
9 is.

10 To put that in perspective we look at our
11 historical workload over years. That first
12 peak you see over there, what describe as "HRE"
13 on that presentation, is -- was during the --
14 President Clinton's regime where the Secretary
15 of Energy introduced -- was concerned about
16 human radiation experimentation. When that
17 came about, a lot more interest in this program
18 was expressed, a lot more inquiries came in,
19 and our workload spiked.

20 Similarly, when Congress passed some
21 legislation that involved plutonium bioassays
22 for some of our veterans, workload also spiked.
23 And now you see after the Green Book was
24 published -- to the far right on there, the
25 National Academy of Science study -- once again

1 peaked our workload.

2 If we look at that workload typically that's
3 right there now, you'll see in this pie chart
4 that there's a few small parts. One is our
5 support of the Department of Justice. They
6 have a presumptive program. We don't have to
7 provide dose reconstructions to them. We can
8 turn around those inquiries fairly quickly, and
9 so it's not a significant part of our workload.
10 Veterans can come directly to us and ask for
11 information, especially if they want to get
12 priority six health care at the Veterans'
13 hospitals, and so we respond directly back to
14 veterans if they come in.

15 In addition, there's certain -- the VA comes to
16 us on some cases that no -- do not require --
17 their presumptive compensation programs that
18 done require a dose reconstruction. Once
19 again, we can turn those cases around very
20 quickly.

21 Where our challenge lies is when we are
22 required to provide a dose reconstruction. And
23 if you look at that blue, almost half section
24 of the pie, those are cases that came back to
25 us to be redone. That's -- those are VA rework

1 cases that are -- we're still trying to bring
2 that backlog down on. Plus we have new cases
3 coming in from the VA for non-presumptive, that
4 purple wedge right there, where dose is
5 required.

6 Because a number of cancers have been put on
7 the presumptive list, we're primarily dealing
8 with prostate and skin dose cases. And when I
9 say prostate and skin, this is with regard to
10 dose reconstruction.

11 If we look where some historical radiogenic
12 data has come from to how we do this process,
13 the place that our National Academy of Sciences
14 and other groups have looked first have been,
15 because of the -- the large cohort that had
16 received significant acute radiation exposure,
17 was the Japanese survivors of the Hiroshima and
18 Nagasaki atomic bomb explosions.

19 What they have found is about 421 excess deaths
20 -- deaths -- have been determined in a cohort
21 of over 50,000 survivors who had received at
22 least 0.5 rem during the period from 1950 to
23 1990. This -- this number will undoubtedly
24 increase as we continue to look at the data
25 past 1990. 2.4 percent of that group had some

1 significant whole body exposures exceeding 100
2 rem.

3 Looking at the population that we serve,
4 though, in the Nuclear Test Personnel Review
5 program, the doses were lower -- perhaps not
6 surprisingly. That's not to say, though, there
7 weren't veterans that received -- a smaller
8 percentage of them -- that still received
9 significant doses, both external and internal.
10 But the average exposures were smaller than the
11 Hiroshima/Nagasaki Japanese survivors of that
12 group I previously cited.

13 The National Academy of Science pointed out to
14 us that even when we redo these dose
15 reconstructions, it may not change too many
16 cases where the -- at least with the prostate
17 cancers, where there is a great tendency -- and
18 Mr. Pamperin, who will be following me, will
19 discuss some of the statistics in the program -
20 - there is a significant chance that where dose
21 reconstructions can have an impact on Veterans
22 Affairs findings with regards to some skin
23 cancers.

24 Why don't we just measure these results
25 directly, take some type of assay and say

1 measure directly in the human body. We go
2 through a procedure where we use statistics to
3 make these determinations. We cannot say -- we
4 look at a veteran who has a cancer -- whether
5 that cancer is due directly to ionizing
6 radiation or not. We come up with these
7 concepts of probability of causation. It would
8 be great if science allowed us to have
9 biomarkers -- for instance, I show a picture
10 here of my own blood from when I was doing
11 graduate work. That blood was taken -- taken
12 from me, irradiated outside of my body, and I
13 did a staining technique using sister chromatid
14 exchange, and if you look at the presentation
15 where the DNA is dividing between two branches,
16 you'll see that some of those black sides have
17 gone over to the white side. What's happened
18 there is ionizing radiation has hit basically
19 the DNA molecule, and when it's repaired
20 itself, it repaired itself incorrectly.
21 In that same cytogenetics lab where I was doing
22 my work, there was another graduate student who
23 was looking at chemical toxins. She also could
24 see similar effects from chemical toxins as
25 compared to ionizing radiation.

1 One of the challenges in looking at biomarkers
2 are how do you say it's due uniquely to
3 ionizing radiation. That's tough to do right
4 now.

5 In addition, on some of these biomarkers they
6 have a tendency, because these are unstable,
7 and other ones are known as -- for instance --
8 dicentric chromosomal abnormalities. Since
9 they're unstable, they have a tendency to
10 disappear with time from the body, and so going
11 back now and looking at some of our atomic
12 veterans with this type of assay would be
13 challenging 'cause that -- they have decayed
14 away with time.

15 Finally, to produce that particular image, we
16 had to give doses on the order of 25 rads or
17 greater. It's not a very sensitive technique.
18 And so what we end up falling back on is
19 looking at radioepidemiological data in a
20 probabilistic approach instead of taking direct
21 measurements on the human body.

22 If we look at cancer statistics, the leading
23 cause of death in this country is currently
24 heart disease, followed by cancer. The
25 lifetime risk of being diagnosed with cancer,

1 from all causes, is 47 percent for males and 38
2 percent for females. But the lifetime risk of
3 a fatal cancer is significantly smaller. It's
4 24 percent for males and 21 percent for
5 females. And a challenge to all of us as we
6 get older is cancer becomes more probable; 76
7 percent of all cancers are diagnosed in people
8 that are 55 years or older.

9 What are the leading cancers occurring among
10 men? Well, the first one's prostate. The
11 second is lung cancer and the third is
12 colorectal. In the case of women, the first --
13 leading cancer is breast, and dependent upon
14 your race, it's either lung or colorectal being
15 number two and number three.

16 So how do we make these determinations whether
17 diseases that our veterans have come down with
18 are actually due to the radiation exposure they
19 received? We have, and what Congress put into
20 place, was a Veterans' Advisory Committee on
21 Environmental Hazards. This committee came
22 into place in 1985, and its mission is to
23 provide advice to the VA Secretary on adverse
24 health effects that may be associated with
25 exposure to ionizing radiation, and to make

1 recommendations on proposed standards and
2 guidelines regarding the VA benefit claims
3 based upon exposure to ionizing radiation.
4 Just recently they gave some -- some advice
5 that's been adopted. The Veterans' Health
6 Administration has changed their procedures on
7 how they do probability of causation
8 determinations from how -- whether cancer was
9 due to ionizing radiation. And this software
10 is publicly available. It's known as the
11 Interactive RadioEpidemiological Program, or
12 IREP, software.

13 On this slide I show the actual site you can go
14 to on the internet. It's at
15 www.irep.nci.nih.gov. NCI is the National
16 Cancer Institute. Some of the scientists at
17 NCI helped develop the basis for this software
18 that was actually implemented through a
19 contractor down at Oak Ridge known as SENES.

20 A variant to this code, the NIOSH-IREP, is used
21 by the Department of Labor in determining
22 probability of causation for a cancer claim
23 under the Energy Employees Occupational Illness
24 Compensation Act of 2000 that we heard just --
25 the previous presentation about.

1 Previous to this we used some
2 radioepidemiological tables that were
3 published. They were more challenging to use
4 for the -- the health physicists, for instance,
5 that calculated this, or other scientists that
6 calculated the probability of causation. We'd
7 spend quite a bit of time doing Excel
8 spreadsheets. The new software that's on line
9 on the internet has made things easier. But
10 for the typical person going in to use that
11 software, it's still a fairly challenging
12 process.

13 One of the challenges in using that software is
14 deciding what we call probability distribution
15 functions, the associated uncertainty with
16 events. Really it takes an experienced person
17 to make a determination what is the appropriate
18 probability distribution function to use. And
19 so although the software is publicly available
20 and you can drill down through the software to
21 -- to look through the underlying basis for it,
22 usually some experienced personnel is required
23 to assist in actually making a formal
24 determination.

25 This probability of causation, I provide the

1 equation for what I've been talking about.
2 It's basically the risk from radiation in the
3 numerator divided by the risk due to all
4 causes. And when you look at something like
5 this, you can see that it's going to be a
6 number less than one. It's going to be some
7 fraction. And the way that the laws work on
8 making compensation for veterans are that the
9 probability of causation needs to be greater
10 than a 50 percent chance. And so if your PC is
11 greater than 0.5, then the Veterans
12 Administration can determine that that
13 particular cancer is radiogenic and appropriate
14 for compensation.
15 The challenge in doing these determinations are
16 we can't state absolutely whether cancer was
17 radiogenic or not. And I'd like to give an
18 example of why this is a challenge, one that
19 most of us are somewhat familiar with, and that
20 is a lifetime of cigarette smoking.
21 We know that if -- as an individual or a family
22 member smokes continuously, they have a higher
23 chance of developing lung cancer. But it turns
24 out the ability or -- to develop lung cancer
25 from cigarette smoking appears to be a largely

1 random process. Scientific studies of
2 cigarette smoking allow us to state that a
3 lifetime of smoking will increase an
4 individual's risk of developing cancer, but we
5 cannot absolutely state that a particular
6 cancer was derived from smoking. Hence, we are
7 uncertain about the -- concerning the causation
8 of a smoker's lung cancer.

9 This concept of uncertainty is applied in our
10 programs in the favor of the veteran at both
11 DTRA and the VA. Specifically, per 32 -- Title
12 32, Code of Federal Regulations part 218, DTRA
13 determines the veteran's mean dose or average
14 dose, and then assigns a larger dose equal to
15 the 95 percent probability that the actual
16 exposure did not exceed the assigned dose.
17 Similarly, the Veterans' Health Administration
18 uses a 50 percent PC threshold at the 99
19 percent upper confidence level when performing
20 the IREP PC determination.

21 In addition we take into account -- and was
22 brought out by the National Academy of Sciences
23 -- the concept of reasonable doubt. The VA has
24 published this in formal guidance in the Code
25 of Federal Regulations where -- when after

1 careful consideration of all procurable and
2 assembled data, a reasonable doubt arises
3 regarding service origin, the degree of
4 disability or any other point, such doubt will
5 be resolved in the favor of the claimant.
6 On the Department of Defense side, we don't
7 have it in the Code of Federal Regulations, but
8 we do have it in our NTPR policy and guidance
9 manual. And therefore, when questions come
10 up, we'll do our best to try and understand
11 them, but ultimately if we can't determine, for
12 instance -- let's take the example whether our
13 veteran's at a certain site, and data may have
14 been destroyed in a fire that occurred years
15 ago at the National Personnel Records Center,
16 it's our policy then to state, based on our
17 best research, even though we can't validate
18 it, that the veteran was actually at that site.
19 I'm going to discuss in a future presentation
20 the impact of the public law that came about in
21 2003, so at this point I'd like to just mention
22 and conclude what my road ahead for my program.
23 My number one priority is serving the veterans.
24 My program staff and I are continually striving
25 to identify new ways to reduce the time

1 necessary to complete dose reconstructions.
2 And finally, I look forward to this Board's
3 input and assistance in improving our program.

4 **ADMIRAL ZIMBLE:** Thank you very much, Dr.
5 Blake. We've got your remarks on the record,
6 and -- and they'll be in the transcript, and
7 that's very, very important.

8 Any comments or questions from the Board?
9 None? Yes, John Boice.

10 **DR. BOICE:** John Boice. I was just curious,
11 you had mentioned 400,000 atomic veterans or
12 participants that are in your database, and I
13 was wondering what -- is there a major source
14 of data on how that was collected, how that was
15 actually obtained? And the follow-- and the
16 follow-up is, did -- have you accessed any of
17 the epidemiologic investigations, such as at
18 SMOKY and the five series and HARDTACK where
19 the participants had been identified by the
20 National Academy and others.

21 **DR. BLAKE:** One, the number is greater than
22 400,000 in our databases. Two, how we
23 collected that information, a lot of it was in
24 the early parts of the program where we send
25 out questionnaires and try to track down the

1 personnel. In addition, where we have -- and
2 I'll discuss in some of my future talks -- all
3 the information that we collect from different
4 groups. We get morning reports. We get unit
5 histories, et cetera. We have a lot of
6 documentation that -- the military was
7 excellent in keeping documentation in those
8 years where we could find participants and list
9 -- of those 400,000 veterans plus that are in
10 our database, we've only formally communicated
11 with about 65,000 of them, with letters and
12 phone calls going back and forth. So we have a
13 num-- a lot listed that we necessarily haven't
14 communicated with directly.

15 With regard to those -- some of those National
16 Academy of Science studies, we provided the
17 input data to a number of those through our
18 databases. But perhaps there are other places
19 we could capture some information there, too,
20 and I appreciate the comments.

21 **ADMIRAL ZIMBLE:** Okay. Dr. Blake, I'm going to
22 congratulate you for completing your
23 presentation exactly when it's time to take a
24 break. So thank you, and with that, let's take
25 a 15-minute break. And Dr. Vaughan, you can --

1 **DR. VAUGHAN:** Yes.

2 **ADMIRAL ZIMBLE:** -- you can relax for 15
3 minutes --

4 **DR. VAUGHAN:** Okay.

5 **ADMIRAL ZIMBLE:** -- and we'll start again at
6 3:00 o'clock.

7 **DR. VAUGHAN:** Okay, and I'll call back in --

8 **ADMIRAL ZIMBLE:** 12:00 o'clock your time, Dr.
9 Vaughan.

10 **DR. VAUGHAN:** Yes, I'll call back in.

11 **ADMIRAL ZIMBLE:** Okay.

12 **DR. VAUGHAN:** Okay. Thank you very much.

13 (Whereupon, a recess was taken from 2:45 p.m.
14 to 3:03 p.m.)

15 **ADMIRAL ZIMBLE:** I'm going to get started, it's
16 past 3:00 o'clock. Elaine? Dr. Vaughan?

17 **DR. VAUGHAN:** Yes, I'm here.

18 **ADMIRAL ZIMBLE:** Okay, good. Just want to make
19 sure you're here, and our Board members are
20 coming back.

21 CURRENT STATUS OF VA RADIATION CLAIMS COMPENSATION

22 PROGRAM FOR VETERANS

23 MR. THOMAS PAMPERIN

24 **ADMIRAL ZIMBLE:** We're now going to hear from
25 Mr. Tom Pamperin, who is -- who is here to give

1 us all the expertise we need to be able to
2 follow the claims process from the VA and to
3 learn of the VA experience so far. Mr.
4 Pamperin.

5 **MR. PAMPERIN:** Thank you, Admiral. Good
6 afternoon, everyone. I'm going to give you a
7 little intro-- based upon some questions that
8 occurred earlier in the day, I realized that
9 perhaps I should have had a couple of earlier
10 slides to put this whole thing in context about
11 VA disability compensation, what it is, how big
12 is it, and that sort of thing. So the -- the
13 Department of Veterans Affairs, Veterans'
14 Benefits Administration, administers all the
15 non-medical benefits, including insurance, home
16 loan guarantee, education, vocational
17 rehabilitation and employment, and what is
18 called compensation and pension.
19 Compensation is a monetary payment for an
20 injury or disease that is incurred during
21 active duty. So it does not mean "caused by,"
22 but "coincident with." Pension is a needs-
23 based program for wartime veterans, and we
24 won't talk about that. But the Compensation
25 and Pension Service is the one that administers

1 those programs.

2 VA currently pays 3.4 million veterans and

3 survivors compensation and pension. Of that

4 number, 2.6 million receive disability

5 compensation. That's up 300,000 in the last

6 five years. We pay compensation at 10 percent

7 increments. You can be service connected for a

8 disability at the zero, one -- or ten, 20, 30,

9 40 through 100 percent. Individual

10 disabilities have specific assignments. For

11 example, migraine headaches cannot be rated

12 higher than 50 percent. Amputations of a lower

13 leg, below the knee, are 40 percent; above the

14 knee, 60 percent; at the girdle muscle, 80 or

15 90 percent, depending upon those -- those kinds

16 of things.

17 A ten percent disability pays you \$108. A 100

18 percent disability for a veteran with no

19 dependents is \$2,293. Beyond that, we can pay

20 what is called special monthly compensation for

21 very seriously disabled people, people who've

22 lost bowel and bladder control, have lost -- or

23 loss of use of limbs, eyes and -- and hearing.

24 The maximum that a veteran -- a single veteran

25 can receive is almost \$7,000 a month, which is

1 for people who have lost both arms, both legs,
2 bowel and bladder. And we have a few of those
3 from Iraq.

4 This year, VBA, Veterans' Benefits
5 Administration, will spend \$31 billion. Of
6 that amount of money, \$27 billion will be in
7 compensation. We also pay -- although we talk
8 about the 400,000 people who were at nuclear
9 tests or Nagasaki, even though that is an aging
10 population, to the extent to which service
11 connection is granted for disabilities and
12 those disabilities contribute to the veteran's
13 death, their survivors can get dependency
14 indemnity compensation, which is a payment
15 that's currently about \$1,000.

16 With specific respect to radiation cancers, we
17 rate cancer one of two ways. You are either
18 zero percent -- for example, you had prostate
19 cancer, you had the prostate removed, you
20 didn't have any other residual effects -- which
21 is unlikely, but say you didn't, you'd be zero
22 percent. If you have active cancer, you are
23 100 percent, by schedule, and you would qualify
24 for the \$2,293.

25 What does that get a veteran? It gets them

1 Category One status in Veteran's Health Care.
2 It gets them vocational rehabilitation and
3 employment, which is in an -- maybe older
4 veterans wouldn't use it, but younger veterans,
5 we will pay -- if -- if you want to be a
6 taxidermist, we will pay for that. If you want
7 to be a doctor and go to Johns Hopkins, we will
8 pay for that, based -- if you're in vocational
9 rehabilitation. It provides CHAMPVA, which is
10 similar to CHAMPUS or Tri-Care, for non-
11 military retirees. It's a health care
12 insurance program for the families of veterans.
13 And we provide an opportunity to have health
14 insuran-- or life insurance which they would
15 not -- which a veteran might not otherwise
16 qualify for in the private sector because of
17 their service-connected disabilities.
18 No, I don't have a slide on this. I was just
19 trying to put this up here.
20 Now what kind of a workload does VBA have, or
21 our compensation have? We have 7,200 employees
22 in 57 regional offices in 140 military
23 installations in the United States, as well as
24 in Germany and Korea. We will, this fiscal
25 year, receive 800,000 claims for either initial

1 or claims for increased disability. We will
2 process 2.1 million awards overall. This
3 includes things like adding and taking off
4 dependents, other kinds of things of all types.
5 We will answer 300,000 letters unrelated to a
6 specific claim, and we will take 6.4 million
7 phone calls from veterans regarding their
8 claims.

9 As of Monday, we had 524,000 pending disability
10 claims in the inventory. Of that number, 18
11 percent were over six months old. A smaller
12 percent were more than a year old. Virtually
13 all of the cases that are over a year old are
14 reconstructed dose cases.

15 In addition to those 524,000 we have 152,000
16 pending appeals, and we have 123,000 other
17 award actions pending, for a total of just
18 under 700,000 cases pending as of Monday, so
19 it's fairly busy.

20 Now -- okay, you've got to be ten percent
21 smarter than the box. Okay.

22 (Pause)

23 Regional Office claims processing overview.
24 Admiral Dan Cooper, who is the Under Secretary
25 for benefits, held a -- was the chairman of the

1 commission that looked at our process, and then
2 he got roped into being Under Secretary after
3 he described how to solve the problem, and we
4 reorganized into what's called a CPI model.
5 There are six discrete steps in that model. By
6 going to the model we dropped our pending
7 inventory by over 300,000 cases in two years
8 and cut processing time by about 75 days, so
9 things were going quite well until we had a
10 couple of court reversals.
11 Now one of the things that you have to
12 understand about VA, and it's fairly unique, is
13 in Title 38 the Secretary of Veterans Affairs
14 is not only charged with being the administer
15 of these programs, but he is also charged with
16 being the veterans' advocate. And under the
17 Veterans' Claims Assistance Act we are
18 specifically charged with assisting all
19 veterans in proving their claims. We will go
20 get any government records that are needed,
21 conduct any exams that are needed, get any
22 medical opinions that are needed, and we will
23 help a veteran get private medical records.
24 However, we don't guarantee success there.
25 Frequently doctors will not -- will either want

1 a fee or something, and then it's on the vets'
2 dime to go get that kind of thing.
3 When we get a claim, we put the claim into
4 what's called triage. Triage is an
5 organization that puts claims under control.
6 Our objective is to get all claims under
7 control so that the entire system knows that
8 they exist within seven days -- seven calendar
9 days of receiving them. They do a lot of very
10 quick things -- notices of death, for example.
11 We want to stop payments as quickly as
12 possible, so -- and that's a fair way, simple
13 award. They take care of very, very simple
14 awards.
15 The predetermination team is responsible for
16 the development of all rating-related issues.
17 The pre-D team is the team that will send a
18 veteran with a radiation risk activity claim
19 the letter asking them to specifically
20 described where they were, did they move toward
21 ground zero, you know, did they have a film
22 badge, all that kind of stuff. And they are
23 the team that will order examinations, medical
24 opinions, attempt to get private records. And
25 they are the team that will prepare the letter

1 to DTRA requesting a reconstructed dose.
2 The rating team is the team that actually does
3 disability determination. The VA and DoD use
4 the VA schedule for rating disabilities. It is
5 Part 4 of Title 38. We divide the human body
6 into 13 body systems, and we have just under
7 800 diagnostic codes that we use that can cover
8 the whole range of disability. Even if -- even
9 if a specific disability isn't covered in our
10 diagnostic codes, if it's like something else,
11 we will write it under the same criteria.
12 The post-determination team actually implements
13 the rating, prepares the award notification and
14 things of that nature. The appeals team
15 handles all the appeal activity.
16 And the public contact team handles our
17 guardianship activity. We have about 120,000
18 beneficiaries who, either due to minority or to
19 mental or physical impairment, cannot handle
20 their own estates and we manage that for them.
21 And they are also the people who do -- answer
22 the phones, do public interviews in our
23 regional offices and attend stand-downs or
24 state fairs or whatever to get the word out
25 about our VA benefits.

1 Okay. I'm really having a time here. Could we
2 go to the next one? Okay.

3 What happens when -- when we get a radiation-
4 related claim? It's received from a regional
5 office after the regional office has developed
6 the claim. And it's -- it comes to a member of
7 my staff for review and referral to DTRA. Now
8 sometimes the field sends them to DTRA without
9 sending on to us first, and I can tell you that
10 of those that are sent to us, we send back
11 about a third of them to the regional office
12 saying you need to do more work; this isn't
13 ready yet. We review the claim for
14 completeness and when DTRA provides a -- a
15 reconstructed dose estimate, we send that to
16 the environmental -- Office of Environmental
17 Health in VHA where Dr. Neil Otchin uses the
18 IREP models based upon the doses that are
19 provided by DTRA to give us a medical opinion
20 as to whether or not the veteran's condition is
21 as likely as not related to radiation.

22 If that comes back in the affirmative, we
23 return the -- it to the regional office and
24 tell them to award benefits. If it comes back
25 in the negative, we tell them to deny.

1 Virtually all claims that we get back from DTRA
2 are negative and are -- are denials.
3 Okay. We have two ionizing radiation
4 regulations, Public Law 98-542, Veterans'
5 Dioxin and Radiation, which you've heard of
6 before, created the -- the ability to service
7 connect radiation to diseases based upon
8 reconstructed doses. Over time, virtually all
9 of the disabilities that are identified in the
10 implementing regulation, 3.311, have been moved
11 to 3.309, which is the presumptive condition.
12 The major disabilities, as was previously
13 stated, that are still outstanding are prostate
14 and skin cancer. However, 3.311 also has as
15 its very last item "and any other cancer", so
16 again, we are mostly talking about skin and
17 prostate here. 3.309 are the conditions that
18 we ask DTRA to merely verify presence at a test
19 or at Nagasaki, unless there is evidence
20 already in the file which would document that.
21 To the extent that you have a 3.309 disability
22 and we verify attendance, it's a grant.
23 We have again three -- and just to -- to go
24 back, I -- we have three different categories
25 of radiation, and I think it's important to

1 recognize that there are three. The first is
2 the occupation of Hiroshima and Nagasaki, the
3 other's atmospheric tests, and the third is
4 occupational exposure. We do get a fair number
5 of occupational exposure claims. These are
6 from people who were X-ray technicians in World
7 War II, nuclear submariners, people who are
8 concerned about depleted uranium, and veterans
9 who -- are typically Air Force veterans who
10 were not at nuclear tests, but who were part of
11 the air crew maintenance function when the --
12 when the planes came back, either from tests or
13 from the monitoring principally of Chinese
14 nuclear tests along the California coast back
15 in the '70s that -- the Air Force flew along
16 the coast picking up the radiation particulate
17 that was coming over from the Chinese tests.
18 We get some of those.

19 In a normal year we will send about 600 cases
20 to DTRA for a reconstructed dose. As was said
21 earlier, we sent 1,200 cases as a result of the
22 review that was done based upon the NRC study
23 in 2003. In 2003 Secretary Principi committed
24 to a full and complete review of all radiation
25 cases that had previously been decided. We

1 used databases that we had and databases that
2 DTRA had and identified just over 15,000 cases.
3 To the extent that the veteran was alive or, if
4 the veteran was deceased, there was a surviving
5 spouse, and wherever the veteran was deceased
6 we queried Social Security records to determine
7 whether or not there was somebody getting
8 survivor benefits. From that process we
9 identified 1,200 cases that we felt needed to
10 have reconstructed doses, and we identified an
11 additional almost 60 cases that had been
12 previously denied as 3.311 cases, usually lung
13 cancer, where those kinds of disabilities had
14 migrated to 3.309 and then we could therefore
15 grant them.

16 Yes, sir?

17 **COLONEL TAYLOR:** I regret interrupting, but
18 what percentage were you talking about? When
19 you said 1,200, what percentage --

20 **MR. PAMPERIN:** It was out of 15,000, so it was
21 maybe about -- what is that, nine percent?

22 **COLONEL TAYLOR:** Around ten percent --

23 **MR. PAMPERIN:** Yeah.

24 **COLONEL TAYLOR:** -- is what you're looking at.

25 **MR. PAMPERIN:** Right.

1 **COLONEL TAYLOR:** Getting an idea of what...

2 **MR. PAMPERIN:** But again, even as the NRC
3 report indicated when they conducted their
4 review of DTRA, they estimated that perhaps no
5 more than 50 additional people may conceivably
6 get granted service connection because of the
7 reconstructed dose.

8 Okay. There -- so then we also have the
9 occupational. And again, the -- the point
10 there is that radiation-related cases continue
11 even after the veteran dies. We get claims
12 from widows and put -- you know, we go through
13 the same process.

14 What is our development process? We determine
15 what specific disability is claimed. If the
16 disability is not one listed in 309 or 311, we
17 will ask for medical evidence, get service
18 medical records to see if we can grant service
19 connection on a direct basis. In order to be
20 granted service connection on a direct basis
21 there would have to be medical evidence that
22 the diagnosis or the symptoms occurred while
23 they were on active duty.

24 If the disability is listed in 309 or 311, we
25 take the following development action. First

1 of all we obtain all the medical evidence
2 that's available, and we obtain verification of
3 participation. Now if we get that and it's a
4 309, we just -- we get an examination, we find
5 out what the current residuals are and we would
6 then service-connect those.

7 For example, as I told you, a cancer is either
8 zero or 100 percent. However, if you have a
9 cancer that then causes other things, if you
10 had prostate cancer and because of that you had
11 a prostatectomy and now you have erectile
12 dysfunction and you have leakage and loss of
13 some bladder control, all of those things would
14 be service connected, as well.

15 The 3.311 disabilities, we obtain the medical
16 evidence, we send out our development letter.
17 We contact the branch for exposure. The field
18 gets in touch with us. We contact DTRA, we get
19 a reconstructed dose. We send it to VHA where
20 they apply the IREP model to it and they give
21 us an answer and we decide the case based on
22 that.

23 Okay. The most important point from a VA
24 perspective is that the upper ingested dose was
25 underestimated. The -- the NRC report

1 indicated that there was high confidence in the
2 overall and -- rate, but because we apply the
3 IREP model to the upper ingested dose at the 99
4 percent confidence level, that's really the
5 only number we're really interested in.
6 Okay. We had 11,000 cases. The 1,250 were
7 returned to the DTRA. There are handouts in
8 the back that show, as of last Monday, what the
9 current status is; that of the 12,000 -- 1,250
10 that were sent, we are still waiting answers on
11 1,062. These are the -- these are the re-
12 adjudications.
13 In addition to that, the normal radiation
14 claims that we would anticipate, and I believe
15 that number currently is about 2,000 that are
16 at DTRA overall.
17 That's in summary what -- what VA does with
18 radiation. It is a -- it's a complex issue
19 that I will tell you, my impression is that
20 because the claims are relatively small and we
21 get 800,000 disability claims a year, we -- our
22 initial efforts in the field to develop them
23 are usually inadequate and they need additional
24 instruction. We intervene in a lot of these
25 cases. And they -- they take a long time --

1 even without considering our interaction with
2 DTRA, because they are so rare, people I think
3 are hesitant to -- not sure, even though there
4 is instructions in the -- in the manual about
5 how to do this.

6 **ADMIRAL ZIMBLE:** Thank you very much, Mr.
7 Pamperin. That's an excellent presentation,
8 helps put things in perspective. I of course
9 have a question.

10 **MR. PAMPERIN:** Yes, sir.

11 **ADMIRAL ZIMBLE:** I learned just recently of the
12 existence of the ionization radiation registry.

13 **MR. PAMPERIN:** Right.

14 **ADMIRAL ZIMBLE:** Can you elucidate a little bit
15 on -- on what it takes to get into the registry
16 and what that -- and what that provides for the
17 veteran?

18 **MR. PAMPERIN:** What that involves is contacting
19 your local VA medical center. It is a registry
20 that is a Veterans' Health Administration
21 registry where they track people. I believe if
22 you identify yourself they will call you in for
23 an examination -- we have a number of these
24 kinds of registries -- to get a baseline health
25 profile. They are not something that normally

1 in a regional office have much significance to
2 us. I think the thing that's important for
3 veterans to understand is that requesting to be
4 placed on an ionizing radiation registry does
5 not constitute a claim with the VA, so you have
6 to contact us and say that you believe you have
7 a radiation-related risk activity. Once we
8 have that -- to the extent that we might need
9 the -- any records generated from that from
10 VHA, those records will be automatically part
11 of our routine development.

12 **ADMIRAL ZIMBLE:** And someone that's in the
13 registry -- first of all, someone who has a 100
14 percent disability from the VBA will
15 automatically be placed in Category One for
16 health care. Is there any increase in the
17 category or any category nomination for those
18 who are in the registry? I'm sorry, I'm asking
19 -- I'm asking VHA questions, I understand it --

20 **MR. PAMPERIN:** If there -- if they are, they
21 are most likely Category Seven or Six. But
22 again in -- in -- what the categories are -- we
23 have eight categories in Veterans' Health
24 Administration for primacy of care. Two years
25 ago Secretary Principi discontinued enrollment

1 of Category Eight veterans, who are veterans
2 who are not service-connected who have
3 substantial needs, because the -- because of
4 the growth and the strain on the system. In --
5 five, ten years ago, Veterans' Health
6 Administration would say that at any given time
7 they had 3 million veterans participating in
8 health care, and over a 3-year period they
9 would have 6 million unique veterans whom they
10 had served. We now have an enrollment of about
11 6 and a quarter million. The Secretary found
12 it necessary to cut off the Category Eights
13 because, quite frankly, about a quarter of all
14 the people who are enrolled in veterans' health
15 are there for pharmacy only, because we are the
16 best drug deal in town. Currently it's \$7 a
17 'scrip, whatever it is, and it's no dollars a
18 'scrip if it's for a service-connected
19 condition.

20 **ADMIRAL ZIMBLE:** Okay, thank -- thank you very
21 -- any other questions from the Board? Dr.
22 (sic) Groves.

23 **MR. GROVES:** Thank you very much for the talk.
24 I guess I'd like to go back to where we talk
25 about what it is that the veterans get if you

1 have a cancer that is determined to be related
2 to activity as -- as an atomic veteran. And
3 you talked about that there is a -- a 100
4 percent disability which gets you Category One
5 status in a VA hospital, vocational training if
6 that is something that you wanted; CHAMPVA,
7 which I think you said includes both the
8 veteran and their family --

9 **MR. PAMPERIN:** It doesn't include the veteran
10 because the veteran gets their health care
11 through VHA or through fee-basis protocols.
12 But by statute, we don't have the capacity to
13 admit family members to veterans' health, so we
14 give them an insurance policy.

15 **MR. GROVES:** Okay. And then there's -- I think
16 the fourth that you mentioned was a life
17 insurance policy.

18 **MR. PAMPERIN:** Right.

19 **MR. GROVES:** You also mentioned that if it was
20 a survivor, that there was a dependency
21 indemnity compensation, DIC.

22 **MR. PAMPERIN:** Right.

23 **MR. GROVES:** Is -- does the veteran themselves
24 get any monetary award as -- as a part of this
25 determination?

1 **MR. PAMPERIN:** Yes, the veteran -- a veteran
2 who is 100 percent disabled -- if it's just
3 him, he doesn't have a wife or kids -- because
4 any veteran who is rated 30 percent or more
5 gets an additional allowance for dependents.
6 But a single veteran rated 100 percent gets
7 \$2,293 a month from us.

8 **MR. GROVES:** Now that is independent of rank or
9 years of service --

10 **MR. PAMPERIN:** Yes.

11 **MR. GROVES:** -- that is a -- okay, so it's a
12 fixed amount?

13 **MR. PAMPERIN:** It's a fixed amount and it is
14 independent of whether or not they're getting
15 Social Security or whether or not they are
16 working.

17 **MR. GROVES:** It is not independent at this
18 point, however, of if they are drawing retired
19 pay?

20 **ADMIRAL ZIMBLE:** Except 100 percent.

21 **MR. GROVES:** Except the fact that being 100
22 percent disabled means that you don't pay
23 income tax, from an over-simplification.

24 **MR. PAMPERIN:** If you are a military retiree --
25 this is another one of my programs -- there are

1 two programs that are available to longevity
2 retirees that will enable them to have restored
3 some or all of their compen-- their retired pay
4 that was waived to receive compensation. If --
5 if you are a radiation veteran, I -- not a
6 radiation technician -- an X-ray technician,
7 but if you were at a nuclear test, you are
8 eligible for what is called combat-related
9 special compensation, which is a -- a program -
10 - you have to apply to your individual branch
11 and there are -- they rate each condition that
12 the VA has granted service connection for, and
13 determine whether or not and which ones of
14 those conditions are (a), as the result of --
15 you had a Purple Heart awarded for it; they
16 occurred while you were in combat, even if you
17 did -- you fell in a trench and, you know,
18 ripped a muscle or something; you were
19 participating in activity simulating combat,
20 such as war games, confidence courses,
21 leadership courses -- but not PT; if you were
22 engaged in hazardous duty, which is generally
23 flying airplanes, jumping out of airplanes, EOD
24 and deep-sea diving; or as a re-- your
25 condition is as a result of an instrumentality

1 of war. And for radiation veterans, because
2 they were exposed to a nuclear explosion,
3 that's an instrumentality of war, and
4 regardless of the level of disability that is
5 assigned for that particular condition, you get
6 automatic restoration of that part of your
7 retired pay.

8 Now concurrent disability and retired pay,
9 what's referred to as CDRP, is the program that
10 only restores retired pay to longevity retirees
11 who are rated 50 percent or more by VA. The
12 advantage to CDRP is that it doesn't matter
13 what the disability is. The advantage of --
14 there are a couple of advantages of CRS and a
15 couple of advantages of CRSC. The first of
16 those are there is no ten-year phase-in. You
17 get the full thing right away. Secondly, it is
18 tax exempt. And thirdly, for those for whom it
19 matters, it's not subject to former spouse
20 subdivision.

21 **MR. GROVES:** One more question, just to close
22 this issue, is -- well, I'll let -- I'll let
23 some other people ask some questions.

24 **MR. PAMPERIN:** Okay.

25 **MR. GROVES:** Thank you.

1 **ADMIRAL ZIMBLE:** Okay, any more questions? All
2 right. Again, thank you very much, Tom. Oop,
3 okay.

4 **DR. ZEMAN:** I'll try to get closer to the
5 microphone. There we go. My name is Gary
6 Zeman and I thank you for your presentation. I
7 -- I have difficulty formulating my question,
8 but let me ask it this way.
9 Most of the dose reconstruction cases that
10 you're currently -- that you send to DTRA and
11 are waiting for answers, that was on the order,
12 I understand now, about two-thirds or more are
13 skin cancer or prostate cancer. If those were
14 approved on the basis of dose and probability
15 of causation, then the question is how is the
16 rating, what is the percent disability rating
17 for those cases? And I know you can't
18 generalize and give one answer, but could you
19 kind of describe in general how those ratings
20 go for skin cancer and how those ratings go for
21 prostate cancer?

22 **MR. PAMPERIN:** Skin can-- let's take prostate
23 cancer first. Prostate cancer, if you have
24 active disease or are under active treatment,
25 to include watchful waiting, you are 100

1 percent disabled. So whether you're active --
2 you're watchful waiting, seed implants or
3 anything else like that, you're 100 percent.
4 If you've had surgery and you no longer have
5 active cancer, your prostate cancer would still
6 be service-connected, but it would be
7 considered zero percent disabling. But any
8 residuals that you might have of that -- a
9 weakened bladder, erectile dysfunction,
10 scarring from radiation -- all of those things
11 would be service-connected and would -- you
12 know, we have -- for the genitourinary schedule
13 we would look at what those things would
14 qualify for.

15 With skin cancer, again, the -- the issue is
16 whether or not you have active cancer. Now if
17 you've had cancer that has been removed, then
18 again, you are zero percent for the skin
19 cancer. And what is most likely to end up
20 being service-connected and potentially
21 compensated for would be any scarring that may
22 have occurred because of the surgery to remove
23 the lymphoma.

24 Now normally speaking, with respect to skin
25 scarring, we evaluate that on basically three

1 criteria. The first is on visibility. Is it
2 in the head and shoulders, exposed parts of the
3 body so that others can see it. The second is
4 whether or not -- and the size of the scarring,
5 and it -- sometimes the scarring can impair
6 muscle movement and things like that. And the
7 third thing that we consider is whether or not
8 the scar is tender. If it is tender to the
9 touch, you get additional -- you will get ten
10 percent at least for that.

11 **ADMIRAL ZIMBLE:** All right. Thank you.
12 Anything else, Doctor?

13 **DR. ZEMAN:** Yes, may I follow up on that,
14 please?

15 **ADMIRAL ZIMBLE:** Sure.

16 **DR. ZEMAN:** Given the delays in the dose
17 reconstruction process, would it be feasible to
18 make these determinations on percent disability
19 either concurrently or beforehand so that, for
20 example, if someone were eligible only for zero
21 percent disability, that would render the dose
22 reconstruction moot and -- and greatly shorten
23 the process.

24 **MR. PAMPERIN:** No. That's a -- that's an
25 interesting concept, and -- but you have to

1 understand the -- if we make the determination
2 that the condition is -- well, you -- okay, if
3 we just did a hypothetical, if this were
4 service-connected, this would be zero, I don't
5 know what that would get you. Because the
6 underlying issue isn't so much whether or not
7 the veteran gets money today, but if he or she
8 dies from that whether or not DIC is now
9 payable. So I think it's the downstream issues
10 that accrue from service connection that make
11 that an important issue.

12 **ADMIRAL ZIMBLE:** Okay. Thank you again. And
13 now it's time, Dr. Blake, for an encore.

14 DOSE RECONSTRUCTION AND VETERANS COMMUNICATION ACTIVITIES
15 DR. PAUL BLAKE

16 **DR. BLAKE:** What I'd like to cover in the next
17 25 minutes is basically where I left off at the
18 last time. I'd like to jump into Public Law
19 108-183, the reason we're here today, then move
20 into the Department of Veterans Affairs and
21 Department of Defense's joint report to
22 Congress. Then I'd like to talk about our
23 current workload, what's pending and where
24 we're going.

25 Public Law 108-183 was enacted in December --

1 excuse me -- in December, 2003. Subsequent to
2 reviews by the General Accounting Office and
3 National Academy of Sciences, this law was put
4 in place. It required the Secretaries of
5 Defense and the Veterans Affairs to jointly
6 conduct a review of the mission, procedures and
7 administration of the dose reconstruction
8 program. It also ensured an ongoing
9 independent review and oversight, including the
10 establishment of this Advisory Board.
11 In the joint review it said determine whether
12 additional actions are required to ensure that
13 quality assurance and quality control
14 mechanisms are adequate and sufficient.
15 It also said determine actions required to
16 ensure that mechanisms for communication and
17 interaction with veterans are adequate and
18 sufficient, including mechanisms to permit
19 veterans to review assumptions utilized in
20 their dose reconstructions.
21 Convey those results of the joint review.
22 Include a plan of required actions. This is
23 under this joint report to Congress.
24 Other recommendations for improvement of the
25 mission, procedures and administration of the

1 dose reconstruction program, as jointly
2 considered appropriate by the Secretaries of
3 Defense and Veterans Affairs.

4 In addition, the requirements for the Advisory
5 Board were to review and provide oversight of
6 the dose reconstruction program.

7 As we earlier discussed, the Board had to be
8 composed of at least one expert in historical
9 dose reconstruction; at least one expert in
10 radiation health matters; at least one expert
11 in risk communication matters; one
12 representative from DTRA and the VA; at least
13 three members, including at least one who is a
14 member of an atomic veterans group.

15 The Board was asked to conduct periodic, random
16 audits of dose reconstructions performed under
17 the dose reconstruction program and decisions
18 by the VA on claims for service connection or
19 radiogenic diseases; assist the VA and DTRA in
20 communicating to veterans information on the
21 mission, procedures and evidentiary
22 requirements of the dose reconstruction
23 program; carry out other activities with
24 respect to review and oversight of the dose
25 reconstruction program as jointly specified by

1 the Secretaries; and as a result of the
2 periodic audits, make recommendations as
3 considered appropriate on modifications to the
4 mission or procedures of the dose
5 reconstruction program.

6 On this slide I show a copy of the -- what some
7 people quote as the 90-day report to Congress.
8 This was submitted as required by Public Law
9 108-183 in June of 2004. As you can see, it
10 was signed out by the Veterans Under Secretary
11 for Benefits, Vice Admiral Cooper; and on the
12 Department of Defense side, Dr. Dale Klein, our
13 Assistant to the Secretary of Defense for
14 Nuclear and Chemical and Biological Defense
15 Programs.

16 This report took those eight recommendations,
17 said how are we going to work on those eight
18 recommendations from the National Academy of
19 Sciences, described them and then expanded upon
20 them. There were 23 findings summarized in
21 this report to Congress that I believe we're
22 going to be putting on line shortly on the VBDR
23 web site. These action plans are expected to
24 overcome the deficiencies in the dose
25 reconstruction and claims adjudication

1 programs.

2 If we look at those 23 findings, 1 through 4
3 are inter-agency actions to improve claims; 5
4 through 14 directly impact my program as DTRA
5 actions to improve NTPR program procedures;
6 findings 5 (sic) through 18 are inter-agency
7 actions to improve communications; and findings
8 19 through 23 are Advisory Board requirements
9 and functions. What I'd like to talk about now
10 are the ones that directly impact my program,
11 findings 5 through 14, and give you an update
12 on those.

13 Finding 5 was inconsistent application of the
14 benefit of the doubt in exposure scenarios;
15 inadequate follow-up with veterans regarding
16 exposure scenarios; and finally, National
17 Academy of Science recommended veterans be
18 allowed to review the scenario assumptions.
19 What have we done on those to date?

20 Well, procedures were -- were revised initially
21 after the National Academy of Science in 2003
22 to engage the veterans from the beginning.
23 Questionnaires, fact sheets and unit histories
24 now go to the veteran early in the process.
25 They go under formal letters back to the

1 veterans.

2 What I described previously, the Scenario of
3 Participation and Radiation Exposure which is
4 performed both through telephone calls and
5 through letters back and forth with the
6 veterans are used to explain the veterans'
7 assertions, documented facts and events and
8 relevant scientific/technical principles. The
9 conclusion of the SPARE is when the veteran
10 signs off on this document that's been
11 prepared, based on their input, by DTRA and
12 returns it to us.

13 The SPARE, as I mentioned, is prepared
14 following telephone interviews with the
15 veterans, and is provided to the veteran for
16 additional comments before we get the final
17 signature.

18 Finding number 6 was several pathways are
19 frequently neglected in exposure scenarios.
20 Specifically, contamination resuspended by the
21 shock wave from the nuclear blast, dermal
22 exposure from skin contamination, and exposure
23 from ingestion of contaminated materials. What
24 have we done on those findings?

25 Actions completed to date are some shock wave

1 resuspension scenarios have been addressed.
2 Skin dose from dermal contamination has been
3 addressed, and finally, ingestion dose has also
4 been addressed.

5 But we aren't finished. We have some ongoing
6 actions. One of the most challenging cases was
7 Operation PLUMBBOB that was at Nevada Test
8 Site. In that case the resuspension has been
9 particularly difficult to determine, and that's
10 an ongoing action.

11 Finding number 7, external gamma dose bounds
12 often were underestimated substantially. What
13 were our actions?

14 DTRA issued interim guidance in July 2003
15 providing factors for determining credible
16 upper bounds from best estimate doses. What we
17 basically said was, based on the uncertainty,
18 let's take a higher level that would
19 incorporate everybody and assign that to the
20 veteran. We've now incorporated that in our
21 NTPR policy and guidance manual.

22 However, we're still looking at other methods
23 improved methodology using probability.

24 Finding number 8, estimates of internal dose
25 are intended to be high-sided, but may not

1 always be so. For example, such as
2 corresponding to upper bounds with a 95 percent
3 confidence. What actions have we completed to
4 date?

5 Well, the interim guidance that we issued in
6 July 2003 that's now been incorporated in the
7 policy and guidance manual similarly provided
8 an upper bound based on high-sided estimates.
9 We are in the process of reviewing a draft
10 report developed on inhalation doses in high
11 resuspension scenarios. Once we approve those
12 concepts, they'll also be incorporated into our
13 policy and guidance manual.

14 Finding -- finding number 9, upper bound on
15 neutron dose component was always
16 underestimated. Once again, we acted promptly
17 through our interim guidance and provided a
18 factor calculating the upper bound as "best
19 estimate" doses.

20 The way we did this was we looked at the mean
21 dose and we made it fairly simple. We assigned
22 it -- depending on whether it was neutron,
23 gamma, et cetera, we multiplied that mean
24 factor by a factor of like times 3, times 6 and
25 so forth to reach an upper bound that included,

1 as we saw it, all veterans. That's now been
2 folded into our NTPR policy and guidance
3 manual.

4 We do have a draft report that's been developed
5 on estimating neutron dose upper bounds. Once
6 that's completed, that will also be folded into
7 our policy and guidance manual.

8 Finding number 10, the VA adds upper bound
9 estimates of the external dose to reported
10 high-sided inhalation doses and/or beta skin
11 dose. This implies unnecessary difficulties in
12 combining dose contributions and their
13 uncertainties.

14 As scientists, adding errors together can be
15 challenging. Actions completed to date, none.
16 We're looking for some input from the Board on
17 this one. We're continuing on this one. What
18 has helped us, though, was the recent
19 recommendation that was adopted by the VA on
20 adoption of the IREP software where we have
21 simply one model that we now have to work with
22 instead of multiple models. Based on that
23 adoption, we're testing some models and we hope
24 to be able next time we report to mention
25 actions completed.

1 Finding number 11, correlations are often not
2 accounted for when combining various doses to
3 arrive at a total organ dose. This was
4 somewhat similar to the previous one I was
5 discussing.

6 Once again, it is hard at -- it's difficult, in
7 some cases, adding uncertainties together. Our
8 current methods have been evaluated by our
9 integrated product team on a case-by-case basis
10 using probabilistic methods to assess
11 credibility in the estimated upper bounds.
12 We're going to continue to investigate this on
13 these correlations between parameters and
14 exposure pathways, and hopefully we'll come up
15 with credible results.

16 Finding number 12, DTRA's specific methodology
17 for reconstruction doses is often poorly
18 documented or not documented at all.

19 We've taken a lot of action on this. Some of
20 the challenges have been -- often we do each
21 one of these cases on an individual basis, and
22 there are many, many different factors. Some
23 cases are similar, but if you do a number of
24 cases you find like ten cases -- ten different
25 cases. It was difficult to come up with

1 standard, specific steps.

2 Well, we -- we've moved ahead on trying to do

3 that, and we've recently released our policy

4 and guidance manual, but I'll tell you, we

5 continue to work on a more -- actual SOP as it

6 form under the policy and guidance manual on

7 standardization, especially in the dose

8 reconstruction process. Not so much the admin

9 process as those are fairly well-documented.

10 Finding number 13, DTRA must develop, implement

11 and maintain an auditable documentation system.

12 Under completed actions, based on the interim

13 guidance for documenting all assumptions, data,

14 historical information, veteran input,

15 evaluations and results of the dose

16 reconstruction, we've now put this into our

17 policy and guidance manual. I believe we're

18 doing this fairly effectively.

19 Finding number 14, DTRA needs to develop a

20 comprehensive quality management system that

21 encompasses all aspects of the dose

22 reconstruction program.

23 As I mentioned earlier, we've gone through a

24 lengthy process to achieve ISO 9001

25 certification. We went through a two-day

1 certification audit, no non-conformities noted.
2 That certification is good for three years.
3 And internal audit schedule is on track and we
4 expect an external ISO auditor to visit us on
5 about a semi-annual basis to continue looking
6 at how well we're doing this program.
7 Here is an overview of the ISO 9001 process
8 that we started based on the interim guidance
9 in 2003. It shows some of the steps through
10 the kick-off, the quality policy, the desk
11 audit, the auditor training, the actual --
12 finally certification audit in 2005. And now
13 we're approaching our six-month checkup.
14 What about looking at our workload, incoming
15 cases? As you can see, it gets changed with
16 time. Right now in mid-2005 the workload's
17 actually a little less on incoming cases, which
18 is fortunate as we're trying to recover based
19 on our backlog. We've broken down the cases on
20 personal cases coming directly to us, non-
21 presumptive and presumptive cases coming from
22 the VA into three different categories there.
23 And as I mentioned before, we hope to have our
24 backlog down and back to normal by September,
25 2006.

1 **ADMIRAL ZIMBLE:** Thank you very much, Dr.
2 Blake. Before we call you back by popular
3 demand, I would like to ask -- I think that for
4 the benefit of the audience and for the benefit
5 of the Board, could you define and explain ISO
6 9001?

7 **DR. BLAKE:** The ISO -- and I may have some
8 challenges here, but the International System
9 of Organization is a -- is a quality
10 assurance/quality management procedure. And in
11 fact some experts on our Board may be better --
12 may want to speak up and speak to that better
13 than I can. We've gone through the process,
14 but would -- I may actually defer to the
15 experts here, Dr. --

16 **COLONEL TAYLOR:** Paul, us deaf tankers can't
17 hear you. Move your mike a little closer,
18 please. Thank you.

19 **DR. BLAKE:** I think I'll defer that question to
20 the experts, Admiral Zimble.

21 **ADMIRAL ZIMBLE:** Okay. Well, I know that we do
22 have an expert on quality management. We're
23 very fortunate to have Dr. Curt Reimann with
24 us, so I just think that for the -- for the
25 record, ISO 9001 needs to be defined.

1 **DR. REIMANN:** Yes, I agree. I agree with that,
2 and -- but I was -- the question I was going to
3 pose to you is that the issues that you raised,
4 let's say about the middle where you say none
5 to date, and you were referring to specific
6 technical complexities or -- I think earlier
7 you described it as almost like an individual
8 master's thesis.

9 **DR. BLAKE:** Right.

10 **DR. REIMANN:** How would standard auditors of --
11 of processes that are used in routine
12 manufacturing and routine services, how do they
13 get by this point? In other words, what does
14 their verification of your process -- would
15 mean if -- if the technical people don't agree
16 on -- on the specific steps? I agree that the
17 -- that the basic approach that requires a
18 setting-out of the appropriate policies and the
19 audit regimens and all of the steps that you
20 describe here are all necessary. But I don't --
21 -- I don't grasp how -- how that penetrates the
22 problems that you're describing, and that's --
23 the technical problems you're describing.
24 And secondarily, how a process analysis can
25 deal with the issues of backlogs and so on

1 which are typically ones of either strategy in
2 handling load or in having some kind of load
3 leveling, which was leading me to raise the
4 question of your work described earlier when
5 you were talking about the number of people
6 that you have directly on staff and the number
7 of people that you have access to via contract.
8 Don't -- do you have any load-leveling
9 capabilities? ISO normally wouldn't deal with
10 -- with questions of the timing. It would deal
11 with the documentation. But if something is
12 actually being followed but being followed very
13 slowly, ISO wouldn't -- wouldn't cite that as a
14 finding because it's not an error with respect
15 to your documented process. So I see this as
16 necessary, but I don't see how it penetrates
17 the issues that you're saying are the most
18 vexing ones to your own work and the most
19 troublesome to the -- to the veterans and they
20 deal with the technical complexity.

21 **DR. BLAKE:** Dr. Reimann, you're exactly
22 correct. When the ISO 9001 auditors came in,
23 both before and then for the formal review,
24 what they went through was our procedures
25 manuals. And on the administrative side, for

1 instance, they could find no problems. On the
2 technical side, as -- as we're still developing
3 and formulating those, the auditor was not a
4 formal health physicist. He -- he does this
5 for a living, and so he looked to see if there
6 are procedures in place, were we following
7 those procedures. But where we had those gaps,
8 he could not evaluate that, and perhaps that
9 was the reason for the -- the finding of no
10 non-conformities, but it still didn't get to
11 the heart of where we're missing on some of the
12 technical challenges. That I think we really
13 have to do with our own scientists and
14 consultants on -- from a technical viewpoint.

15 **DR. REIMANN:** Yeah. My own judgment of that is
16 that as we go forward with these discussions
17 that we identify the types of quality that
18 we're really talking about and that the dose
19 reconstruction, the heart of that, is technical
20 complexity and decisions that have to be made
21 and the detailed criteria related to the
22 associated health effects and so on. If we
23 can't lay those things out in a way that's
24 consistent for -- for your operations and
25 consistent with the decisions that the VA

1 makes, that's a -- that's a basic stumbling
2 block that ISO 9000 or any derivative of it
3 simply can't -- can't get beyond. So I think
4 we -- I think we can't have too much reliance
5 on a process approach where the stumbling
6 blocks are ones where the technical people
7 themselves would argue about the best approach.
8 And so I think that that's going to be one of
9 the major issues.

10 But in terms of what I perceive to be the
11 frustrations of those who call upon your
12 services are ones that process doesn't --
13 doesn't address in a direct way and it relates
14 to things like your ability to manage a load
15 with the staff you have. Or if I read between
16 the lines of Mr. Pamperin's comments about the
17 number of claims coming through, that these
18 represent a small fraction of the claims coming
19 through, that's another issue of complexity and
20 training of individuals to be able to
21 distinguish one kind of claim from another kind
22 of claim. And the processes of this type tend
23 not to get past that. They just say what you
24 do in a particular case, but they can't tell
25 you what to do if that worker also has 75 times

1 as much work to do in some other area.
2 And so as we go forward with the concept of
3 quality management, I think we have to make
4 that distinction of quality management from
5 mere documentation of process and get at the
6 issues of service quality, which is what the
7 veteran is looking for in terms of the -- the
8 response time and the clarity of the responses
9 and the relationship issues associated with
10 that. And I don't see ISO 9000 as -- as
11 handling that.

12 So all I -- all I would say is this is a
13 necessary step and a very important step, but
14 certainly not sufficient and it certainly
15 doesn't get at the central questions that I
16 think that you're properly approaching. And I
17 would assume that from the point of this Board,
18 and perhaps even some learnings from the board
19 described earlier, that we can get some help or
20 recommendations that relate to these areas
21 which are very, very troubling for you and ISO
22 9000 won't really help.

23 So ISO 9000, in the simplest terms, is a -- is
24 a process for laying out the expectations in
25 such a way that anyone can evaluate the steps

1 and someone can then follow-up and audit
2 against the expectations. In other words, you
3 say that these are the steps you go through.
4 You need to document those steps. Someone else
5 could come through -- come by and check that
6 you have in fact followed those procedures.
7 And I -- and I gather that in the past one of
8 the problems was that people couldn't follow
9 those trails, and I would assume that a lot of
10 the work you've done here lately is making
11 those trails more -- more -- more clearly
12 marked, we'll put it that way.

13 **DR. BLAKE:** Exactly, through out --

14 **DR. REIMANN:** But when you get to these branch
15 points where you said you're not quite sure
16 what to do, that's very, very different.
17 That's technical capability and not -- not
18 quality management, per se, because I'm afraid
19 a typical quality manager would say well,
20 you've documented, and you can document the
21 wrong approach just as well as the right
22 approach. And that's -- that's the underlying
23 failing of -- of quality systems, particularly
24 ones that rely on documented process if the
25 process itself isn't a guarantee of success.

1 So carrying over from let's say the business
2 world to what you're doing here is far more
3 complex. We ought to understand that and I
4 think it would be very helpful if the veterans
5 themselves would understand that because it's
6 at the frontier of knowing what to do, so it's
7 not -- you can't be faulted for not knowing
8 what to do if no one else in the world knows
9 what to do, either.

10 So I think that that's -- that's a very, very
11 important distinction and I think a potential
12 stumbling block between when quality
13 management, which tends to deal with general
14 management kinds of things, runs head -- head -
15 - head-on into the places where there are
16 current disagreements among the best minds on
17 exactly how you go about this. And so
18 documenting procedures in a -- in a fluid
19 situation also means leaving a very, very clear
20 trail of the assumptions made so when those
21 assumptions change, you can go back and fix it.
22 I'm not sure the quality inspectors would have
23 the knowledge to help you with that and I think
24 that's something that you're probably better
25 equipped to do than -- than they would be.

1 But anyway, I'll get off my hobby horse here.

2 **ADMIRAL ZIMBLE:** Okay, thank you. I think
3 that's -- that's very helpful and -- to get
4 that documented for us to review and -- and
5 consider as we look at the quality assurance
6 issues. It's -- my understanding is the ISO
7 9001 is a great instrument to -- to determine
8 that the processes are there and documented and
9 auditable, but it is not the total instrument.
10 It's -- it's a hammer that we can use for a
11 nail, but it's not a tool that we can use for -
12 - for cutting a board, so --

13 **DR. REIMANN:** Yes, I think -- I think that the
14 -- the issue is cutting more deeply into the
15 documented process to get at where those
16 stumbling blocks are and what they mean in
17 terms of technical merit and what they mean in
18 terms of time. In some cases the issue is --
19 is that maybe there's a -- there's a route to
20 an answer, but that route --

21 **ADMIRAL ZIMBLE:** Takes too long.

22 **DR. REIMANN:** -- is -- is so -- is so long and
23 the process itself wouldn't -- wouldn't have
24 all those branch points. And so we need to be
25 able to get past that as we move to the next

1 step, I think.

2 **ADMIRAL ZIMBLE:** It does not measure
3 effectiveness or efficiency.

4 **DR. REIMANN:** Doesn't -- right.

5 **ADMIRAL ZIMBLE:** It just measures -- it
6 measures that -- that the expected processes
7 are being carried out.

8 **DR. REIMANN:** Yes. But it would appear from
9 this and the requirements that came out of it
10 is that it sets the stage for a much more
11 rational approach, because I think we'll be
12 able to see the stumbling blocks much more
13 clearly than we would have without this kind...

14 **ADMIRAL ZIMBLE:** Okay. Thank you. Any other
15 questions or comments from the Board? Yes,
16 sir, Dr. -- Dr. Boice.

17 **DR. BOICE:** It's John Boice. I had a question
18 about internal dose. You had mentioned a
19 number of times about the difficulties in
20 getting the best estimate and/or even
21 considering it. And I was wondering -- there
22 are sort of two parts to the question -- is
23 when you do internal dose, you know, the dose
24 varies by the radionuclides that you're
25 assuming the exposure was for, and the organ

1 doses will all differ by the chemistry. So do
2 you actually compute a actual organ dose from
3 the internal radionuclides that are inhaled or
4 ingested?

5 **DR. BLAKE:** We use some software that was
6 designed years ago -- it's a documented
7 procedure that we have line -- line is called
8 FIIDOS where we actually do an internal organ
9 dose computation based on that. But there are
10 large uncertainties associated with that
11 because we -- part of that SPARE, the scenario,
12 was trying to assume what the veteran actually
13 inhaled or ingested. And where that comes in
14 is, for instance, let's say after Operation
15 CROSSROADS, the veteran sometimes went and swam
16 in a lagoon that was contaminated. The
17 assumptions that we'll make for benefit of the
18 doubt was that the veteran swam in that and
19 basically swallowed an exorbitant amount of
20 water, and then we'd compute the internal doses
21 based on that. He may -- that veteran may not
22 have swallowed that much water, but we make --
23 we try to put that into our calculations.
24 Similarly on inhalation doses for some of these
25 resuspension factors, once again we try to give

1 the maximum benefit of the doubt to the veteran
2 on what it is. But we're relying on historical
3 data. We're -- there were radiation surveys
4 and so forth, but there's lots and lots of
5 guesswork here and it's a challenging case.
6 And that's especially true not only on internal
7 dose, but on skin dose on trying to come up
8 with what these actual doses are. And our plus
9 and minuses are big.

10 **DR. BOICE:** Right, and I can understand and
11 appreciate the uncertainties. I was wondering
12 also, though, say that the cancer at risk was
13 the thyroid, that was -- the claim was for
14 thyroid cancer, but none of the mixtures,
15 fission products or radionuclides or uranium or
16 plutonium would go to the thyroid. Is there a
17 need then to do a dose reconstruction on a
18 series of radionuclides that would not affect -
19 - or have just minimum -- minimal effect on
20 dose to the organ in which the veteran is --

21 **DR. BLAKE:** Well, there is some iodine-131
22 that's released that would go to the thyroid
23 during some of these tests and so we -- we do
24 take those calculations --

25 **DR. BOICE:** Yes, I -- I was thinking on the

1 other scenario, on resuspension and -- and --
2 where the iodine would have died away.

3 **DR. BLAKE:** I'm not sure if I follow you, sir.

4 **ADMIRAL ZIMBLE:** Well, they most likely have
5 gone through the half-- all the half-lives of
6 I-131 on material that was resuspended.

7 **DR. BOICE:** But you're saying that they would
8 be coming in earlier enough that there would be
9 some possible dose from iodine that you would
10 have assumed.

11 **DR. BLAKE:** Right, we do take that into account
12 in the thyroid, if I'm following you.

13 **DR. BOICE:** Okay.

14 **ADMIRAL ZIMBLE:** Okay, we're now about 15
15 minutes behind schedule, so you're -- you're --
16 we call -- you're back again, Dr. Blake. One
17 more presentation.

18 DOSE RECONSTRUCTION ACTIVITIES

19 DR. PAUL BLAKE

20 **DR. BLAKE:** I'll move a little faster. What
21 I'd like to discuss briefly in my final
22 presentation today is the team that's involved
23 here, the process, the time lines and a closing
24 note.

25 In our integrated product team, made up both of

1 government and contractors, the first team is
2 communications and outreach, the services team.
3 They're, for instance, some of the people that
4 man the toll-free telephone line.

5 The next group is research and documentation
6 team. A lot of these people are, on our
7 contract side, former military personnel who
8 have expertise in historical military records.
9 For instance, we have some veterans who just
10 focus on Marine Corps records. We -- former.
11 We have some that focus on Navy or Army
12 records, or even Air Force records.

13 The dose assessment team is made up of, as I
14 mentioned before, approximately 14 scientists
15 and engineers.

16 We have a program support team that helps with
17 photocopies, microfilm archiving.

18 There's a three-person information resources
19 management team that runs our servers, our
20 computer systems, works on programming and
21 database management.

22 There's a program quality management team that,
23 for instance, was associated with the ISO 9001
24 process.

25 And finally there's a program management

1 component of both the government side and the
2 contract side.

3 On the veteran assistance services we include
4 communications, outreach and hotline support.
5 There's significant archival research and
6 claims documentation that I'll talk about more
7 a little later. Radiation exposure assessments
8 and dose reconstructions we talked about, and
9 some of these other functions.

10 Here's an overview of the process. One --
11 either requests come in from the agencies or
12 directly from the veteran. If you look at this
13 schematic, you'll see the mailbox. We then
14 take that and do some archive and searches.
15 We'll provide feedback at that time. We'll
16 then move into dose research. We'll provide
17 feedback. The final product, though, is an
18 outgoing letter signed by the government and an
19 update of our database on those 400,000
20 veterans. Every step in the process when we
21 interact with a person is captured in that
22 database when we take a process, so you can
23 follow a process through documentation on our
24 computer systems.

25 Initial processing, what are the key actions?

1 Mail, for instance, is received in my office at
2 the Defense Threat Reduction Agency, and once a
3 week we take these 30 to 40 letters that have
4 come in from different groups out to our
5 contractor's site. There at the contractor's -
6 - when they are received on that date, we date
7 -- we open them up, we date-stamp them and we
8 look to see our -- do they come to our program
9 correctly or should they have gone, for
10 instance, to another program in the Army, Navy,
11 Air Force, et cetera, too. So a few procedures
12 don't follow under our guidelines, we'll
13 redirect that to the correct program to get the
14 proper response.

15 We then take those -- that correspondence
16 that's been date time-stamped out to our
17 contractor's site where they enter it into the
18 database, review it. A letter and
19 questionnaire is then released back to the
20 veteran within about five working days. It's
21 an interim response, and we try to provide an
22 initial questionnaire to the veteran to fill
23 out that's approximately one to two pages.
24 The key factors in this process are did we --
25 did we get adequate information and have we

1 provided the correct enclosures in the letter
2 that we're releasing back to the veteran.
3 The next step is historical research. Here the
4 key actions are to identify and analyze the key
5 research issues, determine the location of
6 records and documents, review and abstract key
7 information, provide findings and conclusions,
8 and prepare the case for dose assessment.
9 What the key factors are are availability of
10 records and a responsive reply from the
11 veteran.
12 I've covered some of this and I'll move right
13 along.
14 What are the types of documents that we'd look
15 at for -- from the veterans? Well, they're
16 extensive, and I'd like to just mention those
17 to you for at least one time. Most of us, as
18 veterans, had a service record, though it's
19 been discontinued recently, that we carried
20 with us. We also carried our outpatient
21 medical record. Both of these records, when we
22 separate or retire from the service, are then
23 forwarded to the National Personnel Records
24 Center in St. Louis, Missouri.
25 We also gather morning reports that the

1 military did, operational orders, operation
2 plans, outgoing message traffic, final
3 operational reports, special orders, temporary
4 duty orders, reassignment orders, personnel
5 rosters that are made up of units, unit
6 rosters, movement logs, flight logs, station
7 lists, unit diaries, war diaries, unit
8 histories.

9 For instance, there's a current requirement for
10 every military facility on an annual basis now
11 to provide a unit history to your different
12 archives. And with my own Naval organization,
13 I provided an annual report that went into the
14 Naval archives right here in Washington, D.C.
15 Those provide excellent information 'cause
16 typically you often will list in that annual
17 report the personnel that are assigned to your
18 attachment.

19 Deck logs, daily diaries, ship movement
20 reports, muster rolls, agency and unit memos,
21 weapon test reports, dosimetry records -- I'll
22 talk a little bit more about those, how we do
23 that in the military -- the questionnaires,
24 personal statements, personal papers, diving
25 records and oral histories all go in our

1 records that we maintain an extensive library.
2 The computer database system is simply a
3 summary. We actually have many, many linear
4 feet of records that we have obtained over the
5 years.

6 Where are the key repositories that we get this
7 information? Well, as I mentioned before, the
8 National Personnel Records Center in St. Louis,
9 Missouri is -- we currently have two
10 contractors working on a -- a daily basis on
11 requests that we put in. But also close by are
12 the National Archives here in Washington, D.C.
13 and College Park. Some of our analysts are
14 required to have both secret and top secret
15 clearances to review some of the information
16 that's over there so we can go analyze it,
17 bring it back, and in some cases get it
18 declassified if we need that.

19 We al-- we -- we keep information at our own
20 resource center. There's the Military Services
21 Historical Centers, mostly in Washington, D.C.
22 For instance, the Marine Corps one is moving
23 down this summer to Quantico, Virginia. The
24 Department of Energy Records Collection that we
25 help support financially out at Las Vegas,

1 Nevada; the Washington National Records Center
2 in Suitland, Maryland; the Federal Archives and
3 Records Center out in San Bruno, California;
4 and Defense Technical Information Center in
5 Alexandria, Virginia. You can see there's a
6 lot of places we go to get information when we
7 can't -- if we can't -- we don't already have
8 it in our extensive files.

9 Who are our military service contacts? A lot
10 of times claims may involve not only our
11 program but other occupational radiation
12 exposure. We work with the services and
13 coordinate that process to help support the VA.
14 For instance, the Army Surgeon General's
15 Office, Office of Preventive Medicine down in
16 San Antonio, Texas coordinates the radiation
17 claims for the Army. Some of those claims may
18 involve dose reconstruction. Some of them may
19 be simply going to the Army Centralized
20 Dosimetry Center.

21 The three services, the Army, the Navy -- which
22 supports the Marine Corps and now the Coast
23 Guard -- and the Air Force all have centralized
24 occupational radiation dosimetry centers. At
25 those three centers are where the services keep

1 their occupational radiation exposure records,
2 with one exception. That one exception, as I
3 mentioned, is out at Las Vegas, Nevada where
4 the atmospheric nuclear weapons tests and so
5 forth are collected, because that fell under
6 the Atomic Energy Commission. So there are
7 basically four repositories for radiation
8 occupational dosimetry records within the
9 military and we -- we work together on getting
10 those. When the services need help out in St.
11 Louis, they come to our program where we'll
12 pull records for them.

13 The Navy, Marine Corps and Coast Guard program
14 is over at Bethesda, Maryland at the Naval
15 Dosimetry Center; and the Air Force Medical
16 Support Agency down in Boling Air Force Base
17 here, the Chief of Radiation Protection
18 Division coordinates where those claims go to.
19 They go to two or three different places in the
20 Air Force.

21 The key information collected, from more of a
22 technical viewpoint we look at personal
23 identification, activity, location; unit
24 identification, activity, location; weather.
25 As you may be aware, for instance, when we look

1 at neutron transport and the doses that may
2 come from prop radiation, a lot of that will
3 depend upon the humidity in the air, how fast
4 those neutrons get slowed down. We need to
5 look at those factors when those -- for
6 instance, those weapons tests occurred.
7 Terrain, if there were shielding involved.
8 Fallout intensity and duration from historical
9 records, field radiation surveys, shot-specific
10 radiochemical data, personnel exposure data --
11 typically film badge results, though not all of
12 our veterans who went through this -- in fact,
13 quite a few of them -- weren't wearing film
14 badges for certain tests. And post-test site
15 project identification.

16 The veteran questionnaire that we send out
17 fairly promptly requests that that veteran
18 return the questionnaire to us in 30 days. If
19 no response after 30 days, we follow up with a
20 phone call. After 60 days we'll go ahead and
21 move ahead without that questionnaire if we
22 don't get it back. Average return time to us
23 right now is typically 35 to 40 days.

24 When these cases come in we basically do a --
25 on the dose assessment, a triage. Are they

1 cases that are very complicated, they'll take
2 longer to process, or are they -- are they
3 simpler cases. And so we go through the
4 following steps, reviewing the VA letter,
5 reviewing all support documents, checking
6 database summary, check for film badge data,
7 prepare a triage report on how we're going to
8 handle that case, and coordinate findings and
9 conclusions with our research and development
10 team.

11 The key factors here are availability of
12 records -- and I discussed where we get some of
13 that information -- and availability of film
14 badge data.

15 What is a dose reconstruction? We've been
16 talking about it today. I'd like to give you
17 at least a schematic. It's certainly a time-
18 consuming and expensive process, but it's a
19 scientific estimate of the total dose received
20 from personnel activities in a defined
21 radiological environment.

22 The first thing we try to do -- and this is --
23 in our process is called the SPARE -- is
24 determine the activities and the areas visited
25 by that particular veteran. We then try to

1 establish the radiation environment, through
2 many cases through our historical records;
3 associate those activities and environment and
4 calculate a total dose; compare it with film
5 badge results; and finally compute the dose
6 uncertainties -- which is what the VA ends up
7 using, but we report both the uncertainties and
8 our calculated mean dose, as per -- per the
9 Code of Federal Regulations, to the different
10 groups that require it.

11 What's involved in that? Well, there's
12 basically two components for our veterans. One
13 is the immediate dose that came from -- from
14 the nuclear weapon, and typically that's
15 initial neutron and gamma radiation. And then
16 there's the delayed effects from, for instance,
17 fallout or induced radioactivity at ground
18 zero. Some of our troops were sent back into
19 ground zero after the tests -- were off and --
20 and so there was induced radioactivity they may
21 -- that they may have been hiking through.

22 What are some of the key actions in developing
23 the SPARE that I've discussed before? Review
24 the file, evaluate supporting documentation and
25 identify gaps; request dosimetry information as

1 needed; consult all related historical records,
2 documents and reports; prepare for and conduct
3 the participant interview. Some of these
4 interviews, because of what we're looking for,
5 actually have to be performed by our physicists
6 and engineers to pull up the appropriate
7 questions. In other cases, they may not
8 require quite as sophisticated an interviewer.
9 Finally after doing those phone calls and
10 reviewing the stuff, we actually develop the
11 scenario of participation and radiation
12 exposure. We then have a quality assurance and
13 quality control review process. DTRA signs off
14 on it -- which would be myself or my deputy --
15 and then the SPARE is returned to the veteran
16 for review and input.
17 Key factors in this process are scenario
18 complexities, responsive reply from the veteran
19 -- I'll discuss a little bit about that --
20 veteran agreement and disagreement with the
21 SPARE, and the -- and the available amount of
22 documentation present for us to work with.
23 This is perhaps, after the National Academy of
24 Science, the most time-consuming process in our
25 -- in our step of dose reconstructions.

1 We ask, once we release the SPARE to the
2 veteran, that they return it to us within 30
3 days. If we don't get it within 30 days, we do
4 a follow-up phone call. If we don't get it
5 within 60 days, we do a second follow-up phone
6 call. And after 90 days we -- we have to move
7 on, if we don't get it, with the dose
8 reconstruction process. Right now there's --
9 in our office, on the order of about 10 to 13
10 cases that haven't gotten back to us after
11 three months, so there are challenges, but to
12 some extent -- our veterans occasionally move.
13 We're trying to track down -- our veterans can
14 also expire and we want to make sure that's not
15 happening, and even if they're no longer
16 around, the cases still need to move ahead
17 because of the possible compensation for the
18 widows and so forth here, too. In many cases
19 the -- the wives and other people have -- help
20 or assist our veterans in actually respond--
21 providing this information back to us.
22 We then move on to the next step of the
23 process, computing this -- the radiation dose
24 assessment, what I was talking about, these
25 rather thick documents that we're now releasing

1 on an individual basis. We cal-- by Code of
2 Federal Regulations, we calculate the external
3 dose, we calculate the internal dose, we
4 evaluate the uncertainties. We determine the
5 upper bound. We prepare the final report, and
6 then that's called -- that's reviewed by a
7 separate physicist as part of the quality
8 assurance and quality control reviews, and
9 that's what's eventually released back to the
10 VA, with a copy to the veteran.

11 In all -- in almost all cases when we're
12 interacting with another agency, a simultaneous
13 copy of that letter is going back to the
14 veteran so they're kept involved in what we're
15 doing.

16 The key factors in this case are availability
17 of radiation data, approved dose calculation
18 methodologies and approved technical approach
19 to address the SPARE issues.

20 Final processing. DTRA, as I mentioned,
21 approves -- reviews and approves the RDA and
22 it's sent out. We added into our database and
23 currently we're archiving all our paper data by
24 microfilm. Currently we're -- we're in the
25 process of changing over to optical scanning

1 and documenting eventually through Adobe PDF
2 files.

3 We talked about this before, the length to do
4 the challenging cases is -- has grown
5 considerably since the National Academy of
6 Science review. What are some of the
7 challenging cases where this grows? Well,
8 sometimes, as Mr. Pamperin mentioned, if we
9 don't get sufficient information from the VA,
10 that can be a challenge. Lack of records can
11 also slow us down. Delays in veteran response
12 can be a problem. Delays in the phone contact,
13 there -- there are numerous places where --
14 where the process can slow down.

15 However, there are many other cases where we
16 move much faster than that 204 days. For
17 instance, if it's a non-participant -- a VA
18 non-participant case where we don't have to do
19 the dose calculation, we can normally get that
20 done in 45 days to 66 days. There are cases
21 where the -- it's not so unique, the -- the
22 veterans have cases that are almost identical
23 to other cases we've done where we can come up
24 with templates to really speed the process. In
25 the place where we're -- and this is one place

1 we're continuing to work on developing
2 additional templates to go into our standard
3 operating procedure. There we can knock the
4 procedures down from 204 days down to 112.
5 This really depends upon the SPARE and when we
6 review that, is that case very, very similar to
7 another veteran's case we've already done, or
8 is it so individualistic that we can't use that
9 particular generic template to expedite the
10 process.
11 Other presumptive cases, the typical 45-day
12 turnaround or less. Department of Justice case
13 processing, 45-day or less. Personal case
14 processing, similar.
15 So in closing, my program is making new efforts
16 to facilitate dose reconstruction process,
17 reduce the delays, shorten time lines and
18 eliminate the case backlog. The dose
19 reconstruction process action team is examining
20 all facets of the process. We've put together
21 tiger teams to try to see how can we improve
22 the process. We're implementing dose
23 reconstruction templates where appropriate, and
24 we're certainly going to improve on aggressive
25 follow-up by veteran outreach staff with phone

1 calls back and forth to the veterans.

2 And with that, I'll close.

3 **ADMIRAL ZIMBLE:** Dr. Blake, I want to
4 congratulate you on the 15-minute backlog that
5 you started with. You've regained ten minutes,
6 so -- so we're only five minutes behind
7 schedule now, and I appreciate that.
8 Any comments or questions from the Board?

9 (No responses)

10 Okay. Thank you very much, Paul.

11 **DR. BLAKE:** You're welcome --

12 **ADMIRAL ZIMBLE:** Oh, well -- well, wait, wait.
13 Did you have a question?

14 **MR. PAMPERIN:** Yeah, just one question. When
15 you were talking about looking for records at
16 the National Archives, do you ever come back to
17 us, to the VA? Because if you're talking about
18 medical records, if the veteran had previously
19 filed a claim for some other condition, we have
20 all of his military medical records.

21 **DR. BLAKE:** That's a good question. I don't
22 know for a fact. I'll follow up on that,
23 though.

24 **ADMIRAL ZIMBLE:** Okay, that's another -- here's
25 an advantage of the Board right here. We've

1 gotten -- we've gotten two agencies talking to
2 each other on a -- on an issue that may resolve
3 some of the problems. Thank you.

4 PERSPECTIVES OF THE NATIONAL ASSOCIATION OF ATOMIC
5 VETERANS

6 NAAV COMMANDER R.J. RITTER

7 **ADMIRAL ZIMBLE:** Now we -- we chose Tampa for
8 this first meeting so that it would be
9 contiguous to a meeting -- an annual meeting of
10 a very important organization. As I mentioned
11 earlier, the organ-- veterans -- various
12 veterans' organizations can be extremely
13 helpful in allowing agencies of the government
14 to communicate more effectively with the
15 veterans. One such organization is the
16 National Association of Atomic Veterans, which
17 is -- as its mission statement, is there for
18 all military personnel who are associated with
19 atomic testing with -- with any of the various
20 atomic tests -- atmospheric tests, as well as
21 Hiroshima and Nagasaki occupational forces and
22 POWs, among others. And so we're very
23 fortunate in -- in being able to have a
24 perspective of the National Association of
25 Atomic Veterans presented to us today by its

1 National Commander, so I'll ask Mr. R. J.
2 Ritter to -- to come forward and -- and I
3 appreciate your patience in waiting, R. J. The
4 floor is yours.

5 **MR. RITTER:** On behalf of America's atomic
6 veterans, I want to thank Admiral Zimble and
7 his associates for the opportunity to present
8 their views and strong objections to the
9 continuance of dose reconstruction by the DTRA.
10 The National Association of Atomic Veterans was
11 incorporated in 1979 as a non-profit veterans'
12 service organization for the primary purpose of
13 giving America's atomic veterans a single-voice
14 platform to express their frustrations related
15 to their inability to obtain service-connected
16 compensation and fair treatment from the
17 Department of Defense and the Department of
18 Veterans Affairs.
19 Additionally, and within the last 36 months,
20 directors, officers and state commanders have
21 been instrumental in securing survivor's
22 benefits for several widows of deceased atomic
23 veterans, in keeping with current Congressional
24 guidelines governing the awarding of such
25 benefits.

1 There are some questions related to the
2 accuracy of the number of America's military
3 veterans who have been exposed to ionizing
4 radiation from atomic weapons tests while
5 serving their country. The Department of
6 Defense and the DVA has officially estimated
7 that there were approximately 410,000 military
8 personnel exposed to some degree of
9 atmospherically-dispersed ionizing radiation
10 particles by above-ground and underwater tests
11 from 1945 to 1962.

12 In 1984 the U.S. Congress chartered the
13 Veterans Affairs Committee on Environmental
14 Hazards, in accordance with Public Law 98-542,
15 to determine the number of additional military
16 personnel who may have been exposed to ionizing
17 radiation from continued testing programs after
18 1962.

19 As a matter of sheer interest, it is well to
20 note that from July 1945 to September 1992 the
21 United States sponsored 1,149 atomic device
22 detonations. Some of these detonations were
23 double-shot tests after the testing went
24 beneath the surface.

25 It is also estimated that there may be even

1 several thousand additional veterans exposed to
2 post-test residual radiation particles while on
3 various maneuvers in and around nuclear weapon
4 detonation test sites. These collective
5 studies would suggest that more than one
6 million U.S. military veterans may be suffering
7 from the long-term effects of ionizing
8 radiation-induced mutants that are slowly
9 changing and altering their internal body
10 chemistry and processes with deleterious end
11 results. The results of frustrations and anger
12 -- the levels, rather, of frustration and anger
13 that was exhibited by America's atomic veterans
14 in 1979 have, to this date, not diminished, for
15 a host of reasons.

16 For the last 45-plus years the U.S. Congress,
17 in concert with the Department of Defense and
18 the Department of Veterans Affairs, has
19 commissioned numerous panels and advisory
20 boards, and has hired a host of contract
21 consultants, for the purpose of developing the
22 methodology to properly recognize and address
23 the monetary and medical needs of America's
24 atomic veterans. Most of these board members,
25 scientific advisors, contract consultants and

1 senior opinion shapers have two things in
2 common. They all possess impeccable
3 credentials and impressive bios.

4 To America's sick and aging atomic veterans,
5 however, these credentials and bios are rather
6 shallow and totally meaningless. And while
7 they continue to slowly waste away from
8 radiation-induced illnesses, the learned
9 consultants continue to generate theoretical
10 opinions and hypothetical scenarios, all of
11 which have consistently denied the atomic
12 veterans of his or her fully-earned recognition
13 and benefits.

14 The only meaningful credential that is of any
15 value to America's atomic veterans is their
16 inability to physically display the badge of
17 courage they so nobly earned while standing in
18 harm's way and in the face of an invasive enemy
19 while performing their sworn duty to protect
20 the national security and to uphold and defend
21 the Constitution of the United States of
22 America.

23 While performing these assigned duties their
24 bodies were invaded and penetrated by an enemy
25 that would continue to have compound adverse

1 effects on their internal chemistry and bodily
2 processes for the rest of their unnatural
3 lives. This enemy would also invade and have
4 adverse effects on the health of a large
5 percentage of their children, and in many cases
6 their grandchildren and even great-
7 grandchildren.

8 The enemy I refer to is ionizing radiation-
9 induced mutants, which has had and continues to
10 have a profound effect on the natural life
11 expectancy of America's one million atomic
12 veterans.

13 After careful review of the comments listed in
14 the "Radiation Dose Reconstruction Report to
15 Congress" submitted to the 108 Congress by the
16 Department of Defense and the Department of
17 Veterans Affairs on June 3rd, 2004, me and my
18 colleagues, or I and my colleagues can now
19 fully understand why only 50 of the
20 approximately 280,000 claims submitted for
21 service-connected radiation illnesses were
22 approved by the system. In fact, after being
23 exposed to the complexities of the system, I am
24 utterly amazed that 50 of these claims actually
25 made it through the maze of theoretical

1 assumptions and radiation exposure projection
2 models.
3 Since atomic veterans were standing in the
4 presence of ionizing radiation particles
5 without proper protection, I like to compare
6 the process of arriving at theoretical exposure
7 level assumptions to standing in the rain
8 without a raincoat. The DTRA would have to
9 agree that you were indeed standing in the rain
10 without a raincoat. However, their theoretical
11 model might well indicate that it cannot be
12 proven that you got wet enough while standing
13 in the rain to officially be classified as
14 being wet enough while standing in the rain.
15 This would accurately describe a classic catch-
16 22 situation.
17 Parenthetically, dose reconstruction is a
18 catch-22 situation, denying atomic veterans
19 access to a realistic and believable service-
20 connected compensation process.
21 So as not to lose sight of the most -- of the
22 root purpose of why we're gathered here today,
23 I would like to take this opportunity to
24 highlight a few milestone events that occurred
25 in the lives of America's atomic veterans from

1 1945 to 1967. These highlights will also be a
2 tribute to atomic veterans who have since died
3 from radiation exposure events without
4 receiving proper recognition for their
5 sacrifices on behalf of their own country.
6 July 16th, 1945 was of course the day of
7 TRINITY, test "Gadget." In the desert of
8 Alamogordo, New Mexico the Manhattan Project
9 gave birth to the world's first atomic bomb.
10 This was also the first event resulting in the
11 atmospheric dispersion of atomic radiation
12 particles. And it was also the first day that
13 America's atomic veterans were exposed to
14 ionizing radiation.
15 Military and civilian personnel present at this
16 event were not issued any protective clothing,
17 and only a few had issued -- were issued RAD
18 badges.
19 On August the 6th, 1945 the city of Hiroshima,
20 Japan was destroyed by the first atomic bomb
21 dropped on enemy soil during an act of war.
22 On August 9th, 1945 the city of Nagasaki, Japan
23 was destroyed by the second atomic bomb dropped
24 on enemy soil during an act of war.
25 The Empire of Japan surrendered unconditionally

1 just 28 days after the TRINITY test in New
2 Mexico.

3 On August the 17th, 1945 occupation forces
4 liberate America's -- Americans, rather, from
5 the prisoner of war camp on the outskirts of
6 what was left of the city of Nagasaki, Japan.
7 One of those liberators is with us today.
8 September 1945 additional U.S. military
9 personnel were ordered to enter the cities of
10 Hiroshima and Nagasaki for the purposes of
11 occupation and damage assessment. The majority
12 of those who participated in these exercises
13 have since developed cancers and other
14 illnesses associated with their exposure to
15 airborne radiation particles and other hot zone
16 materials in and around surface zero of both
17 cities.

18 As a note of interest, in October of 1945 the
19 Atomic Bomb Casualty Commission, primarily
20 composed of scientists and technicians from the
21 original Manhattan Project, were tasked with
22 visiting Hiroshima and Nagasaki for the purpose
23 of determining the actual destructive factors
24 of the atomic bombs detonated over both cities.
25 These scientists were equipped with radon-

1 calibrated Geiger counters which were
2 considered, at that time, to be top of the line
3 instruments. They recorded approximately 30
4 rem in and around Nagasaki, and a slightly
5 lower level in and around Hiroshima. A copy of
6 their report can be made available from NAAV
7 upon request.

8 On June 30th, 1946 Operation CROSSROADS. There
9 were approximately 41,000 military personnel
10 and 150 civilian scientists and technicians
11 gathered at Bikini Atoll in the Marshall
12 Islands for the two CROSSROADS tests. The
13 first test was an air drop that missed the
14 target by 1,200 yards. The second test was a
15 detonation 90 feet beneath the surface of the
16 lagoon.

17 Almost all of the military participants have to
18 date developed radiation-induced health issues.
19 Many of these victims were tasked with post-
20 test cleanup duties, their bodies absorbing
21 radiation particles from sensing devices and
22 hot debris, while others were exposed to
23 radiation from animal specimens retrieved from
24 test ships and vessels in and around the
25 lagoon.

1 April 14, 1948, Operation SANDSTONE at Enewetak
2 Atoll in the Marshall Islands. This was chosen
3 for this particular test and for shots X-ray,
4 Yoke and Zebra. I received a photo from the
5 commander of the B-29 assigned to cloud
6 sampling duties for all three tests. The photo
7 shows all crew members lined up in front of
8 their aircraft while a technician checks each
9 one with a Geiger counter. The aircraft name,
10 "Overexposed," was clearly visible just above
11 the nose identification number.

12 On January 27th, 1951 Operation RANGER
13 commenced at the Nevada Test Site. Subsequent
14 atmospheric release tests were performed at
15 Nellis Air Force Base, Yucca Flats, Frenchman's
16 Flat, Pahute Mesa, Rainier Mesa and in Fallon,
17 Nevada. The RANGER series also marked the
18 first use of U.S. trench troops as test
19 monitors, some of whom were only 6,000 feet
20 from surface zero. These troops were not
21 issued or equipped with radiation exposure
22 protective clothing, and a large percentage
23 were not issued RAD badges.

24 Oh, thank you. Excuse me, I was getting a
25 little dry here.

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(Pause)

Many of those military test subjects who are still alive are suffering from a host of radiation-induced health issues, and have been referred to as America's atomic test guinea pigs.

February 25, 1954, Operation CASTLE. At Bikini Island there were six atomic weapon tests from February '54 to May of '54. Several of these were thermonuclear device detonations. The total yield of all six tests was 41.37 megatons. This is the equivalent of 41,370,000 tons of high-yield explosives and the airborne distribution of ionizing radiation particles associated with such a force.

Shortly after the CASTLE series of tests a Japanese fishing fleet harvested 450 metric tons of radiated tuna, causing the U.S. to ban all fish imports from Japan for one year. It is unclear as to the disposition of those radiated within the Japanese homeland seafood market.

On May 14, 1955 Operation WIGWAM occurred off the coast of California. On this day 25 Naval vessels, five Scripps Institute research

1 vessels, 35 military surveillance or monitoring
2 aircraft and 6,700 personnel and 120 scientific
3 types converged on a designated spot in the
4 Pacific Ocean southwest of San Diego,
5 California for Operation WIGWAM.
6 The WIGWAM director was a Dr. Alfred Folke, who
7 was a U.S. Navy explosives expert assigned to
8 the Scripps Oceanographic Institute in San
9 Diego. The codirector was Rear Admiral John
10 Sylvester, who was also Commander of Naval Task
11 Group 7. And Commander Roger Revelle, a Navy
12 expert in oceanographic aspects of atomic
13 testing, was the Scripps scientific and
14 tactical -- technical team leader, so it was
15 all Navy-sponsored.
16 All ships and monitoring devices were carefully
17 positioned in this spot of the ocean to
18 detonate a 30 kiloton plutonium-core fusion
19 bomb for the purposes of assessing the
20 destruction and radiation effects on submarine
21 hulls pre-positioned at various distances and
22 depths from ocean zero. I was one of the crew
23 members assigned to the Navy vessel that was
24 tasked with towing the bomb when it was
25 detonated. Seconds after the final countdown a

1 one-and-a-half-mile area of ocean erupted,
2 dispersing 331 billion cubic feet of highly
3 radiated seawater in all directions, as the
4 fireball bubble rapidly rose to a height of
5 12,000 feet.

6 Several Navy and Scripps research vessels in
7 close proximity to the center of the eruption
8 were completely inundated by the resulting
9 1,200-foot tidal wave surge, causing several
10 damage -- severe damage to superstructures,
11 while destroying deck machinery, communication
12 equipment and ships' hydraulic systems.

13 After the ocean settled back to near normal,
14 our vessel was tasked with the retrieval of
15 approximately 40 radiation-sensing pods -- or
16 RAPs, as we called them. These RAPs were
17 placed on the ship's fantail and along the port
18 side main deck, adjacent to the ship's galley
19 and crew mess hall.

20 Within 12 hours the Scripps scientist assigned
21 radiation monitoring duties aboard our vessel
22 declared the galley and mess hall off-limits to
23 all ship's personnel because of dangerously
24 high radiation levels that penetrated the
25 bulkhead between the main deck and the cooking

1 and dining spaces.

2 Twenty-four hours after the initial test

3 detonation a 9,900-foot diameter of highly

4 radiated ocean surrounding surface zero,

5 identified by the Scripps scientists as post-

6 test hot spot, began to drift slowly to the

7 southwest. Navy vessels with Scripps

8 scientists aboard were tasked with tracking and

9 monitoring the slowly-drifting hot spot, taking

10 periodic samples of radiation readings at

11 various ocean depths. On the 41st day of

12 tracking and monitoring, radiation levels at

13 all depths began to diminish to what was then

14 considered to be non-critical levels. There is

15 no way of knowing how many tons of migrating

16 fish passed through that hot spot, or how many

17 of these fish were harvested and served to the

18 American or Latin American public.

19 Prior to the WIGWAM test, Scripps technicians

20 quietly placed several airborne radiation

21 monitors from California -- the

22 California/Mexican border south of San Diego to

23 the City of Oceanside north of San Diego. The

24 monitors in the greater San Diego area measured

25 higher than normal levels of radioactivity over

1 the city four days after the WIGWAM test.
2 Radioactivity readings continued to skyrocket
3 to levels 20 times above normal background
4 levels over the next nine days. None of the
5 San Diego residents were aware of these
6 developments, and this information remained top
7 secret until several years ago.
8 After the test one of the highly-radiated
9 submarine hulls was placed on a barge and a
10 Navy Auxiliary vessel was tasked with towing
11 the barge to Long Beach harbor. While
12 traversing rough seas just off Catalina Island,
13 the barge capsized and the "hot" submarine hull
14 was scuttled in a prime fishing area. Orders
15 were then issued to the towing vessel to sink
16 the barge with 40 millimeter cannons on the --
17 in the same general area. The possibility that
18 radioactive contamination affected these waters
19 just off the California coast cannot be
20 discounted, although it has not been addressed
21 by any of the declassified charts of the
22 region. Checks of navigational charts up to
23 1980 failed to show a sunken submarine or a
24 barge.
25 In the late 1960s, however, a sports diver who

1 was also a crewman on the Navy vessel that lost
2 the submarine hull, reported seeing the hull in
3 the same general area where it was sunk. After
4 receiving several inquiries about the sinking
5 of that radiated submarine hull just off the
6 coast of California, the official response from
7 the Navy at that time was no response at all.
8 The official Department of Defense position
9 papers, declassified several years after the
10 event, paints a very mild picture of limited
11 radiation exposure risks associated with that
12 operation, and makes no mention of any post-
13 event radiation concerns, nor does it mention
14 elevated levels of radiation in and around San
15 Diego just days after the test.

16 When I prepared the first draft of this
17 presentation I was tempted to pay individual
18 tribute to a host of Navy personnel who
19 participated in the WIGWAM test and whose lives
20 have been shortened by the cancers and health
21 issues precipitated by their exposure to
22 ionizing radiation particles. However, I
23 decided to mention only one specific case of
24 interest to these proceedings. The first --
25 the first list included several of my -- of my

1 shipmates.

2 Captain Richard Purdy was the skipper of the
3 U.S.S. Marion County, LST-975. The ship's bow
4 doors were severely damaged, along with deck
5 machinery, and he couldn't sail his ship in a
6 forward -- a forward motion. Faced with the
7 inability to do this, he had to traverse the
8 480 nautical mile trip back to Long Beach
9 harbor in reverse. After the ship had docked
10 in a classified area of the harbor, Captain
11 Purdy proceeded down the gangway to meet his
12 wife. When Purdy reached the bottom of the
13 gangway a technician from Scripps Institute
14 checked him with -- with -- for evidence of
15 radiation. His wife was horrified as she
16 watched her husband turn to the ship -- return
17 to the ship because his shoes were too hot to
18 allow him to leave the vessel.

19 A few years after the WIGWAM test Captain Purdy
20 was diagnosed with leukemia and lung cancers.
21 His current status is deceased.

22 I wonder if dose reconstruction can determine
23 with any degree of believability what the
24 radiation count was on Captain Purdy's shoes.

25 I also wonder if dose reconstruction can

1 determine with any believable degree of
2 accuracy the amount of radiation exposure
3 absorbed by all the brave, sick and deceased
4 servicemen and technicians who participated in
5 Operation WIGWAM.

6 On May 28th, 1957 Operation PLUMBBOB. From May
7 28th to March 14th, the PLUMBBOB series of
8 tests included 33 fission weapon device
9 detonations at Yucca Flats and Frenchman's
10 Flat, Nevada. I received a photo of members of
11 the 11th Airborne who were air-dropped over
12 surface zero just less than an hour after a
13 test detonation. The photo clearly shows the
14 paratroopers walking through smoking ruins.
15 Additional photos from previous post-test
16 events at the Nevada Test Site would suggest
17 that walking through the smoking ruins of
18 ground zero shortly after a test blast was
19 considered to be standard procedure, for after-
20 effects purposes, by the Department of Defense.
21 None of the soldiers in any of the photos seen
22 walking through these ruins were wearing any
23 visible protective clothing, nor were they
24 wearing any breathing apparatus. Without a
25 doubt, all either inhaled or ingested free-

1 floating ionizing radiation particles or hot
2 dust particles kicked up by their shoes.
3 On July 17th, 1962 Operation SUNBEAM occurred
4 at Pahute Mesa, Nevada. It was a Mark 54 150
5 millimeter Davey Crockett rocket propelled nuke
6 mounted on the rear of a Jeep. The code name
7 assigned to that test was Little Feller I, and
8 the Army also had a 120 millimeter version of
9 this same weapon that was fired from a free-
10 standing recoilless rifle. The 35-pound
11 fission-core device detonated two miles
12 downrange of the firing point with the
13 explosive force of 44,000 pounds of TNT. This
14 would be the last atmospheric test of a nuclear
15 weapon on American soil.

16 And then in the Pacific Ocean Operation
17 FISHBOWL occurred on November 4th, 1962, the
18 last U.S.-sponsored atmospheric test in the
19 Pacific. It was a high-altitude rocket-
20 propelled detonation, code named "Tightrope."
21 It was a thermonuclear weapon launched from a
22 firing pad on Johnston Island southwest of
23 Hawaii, designed to measure the effects of
24 electromagnetic pulse generated by a
25 thermonuclear detonation on radio waves and

1 high frequency communications transmissions.
2 An earlier test of a 1.4 megaton thermonuclear
3 weapon detonated 480 nautical miles above
4 Johnston Island on July 9th, 1962 interrupted
5 radio signals from Hawaii to Australia for
6 several days after the test.
7 Although the U.S. had now gone underground with
8 their atomic testing program in keeping with
9 the Atmospheric Nuclear Test Ban Treaty, I must
10 mention as a matter of sheer interest that
11 three of these sponsored tests were performed
12 in the State of Mississippi. This was on
13 October 22nd, 1964 as part of Operation
14 WHETSTONE, Test Salmon, and December 3rd, 1966,
15 Operation LATCHKEY, Tests Sterling I and
16 Sterling II.
17 These three fission devices were detonated in a
18 shaft penetrating a salt mine on the outskirts
19 of Hattiesburg, Mississippi. Documents
20 indicate that there were 90 civilian contractor
21 compensation claims filed for illnesses
22 attributed to post-test radiation exposure. Of
23 those 90 claims only one was approved. In this
24 case the approval ratio of the contractor
25 claims was 89 to one. If we apply this ratio

1 to the number of claims filed by America's
2 atomic veterans versus the number of approvals
3 to date, the DVA should have approved more than
4 3,000, rather than a paltry 50.
5 Additionally, and the most insulting to
6 America's atomic veterans, was the act of then-
7 President Clinton, who with a stroke of his pen
8 amply compensated government contractor
9 employees who worked at the nuclear weapons
10 material plant in Paducah, Kentucky without
11 question, without means-weighted formulas, and
12 apparently without review from the DTRA. This
13 system of unfairness continues to promote gross
14 injustice to all of America's atomic veterans.
15 In light of these issues, it would seem that
16 Congress -- the Congress of the United States
17 refuses to adequately address the issues or to
18 act to correct such injustices. America's
19 atomic veterans do not have the luxury of
20 waiting another five to ten years for Congress
21 to fix or repair an existing system that
22 continues to deny them their rightful
23 recognition for having wounded -- been wounded
24 by an invisible enemy while honoring --
25 honorably serving their country.

1 It is in their collective feeling that the deck
2 has been stacked against them and any
3 reasonable chance for fair treatment for
4 several reasons, including but not limited to
5 the following.

6 Atomic veterans were sworn to secrecy and told
7 straight up that discussing their experiences
8 with anyone, including family members, could
9 result in their spending several years in a
10 Federal prison. It was only just recently that
11 former Secretary of Defense William Perry
12 released these men and women from their oaths
13 of silence.

14 The availability of their individual RAD badge
15 readings were, in most cases, and still is
16 unavailable or non-existent. The personal RAD
17 badges that were made available registered much
18 higher exposure limits at the actual detonation
19 event than the "official" DTRA dose
20 reconstructed assumptions that were
21 subsequently submitted to the atomic veteran
22 and to the Department of Veterans Affairs. It
23 is highly suspect that the official DTRA
24 reconstructed radiation exposure levels
25 associated with atomic veterans' compensation

1 claims are always just below the threshold
2 level required for service-connected disability
3 compensation.

4 The atomic veteran's DD-214 discharge document
5 did not mention any connection with atomic
6 weapons testing. Therefore the veteran had no
7 written proof that would convince the
8 Department of Veterans Affairs of his or her
9 participation in such events.

10 The current list of presumptive radiation-
11 induced illnesses that the Department of
12 Veterans Affairs is supposed to recognize for
13 service-connected compensation purposes without
14 dose reconstruction documentation is not a
15 minor roadblock. It appears to be a massive,
16 multi-tiered concrete wall.

17 The intent of the presumptive illness list was
18 for the purposes of assuming that if you were
19 present at any atomic test which resulted in
20 the atmospheric dispersion of ionizing
21 radiation particles, and you were diagnosed
22 with any of the 21 diseases or illnesses on the
23 current presumptive list, then there will be no
24 need to question the degree of your radiation
25 exposure from said event. So if you went

1 ashore at Hiroshima or Nagasaki or if you
2 participated in any of the atmospheric or
3 underwater tests resulting in atmospheric
4 dispersal of radiation particles, or if you
5 were a part of the Flintlock Test in 1954 or
6 the Mandrel Test in 1959, both of which were at
7 Amchitka, Alaska, and you developed any of the
8 21 illnesses listed as presumptive, the DVA
9 must assume without question that the cause of
10 your illness was the result of your being
11 present at these events.

12 This was supposed to be a simple method of
13 dealing with questionable service-connected
14 situations. However, the hundreds of thousands
15 of atomic veterans who are qualified to receive
16 the intended benefits are still having a hard
17 time convincing anyone within the Federal
18 government hierarchy, including the Department
19 of Defense and the Department of Veterans
20 Affairs, that he or she qualifies for any
21 service-connected benefits.

22 Implementing the good-deed wishes of Congress
23 is often left to third party contractors with
24 absolutely no first-hand background experience
25 related to the actual events and issues. Nor

1 do they have a clear understanding of the
2 aftereffects of the issues. None of the
3 current experts of record were on-site
4 participants in any atomic weapon detonation
5 event.

6 In my travels across the country I've found
7 that many key personnel at most VA medical
8 facilities have no idea that there is an
9 Ionizing Radiation Registry, or what the
10 purpose of such a registry is all about. The
11 vast majority of physicians assigned to VA
12 medical facilities do not clearly understand
13 what ionizing radiation-induced mutants are, or
14 the long term effects of such mutants on the
15 human mechanism. Additionally, I've been told
16 by several VA medical facility personnel that
17 it is difficult to understand the current VA
18 rules as they apply to the acceptance,
19 disposition and treatment of America's atomic
20 veterans.

21 It is also a known medical fact that a wound
22 inflicted by a bullet or a piece of shrapnel
23 from an enemy weapon in the majority of
24 instances will not inflict further damage on
25 the health of the wounded after the fact. A

1 bullet or shrapnel wound is easily
2 recognizable. There is no doubt that the wound
3 exists, or where it exists. Nor is there any
4 doubt about the prescribed method required to
5 treat and heal such a wound.

6 It is scientifically proven that most health
7 issues precipitated by the inhalation or
8 ingestion of ionizing radiation particles are
9 forever and cannot be reversed, causing health
10 issues to continue to surface as long as 50
11 years or more after the exposure events. These
12 wounds are not easily recognizable, not easily
13 or accurately diagnosed, and the DTRA casts
14 serious doubt that any such wound was actually
15 precipitated by a radiation exposure event.

16 It is also a known fact that a bullet or
17 shrapnel wound suffered by the -- in the field
18 of battle will not affect the health of the
19 children born to those who are the recipient of
20 such wounds. It is a proven scientific fact
21 that mutations of reproductive processes will
22 affect the health of a large percentage of
23 children born to atomic veterans, and even in
24 the third -- even into the third generation.
25 The National Association of Atomic Veterans,

1 Inc., since 1979, developed and maintained a
2 medical database of those members who elected
3 to submit their illness histories for such
4 purposes. In submitting this data most of
5 these veterans included comments about their
6 children born with deleterious and suspicious
7 health anomalies.

8 It was discovered that approximately 18 percent
9 of the children born to atomic veterans can be
10 classified as genetically impaired offspring.
11 When comparing the NAAV medical database
12 results to the total estimated number of
13 veterans exposed to ionizing radiation, it
14 would suggest that there were approximately
15 180,000 genetically impaired offspring born to
16 America's atomic veterans. An accurate
17 estimate of the number of third generation
18 genetically impaired offspring is not readily
19 available.

20 While on a business trip to northern England
21 and Scotland just after the Chernobyl power
22 plant meltdown, I happened to notice that all
23 the sheep along the country roads that I
24 traveled had a large red spot on their flank.
25 Later that evening over dinner I asked about

1 the red spots on all the sheep. The following
2 was the reply from a medical doctor who was
3 dining at the same -- the next table, or the
4 table next to ours, I should say, and who
5 happened to overhear my conversation about the
6 effects of radiation exposure on America's
7 atomic veterans. He related that the northern
8 portion of England and all of Scotland were in
9 the path of the Chernobyl radiation fallout
10 pattern. Given this and the fact that most of
11 the sheep harvested were harvested for wool and
12 food stock to be distributed to a large part of
13 Europe, the U.K. scientific community decided
14 that all sheep exposed to the fallout pattern
15 must be marked with a red spot on their flank,
16 and that no mutton was to be sold as food
17 stock. It was also decided that all second-
18 generation sheep would then be marked with a
19 different color spot on their flank, and no
20 mutton was to be sold at food stock. And
21 accordingly, all third-generation sheep would
22 be treated similarly. Only fourth-generation
23 sheep could then be harvested for their wool
24 and the mutton could then be sold as food
25 stock.

1 It would seem from the good doctor's
2 explanation that the U.K. scientists know much
3 more about harmful effects of genetic -- of the
4 genetic impact of ionizing radiation mutants on
5 first, second and third-generation offspring
6 than our own governmental agencies or
7 scientific community may be willing to admit.
8 In a statement recognizing July 16th, 2002 as
9 National Atomic Veteran's Day of Remembrance,
10 President George W. Bush compared America's
11 atomic veterans exposed to nuclear radiation as
12 being just as gravely wounded as a veteran hit
13 by an enemy projectile, both of whom were
14 wounded while standing in harm's way to protect
15 the national security and the freedoms of the
16 citizens of the United States of America.
17 America's atomic veterans firmly believe that
18 the President's statement was both
19 compassionate and accurate, and offer their
20 thanks for his personal interest in the general
21 welfare of all military personnel, those
22 currently in uniform, all veterans of past
23 conflicts, and veterans of the U.S. atomic
24 testing programs.
25 Additionally, all of America's atomic veterans

1 grieve for those who were so amply rewarded by
2 the U.S. government and the outpouring of
3 contributions from the American public after
4 losing their loved ones during the terrible
5 events of September 11, 2001. The U.S.
6 Congress was quick to open the taxpayer purse
7 strings for ample reparations, and without
8 question, since this was fresh in the minds of
9 all Americans.

10 It is, however, an established fact that the
11 experiences and plight of America's atomic
12 veterans are kept secret and unknown from the
13 general public. If the American people were to
14 be fully informed of this sterling example of
15 how Congress has continued to drag their feet
16 in addressing the life and death issues of
17 America's atomic veterans, they would be
18 totally and completely outraged.

19 It is also an established fact that America's
20 atomic veterans are still lying mortally
21 wounded and slowly dying on their home front
22 battlefield, with no visible hope of being
23 properly recognized, medically assisted or
24 amply compensated without question for their
25 continued sacrifices on behalf of the citizens

1 of their own country. They must continue to
2 rely upon those of us who may wish to listen
3 and who may wish to care. Until this situation
4 is rectified, each day in the life of an atomic
5 veteran without proper and adequate recognition
6 will continue to be a sad day for all of
7 America.

8 The key issue of major concern to America's
9 atomic veterans is post-exposure radiation-
10 induced mutations, regardless of how small the
11 exposure dose is considered to be by the dose
12 reconstruction calculation process. It is the
13 firm belief of the National Association of
14 Atomic Veterans, and other veterans'
15 associations as well, that dose reconstruction
16 was and continues to be a waste of taxpayer
17 funds, and the results cannot be fully and
18 accurately substantiated, nor can they be
19 verified as being realistically believable.
20 It is also the firm belief of NAAV, Inc. that
21 all atomic veterans, regardless of whether they
22 are currently suffering from health issues that
23 may be associated with their exposure to
24 ionizing radiation or not, should be
25 immediately placed in the same DVA medical care

1 group as those veterans who were awarded the
2 Purple Heart, without hesitation, without
3 limitations, and without means-weighted
4 restrictions.

5 Perhaps the U.S. Congress would rather wait
6 until America's last atomic veteran has
7 expired, without compassion, without
8 recognition, without compensation and without.
9 Atomic veterans from Great Britain, Australia
10 and New Zealand who participated in U.K.-
11 sponsored weapons tests were issued an Atomic
12 Veteran Service Medal. These radiation
13 exposure medals are viewed by the recipients as
14 their equivalent of our Purple Heart, and
15 rightfully so.

16 It is our hope that this Veterans Advisory
17 Board will convey these remarks and the deep
18 concerns of America's atomic veterans to
19 Congressional committee for which they were --
20 have been established. It is also our hope
21 that the Congressional committee exploring the
22 need to abolish dose reconstruction will fully
23 recognize the years of suffering experienced by
24 America's atomic veterans, who have not only
25 been burdened with the monetary

1 responsibilities of having to fend for
2 themselves, but who have also -- in a large
3 percentage of instances -- have been burdened
4 with the monetary responsibilities of having to
5 fend for the needs of their genetically
6 impaired offspring, as well.

7 These are America's Cold War warriors who
8 continue to sacrifice themselves from day to
9 day for the sake of their country, years after
10 being released from their military obligations.
11 They are all hopelessly trapped in a twilight
12 zone of Congressional procrastination and
13 political indecisiveness. I think it is time
14 for a major change on their behalf. Is America
15 really listening? The silence is deafening.
16 Thank you.

17 **ADMIRAL ZIMBLE:** Okay. Commander Ritter, one
18 second, just a minute. First of all I want to
19 thank you for giving a very articulate
20 expression of the perceptions and feelings --

21 **MR. RITTER:** Thank you, sir.

22 **ADMIRAL ZIMBLE:** -- of -- of the atomic
23 veterans. I assume that you're speaking for
24 your organization, for the NAAV.

25 **MR. RITTER:** I'm speaking for all of the

1 veterans who were in all of the tests from day
2 one. And we also now include a great deal of
3 concern for those veterans who were exposed to
4 depleted uranium in the Gulf War and currently
5 to today -- fighting for our country today.
6 This is going to be another group of
7 radioactive veterans that the government's
8 going to have to contend with.

9 **ADMIRAL ZIMBLE:** That -- you certainly have
10 conveyed to this Board the sense of the
11 feelings and the -- and the perceptions --

12 **MR. RITTER:** Yes, sir.

13 **ADMIRAL ZIMBLE:** -- and -- and so we'll take --
14 we'll take that aboard and we'll look at that.
15 Any comments or questions? Okay, thank you
16 very much --

17 **MR. RITTER:** Thank you. Thank you, sir.

18 **COLONEL TAYLOR:** One thing. As a member of
19 that --

20 **MR. RITTER:** Yes, sir.

21 **COLONEL TAYLOR:** -- organization, I can echo
22 that.

23 **MR. RITTER:** I'm sorry, sir?

24 **COLONEL TAYLOR:** As a member of that same
25 organization, I can echo his remarks and say I

1 applaud him for saying them. Thank you.

2 **MR. RITTER:** Thank you, sir. Pleased to be
3 here.

4 **ADMIRAL ZIMBLE:** Okay. Thank you. With that,
5 we're -- we're 20 minutes behind schedule.
6 We've allowed in the original agenda two hours
7 for -- for dinner. I'm going to therefore take
8 the prerogative of the Chair to say that we
9 will reconvene not at 7:00 but at 7:15.
10 Now we have, as I understand it, eight -- eight
11 people have -- have asked to testify this
12 evening, and I think that I would like to allow
13 around seven to ten minutes for each
14 presentation. Try not to exceed that so we can
15 -- we can get through the evening -- hope -- I
16 hope that none of the folks who are testifying
17 have insomnia so we can be sure that we can
18 complete before 10:00 o'clock, if possible.
19 But at any rate, I think you all for this
20 session. If there is anyone else that wants to
21 testify, please register now so that we can do
22 so, and I'd like to see everybody back here
23 promptly at 7:15. Thank you very much.
24 (Whereupon, a recess was taken from 5:20 p.m.
25 to 7:15 p.m.)

1 PUBLIC COMMENT SESSION

2 **ADMIRAL ZIMBLE:** Ladies and gentlemen, let's
3 get started with our evening session. I would
4 like to ask any visitor that wants to testify
5 that has not signed in to please sign in your
6 request to make a public comment. I -- I have
7 eight names on this list. Understand there may
8 be a ninth name, and I'm going to adjust the
9 order just a little bit and ask first for --
10 for Mr. Jim Taylor, who wanted to speak, to
11 come forward now. And I -- and I want you to
12 speak right into that -- the mike there --

13 **MR. TAYLOR:** Okay, do you want me to -- is it
14 on? Okay. You want me to introduce myself?

15 **ADMIRAL ZIMBLE:** I'd like you to introduce
16 yourself.

17 **MR. TAYLOR:** All right.

18 **ADMIRAL ZIMBLE:** Jim, just -- if you'd like,
19 introduce yourself, and try to limit your
20 remarks to between five and seven minutes, if
21 you can.

22 **MR. TAYLOR:** Yes, sir.

23 **ADMIRAL ZIMBLE:** Okay.

24 **MR. TAYLOR:** Okay, I'm Jim --

25 **ADMIRAL ZIMBLE:** That's on.

1 **MR. TAYLOR:** I'm Jim Taylor and I'm the -- with
2 the National Association of Atomic Veterans.
3 I'm the Area Commander for northeast Florida.
4 Excuse me, I have to read from notes because I
5 just come off chemo last week and my memory's
6 still -- they call it chemo brain, you know,
7 but memory's still kind of short so I'll be
8 referring to notes here.
9 And I hope that you haven't already touched on
10 this and I missed it, but what I'm going to
11 speak about -- possibly -- Paul touched on it
12 when he mentioned about the sailors swimming in
13 the lagoon being exposed to the sea water. By
14 the way, I want to commend DTRA for their
15 excellent record-keeping. I thought I had been
16 exposed to ten atomic bombs and I found out it
17 was 18 -- 17 atomic and one hydrogen. But
18 anyway, because of them records, I have that,
19 and how far away I was on some of them shots.
20 And that brings to the point of -- I was at
21 Eniwetok in 1958, June 9th, 1958 at 11:45 a.m.,
22 the Umbrella Shot, which was the underwater
23 detonation, went off -- 7,100 yards, 71
24 football fields away from where we was at.
25 Okay? Now working in the boiler room -- I

1 found out, by way of my division officer who
2 got ahold of me by way of the internet, that
3 the highest readings they got on that whole
4 ship was in the boiler room where we worked,
5 because we handled all the water. Okay.
6 Not only that, is we boilermen had to take
7 about three to four showers a day. Every time
8 we come off watch, we had to take a shower.
9 The crew would make sure of that, so -- but --
10 so -- by the way, in that shower, I never
11 recall wearing my badge. It kind of hurt when
12 you'd try to stick it in the skin there, but --
13 so we never wore badges then. We drank that
14 water. We bathed in that water.
15 And so my -- as a retired computer consultant,
16 I know what goes into computers and what you've
17 got to have to make decisions. My question is,
18 has anybody thought of the boilermen that has
19 to take more showers than anybody else, or the
20 engine men or whoever works in them higher
21 areas have to take a lot of showers, drank a
22 lot of water, and we was only 7,100 yards from
23 an underground explosion, so we're bathing in
24 that water, drinking that water, eating that
25 fish and everything else. And I think we need

1 more data and if -- if I missed that, again, I
2 apologize, but I don't believe we have the data
3 on each individual sailor on what he was
4 exposed to with the exception of what Dr.
5 Blake's mentioned about the sailors swimming in
6 the lagoon. That's the only thing I -- I
7 picked up on that. And that's -- that --

8 **ADMIRAL ZIMBLE:** Okay. Well, Jim, I just have
9 one question.

10 **MR. TAYLOR:** Sure.

11 **ADMIRAL ZIMBLE:** If you don't mind answering
12 this. You don't have to, but if you're on
13 chemotherapy, would you mind telling us what
14 your diagnosis is?

15 **MR. TAYLOR:** I'm diagnosed with non-Hodgkin
16 lymphoma.

17 **ADMIRAL ZIMBLE:** Okay. All right. Any -- any
18 questions or comments from the Board?

19 (No responses)

20 All right. Mr. Taylor, I thank you very much
21 for your -- for your comments.

22 **MR. TAYLOR:** Thank you. You're welcome.

23 **ADMIRAL ZIMBLE:** I would now like to call
24 Bettie Jo Taylor. And Mrs. Taylor, if you
25 would state your name and speak very closely

1 into that mike.

2 **MS. TAYLOR:** Okay. I'm Bettie Jo Taylor, I'm
3 the wife of Jim Taylor, and mostly my questions
4 are directed to benefits of VA because this --
5 I'm the household accountant and I take care of
6 the records at home and everything, and I have
7 some questions and we've done some things
8 already. I've gotten some answers, but just
9 for the record, I will voice them up here. My
10 question is, if you have a presumptive and a
11 non-presumptive cancer, why can't the VA begin
12 benefits to the veteran on the presumptive
13 while the dose reconstruction's being worked on
14 on the non-presumptive? And I've already
15 gotten an answer of that, but it should have
16 been done and it's kind of fell through the
17 cracks right now, and that's going to be taken
18 care of. So I just wanted that to go on the
19 record.

20 **ADMIRAL ZIMBLE:** Right, I appreciate that and
21 appreciate that going on the record. We also
22 have the letter that you submitted, and that
23 will be part of our -- part of our database.

24 **MS. TAYLOR:** I have another question, and it's
25 would the claim be retroactive to the date that

1 we filed the claim or would it be retroactive
2 to the date of the diagnosis of the disease?

3 **MR. PAMPERIN:** The effective date normally is
4 the date of your application. The only time
5 it's earlier than that is if the particular
6 disability was newly made presumptive. When
7 you -- say you already had lung cancer and lung
8 cancer went from 311 to 309, we could go up to
9 a year, but not earlier than the date we made
10 it presumptive. But that's the only time you
11 can go retroactive. Otherwise it's date of
12 claim.

13 **MS. TAYLOR:** Okay. My last question is if the
14 veteran has received RECA, which must be repaid
15 in order for the veteran to receive disability
16 from the VA, is it possible that the medical
17 expenses already paid by the veteran for this
18 cancer, can it be included in this repayment to
19 RECA?

20 **ADMIRAL ZIMBLE:** Mr. Pamperin, if it's easy for
21 you to answer that question, do so. If it --
22 if it needs any research, we can take that for
23 the record and get back to you.

24 **MR. PAMPERIN:** I would rather we did that.

25 **ADMIRAL ZIMBLE:** Okay. I think on these

1 individual questions --

2 **MS. TAYLOR:** Right.

3 **ADMIRAL ZIMBLE:** -- we will -- we will not
4 ignore them, but we will -- we will make sure
5 we give you the right answer, and we will send
6 that to you individually.

7 **MS. TAYLOR:** I understand.

8 **ADMIRAL ZIMBLE:** Please make sure that you --
9 we have all the contact data that we need to be
10 able to get in touch with you.

11 **MS. TAYLOR:** Okay.

12 **ADMIRAL ZIMBLE:** Okay? If it's -- and just as
13 an aside, if the question is generic, we may
14 take it for the record. We'll then publish
15 that answer on the web so that if it affects
16 more than -- more than one or two individuals.

17 **MS. TAYLOR:** Okay. This -- this is something
18 that I just wanted to get before y'all because
19 --

20 **ADMIRAL ZIMBLE:** Okay.

21 **MS. TAYLOR:** -- I don't think there's a
22 precedent for it.

23 **ADMIRAL ZIMBLE:** Okay.

24 **MS. TAYLOR:** Thank you.

25 **ADMIRAL ZIMBLE:** Thank you very much,

1 appreciate that.

2 All right, next --

3 **DR. BOICE:** Oh, Admiral --

4 **ADMIRAL ZIMBLE:** Oh, excuse me.

5 **DR. BOICE:** -- I'm sorry -- ask a question for
6 Paul Blake regarding --

7 **ADMIRAL ZIMBLE:** Sure.

8 **DR. BOICE:** -- Mr. Taylor's comment. Paul, you
9 had mentioned that you send out a questionnaire
10 when there's a claim. Would that be the
11 opportunity for the sailor or the veteran to
12 write his activities, such as his concern about
13 bathing in contaminated water, taking frequent
14 showers, so that -- is that the opportunity
15 where this would come to your attention?

16 **DR. BLAKE:** It certainly is. What we'll do
17 after we get that questionnaire is that we will
18 put that all together in the SPARE, forward it
19 back -- after phone calls and so forth, back to
20 the veteran. If they have any final comments,
21 they can input that into the case and finally
22 sign off on it, and that's the basis for when
23 we start the radiation dose reconstruction.

24 **ADMIRAL ZIMBLE:** Okay. Thank you.

25 **MR. GROVES:** And just to follow up, Paul. Are

1 the issues that I think were very -- very well
2 articulated about, you know, much contaminated
3 seawater going through the compartment that the
4 gentleman was stationed in, are those kind of
5 things able to be calculated as a part of the
6 dose reconstruction as it's currently
7 configured?

8 **DR. BLAKE:** We -- we do calculate those, but
9 there's lots of uncertainty associated with it.
10 We have to take into account shipboard surveys
11 at the period of time --

12 **MR. GROVES:** Okay.

13 **DR. BLAKE:** -- the fallout that fell in, but
14 there's still a big plus or minus that goes
15 into that calculation.

16 **ADMIRAL ZIMBLE:** Okay. And again, almost all
17 of these uncertainties will go in the fav--
18 towards the favor of the veteran.

19 **DR. BLAKE:** Yes, sir.

20 **ADMIRAL ZIMBLE:** Okay. Will Mr. Charles Wiener
21 -- Wisner, I'm sorry.

22 **MR. WISNER:** That's all right, Admiral, I get
23 called a lot different --

24 **ADMIRAL ZIMBLE:** Yeah, but let me just call you
25 Chuck -- Chuck Wisner.

1 **MR. WISNER:** Thank you.

2 **ADMIRAL ZIMBLE:** Right.

3 **COLONEL. TAYLOR:** Among other things, Charlie.

4 **MR. WISNER:** All right.

5 **ADMIRAL ZIMBLE:** Please identify yourself for
6 the record.

7 **MR. WISNER:** My name is Charles Wisner, and I
8 first of all am an atomic veteran with
9 Operation Greenhouse, 1951. I'm past National
10 Association of Atomic Veterans, Inc. -- past
11 commander. And more importantly, the National
12 VA Volunteer Services representative and the
13 NAAV V-- National VA medical representative.
14 And it's from this perspective that I'd like to
15 address the Board tonight.

16 Mr. Chairman, Advisory Board members, fellow
17 veterans and guests, up until a few years ago
18 our atomic veterans had experienced a very poor
19 relationship with the VA and the Defense Threat
20 Reduction Agency. Our people knew very little
21 because they were bound by secrecy mandates.
22 There was no open communication. The VA
23 ignorance and the denial after denial because
24 of no or very low dose reconstruction
25 renderings given by the VA -- by DTRA, some of

1 our people have been fighting the system for
2 over 40 years and are still without medical
3 assistance, compensation or benefits. Many
4 have died and have widows who are left behind
5 with absolutely nothing, financially speaking.
6 Or if living, must pay for their own medical
7 expenses, as well as their genetically-involved
8 offspring.

9 If the veteran is still healthy enough to work
10 and earn an income, unfortunately if he exceeds
11 the VA means test, they are denied access into
12 the system.

13 Congress has of course come out with several
14 Public Laws to address some of these
15 inequities. However, there are so many
16 bureaucratic layers of red tape,
17 misinterpretations of what has -- is already
18 written in deference to the individual
19 veteran's plight or circumstances and -- that
20 they are told they do not qualify for medical
21 services, compensation or benefits. You add
22 this to the many lies of the past, denial after
23 denial, rejection after rejection, and what do
24 you have? You have another irate, disgusted,
25 paranoid veteran who feels that he's been

1 shafted.

2 To the credit of the VA -- and some of my
3 people will disag-- will disagree with me on
4 this, but I have to say it because I work in
5 the VA system. To the credit of the VA, most
6 everything having to do with the atomic veteran
7 is succinctly written. This would include the
8 whys and the wherefores and what the VA is --
9 what the VA is required to do and what the
10 veteran himself must do to fulfill the process.
11 And I have here in this three-ring loose leaf
12 manual most everything that's off of the
13 internet. I'm going to be submitting this to
14 the -- to the Board.

15 They've established the ionized radiation
16 program that would meet most of the veterans'
17 needs if evenly -- and I emphasize the word
18 "evenly" -- put into practice. But I'm finding
19 out that on a national level what is written is
20 not apparently being taught to the support
21 staff at the local VA medical facility level.
22 Every facility seems to operate differently,
23 and consequently there is no continuity with
24 what has been written. Each facility is left
25 to their own interpretations, usually by

1 management, and the line staff are simply
2 instructed to follow and do what they're told.
3 Here's some examples. Just since the first of
4 the year I received an average of ten to 15 e-
5 mails or telephone calls per week stating that
6 when the veteran went to their local VA medical
7 center they were told that there was no such
8 thing as the Ionized Radiation Registry, or
9 that they, the contact person, did not know
10 anything about Ionized Radiation Registry.
11 At another medical center the VA -- the veteran
12 was told that only those that were involved at
13 Hiroshima and Nagasaki qualified for the
14 program. Others are being told that their DD-
15 214 does not indicate that they were involved
16 in any atomic test, so they do not qualify for
17 the IRR. None of the DD-14s (sic) from that
18 era contain that information. Declassification
19 did not begin until the Clinton administration.
20 Others were told that they did not have any way
21 of verifying the veteran's present or -- and/or
22 exposure by ship, unit, squadron, atomic test,
23 et cetera -- now this is coming from the line
24 staff in the VA; I know that DTRA has that
25 information, but the VA doesn't -- wherefore

1 they do not qualify for the program.
2 Still others are being told that they must
3 contact DTRA first and get this information,
4 and then come back to enroll. Still others who
5 were fortunate enough to enroll, have their lab
6 and X-ray and physicals, are never contact by
7 the -- contacted by the VA to let them know
8 that they were on the IRR or denied, and what
9 reason -- and if I read the book right, it says
10 approximately two weeks -- or they have not
11 experienced any type of follow-up, even after
12 being told they had a problem and should be
13 seen by a specialist.
14 The question to me has been what is going on;
15 what do I do next? And I could go on, but I
16 think you all are getting the picture.
17 Defense Threat Reduction Agency. The other
18 area of great concern has been DTRA. This has
19 been a very sore subject for many years. For
20 whatever reason, right or wrong, our veterans
21 have never really received a fair shake from
22 this organization regarding their dose
23 readings. Most communication from the veteran
24 has been ignored, or they received a response
25 with a lot of double-talk that could not be

1 understood. Many of their names were mis-
2 spelled, wrong birth dates, wrong service
3 number, wrong Social Security numbers or other
4 pertinent information was wrong. Many felt
5 that they received the wrong reading and was
6 given someone else's. Many felt, and still
7 feel, that they received a reading based on a
8 unit as a whole and not a personal reading,
9 particularly when they knew they were part of
10 circumstances that was not taken into
11 consideration.

12 The unit station-- this is an example. The
13 unit stationed in Kwajalein but their planes
14 flew -- they flew planes that entered into the
15 atomic clouds and they still received a zero
16 reading. The majority were denied VA claims
17 because these low readings went -- these low
18 readings when -- what they have read on the
19 internet and articles in books published have
20 indicate otherwise. One asked and -- Mr.
21 Taylor addressed this one -- we swam in the
22 lagoons and in the waters, and this is
23 Kwajalein that's being talked about here, in
24 the waters where some 49 ships had been sunk
25 from a previous test. We ate food, drank

1 water, showered in contaminated water. We had
2 to work in swill. We were on aircraft highly
3 exposed to radiation. Doesn't that count for
4 something?

5 The majority of these people were not issued
6 dosimeters, goggles, protective clothing before
7 or during the detonations. Our people were
8 being told unless DTRA gives -- and this is
9 something that you need to address. Our people
10 are being told unless DTRA gives you a reading
11 of five rems or more, the VA will continue to
12 deny their claims for compensation.

13 In all fairness, I must say that since Dr.
14 Blake came on board DTRA there has been some
15 positive progress made. Mr. (sic) Blake has
16 been instrumental that I know of in three or
17 four different cases of getting -- facilitating
18 dose reconstruction on these people.

19 There has been some progress made.

20 Communication with our veterans has increased
21 and their cases are being reviewed more
22 expeditiously, and I hope this can continue in
23 the future.

24 And I was going to read a lot of e-mails, but
25 they're in this book, and I'm going to give

1 this to the committee, along with my
2 presentation so you'll have it. But there is
3 one question, and I received this before --
4 just before I left home.

5 And it says, During Operation CROSSROADS, Shot
6 Baker was a plutonium bomb, thus bringing me to
7 my question. In 1946 did the health physicists
8 in Bikini during Crossroads testing have use of
9 reliable alpha counters? Plutonium, an alpha
10 emitter, generally recognized by science as one
11 of the most deadliest materials known to man.
12 This man has been trying to get compensation
13 year after year, year after year. He's just
14 found out about this plutonium and he -- his
15 question is, back there during Crossroads, did
16 they have the right -- right instrumentation
17 that's -- he could get a reading. And I thank
18 you very much.

19 **ADMIRAL ZIMBLE:** Thank you very much, Mr.
20 Wisner. Would you stay at the microphone for
21 just a moment?

22 **MR. WISNER:** Yes, sir.

23 **COLONEL TAYLOR:** I have a question of him.

24 **ADMIRAL ZIMBLE:** Colonel Taylor.

25 **COLONEL TAYLOR:** How long --

1 **ADMIRAL ZIMBLE:** Colonel Taylor, would you
2 speak into the microphone, please?

3 **COLONEL TAYLOR:** Charlie, how long have you
4 been involved in this program and what range of
5 time are you talking about in that
6 presentation?

7 **MR. WISNER:** Well, I'll put it this way. I
8 have been involved as a VAVS representative for
9 over 11 years. I have been with NAAV in this
10 position -- it was a newly-adopted position two
11 years ago. And because of my background and
12 expertise, they asked me if I would develop
13 this program in NAAV, and so we're -- we're in
14 the baby stages with NAAV. But already we have
15 nine representatives at various VA sep-- VA
16 facilities.

17 **COLONEL TAYLOR:** Thank you. I think I can add
18 a note to the Board that's worthwhile. I know
19 him. I've worked with him for some time now, a
20 year or two. He has just suffered his fourth
21 heart attack is the reason he resigned the job
22 as the chairman, and he's still at work. Thank
23 you.

24 **MR. WISNER:** Thank you.

25 **ADMIRAL ZIMBLE:** Thank you very much, Mr.

1 Wisner, and please submit those e-mails.

2 **MR. WISNER:** I gave it to...

3 **ADMIRAL ZIMBLE:** Okay, 'cause that'll be --

4 **MR. WISNER:** (Unintelligible) my copy.

5 **ADMIRAL ZIMBLE:** That'll be very useful to --
6 to the subcommittee work.

7 **MR. WISNER:** Okay, thank you.

8 **ADMIRAL ZIMBLE:** All right. Thank you. All
9 right, now I would like to ask Ms. Pat Broudy
10 to please come forward.

11 **MS. BROUDY:** My name is Pat Broudy. I'm the
12 widow of Charles Broudy, who died of lymphoma
13 in 1977 as a result of his radiation exposures
14 at Nagasaki, the ABC School at Mare Island, and
15 at Shot Hood in Operation Plumbbob.

16 I'd like to read just a few historical
17 documents, and the first one is dated March the
18 3rd, 1995. It is from the Defense Nuclear
19 Agency. (Reading) I am forwarding to you the
20 historical dose reconstruction contracts which
21 I indicated in my February 1995 letter would be
22 retrieved from archival storage and copied for
23 you. You will find copies of eight contracts
24 attached and identified as follows.

25 And they're listed here in this document, which

1 I will give you a copy of.

2 (Reading) The archival search encompassed
3 locating ten contracts. However, only the
4 eight listed above survive. Two of the
5 contracts, DNA 001-78- -- well, there's several
6 of them and they're long numbers -- the oldest
7 of the ten are no longer available. They were
8 destroyed at the Suitland, Maryland Federal
9 Records Center in December '88 and January '91,
10 respectively, according to the Federal
11 Acquisitions Regulations which specifies
12 schedule for the destruction of contracts after
13 closeout. The total costs and periods of
14 performance summarized in my 3 February 1995
15 letter are accurate representations for these
16 destroyed contracts, because summary abstracts
17 for these Defense Nuclear Agency contracts,
18 copies attached, are retained on file. I hope
19 the attached contracts provide you useful
20 information. Please contact me if I can be of
21 further assistance. Sincerely, Kenneth L.
22 Haggeman.

23 There is an attachment of a list of years and
24 funding dollars. At the top it says total
25 funding for the Nuclear Test Personnel Review

1 program, 1978 to 1994. It starts with 1978 at
2 a funding level of \$3.9 million. And the very
3 last total of the ten contracts listed is \$96.5
4 million. The source -- NTPR, for the record --
5 a history of the Nuclear Test Personnel Review
6 program, 1978 to 1993, final draft of DNA6041F.
7 The next page lists the DNA costs for NTPR dose
8 reconstructions. It lists the ten contracts.
9 It lists the dates and it lists the contract
10 value, a total value of \$13,598,939. That is
11 for ten contracts. And I have the contracts at
12 home. I didn't bring them because they take up
13 this much room. But I do have a breakdown of
14 them, which I did not bring with me because it,
15 too, is too voluminous. So I will read to you
16 also some very small facsimiles, and one of
17 them is dated April 8, 1996 and it's addressed
18 to me from Cathy Collier, VBA, VA Central
19 Office, Washington.

20 (Reading) Comments. Mrs. Broudy, in response
21 to your questions: (1) the number of veterans
22 receiving compensation under the presumptive
23 laws, our databases show 463 veterans receiving
24 compensation as of January 1, 1996; and (2) the
25 number of veterans receiving compensation under

1 Public Law 98-542, VA Regulation 38 CFR 3.311,
2 I must defer to my earlier response.
3 Unfortunately we do not maintain this
4 information and cannot extract it from our
5 databases.
6 It gets better. On the 23rd of April, 1996 I
7 received a letter, another FAX, from Cathy.
8 (Reading) Mrs. Broudy, in response to your
9 April 18, 1996 memo which was FAXed to Brad
10 Underwood, let me try to explain why we are
11 unable to provide a response at this time.
12 Specifically, you have requested the number of
13 veterans receiving compensation under Public
14 Law 98-542, a breakdown by veteran and
15 surviving spouse, and the percent assigned to
16 the veteran's condition. As I responded
17 earlier, we do not maintain these data. Let me
18 clarify this statement. Our databases do not
19 maintain statistics on actual grants of service
20 connection under 38 CFR 3.311, and we have no
21 way to retrieve this information from our
22 automated databases. This information would be
23 obtainable only through a manual review of over
24 18,000 claims folders. Since historically the
25 grant rate under this regulation has been quite

1 small, we believe that it currently would be
2 fewer than 50. But that number is only an
3 unverified estimate.

4 As to the breakdown by veteran and surviving
5 spouse on presumptive grants of service
6 connection, 38 CFR 3.309(d), we do not maintain
7 this information on a routine basis, and cannot
8 provide it immediately. To obtain this
9 information we must make a special request to
10 our data information and systems staff. That
11 type of project requires at least a week to
12 perform since the procedure for extracting the
13 data is complex and time-consuming. Given your
14 time constraints of a matter of hours, I
15 responded that the information could not be
16 supplied. I have asked that this project be
17 initiated. However, let me point out that the
18 database from which the information must be
19 extracted may impose limitations. But I will
20 explain them to you once the information is
21 obtained.

22 I never obtained it -- never received it.

23 (Reading) Again let me point out that this type
24 of project requires at least a week to
25 complete, so I am not sure it will be available

1 to you before you testify at the April 30, 1996
2 Congressional hearing. We will try to
3 accommodate your schedule. Signed, Cathy
4 Collier, Staff Consultant, Office of the
5 Director, Compensation and Pension Service.
6 This is the last one; it's very short. This
7 one is dated June 20, 1996. (Reading)
8 Comments. This response to your request for a
9 breakdown of the number of veterans and
10 surviving spouses receiving benefits based on
11 presumptive grants of service connection, 38
12 CFR 3.309(d), our databases show 272 veterans
13 are receiving compensation and 133 surviving
14 spouses are receiving DIC. This total, 405,
15 doesn't match the total of 463 previously
16 reported. The number of 405 was obtained using
17 different selection criteria, and we believe it
18 to be correct. Hence, it seems that 58 cases
19 were coded incorrectly.

20 And what I am trying to accomplish by reading
21 all this history is that I have received the
22 ten contracts, and I went through it, page by
23 page, numbers by numbers. It wound up, for the
24 10-year period, of several hundred million
25 dollars. Now out of that amount, fewer than 50

1 awards have been made, even as the Green Book
2 was published in 2003. Thank you.

3 **ADMIRAL ZIMBLE:** Thank you very much, Ms.
4 Broudy. Make sure we have that -- those --
5 those letters, or copies of those letters. And
6 also you made a statement at the NAAV
7 convention. Do we have a copy of that
8 statement?

9 **MS. BROUDY:** (Off microphone) (Unintelligible)

10 **ADMIRAL ZIMBLE:** No.

11 **MS. BROUDY:** (Off microphone) I gave
12 (unintelligible) a copy (unintelligible).

13 **ADMIRAL ZIMBLE:** All right, we do have a -- we
14 do have a copy of that statement, right. Okay,
15 good. Thank you very much. I appreciate that.
16 Any comments from the Board?

17 (No responses)

18 Okay. The next speaker -- the next speaker is
19 Mr. Charles Clark.

20 **MR. CLARK:** Mr. Chairman, Board members, I want
21 to thank you first for this opportunity.

22 **ADMIRAL ZIMBLE:** Please -- please identify
23 yourself.

24 **MR. CLARK:** My name's Charles Clark, and I'm
25 from Hawaii --

1 **ADMIRAL ZIMBLE:** Okay.

2 **MR. CLARK:** -- I'm dressed like one. I would
3 like to bring to the attention of the Board
4 perhaps a disparity of which I have found in
5 the report that we received yesterday from NTPR
6 wherein on page 29 of that particular document
7 there's a citation on page 29 that says
8 (reading) only those Nagasaki occupation forces
9 that regularly entered the Nishiyama area had
10 the potential to receive doses up to one rem.
11 I would like to submit if I may, please, for
12 your attention, this report is bilingual,
13 English and Japanese, as submitted by the
14 Atomic Bomb Casualty Commission. The Atomic
15 Bomb Casualty Commission was dispatched by
16 President Truman to the areas of Hiroshima,
17 Nagasaki, and did the report in October --
18 namely October 3 through 7, 1945. In this
19 report it gives the following, if I may,
20 please. It cites the fact that the
21 measurements were made with Geiger counters
22 that had been calibrated with radium standards,
23 first of all, to do their work. It cites the
24 dates of 3 through 7 October 1945 for the
25 survey, and it goes into dissertation. The

1 fallout in the Nishiyama area of Nagasaki was
2 much higher, registering 1.0 millirems per
3 hour. It continues down and we find that the
4 radiation dose, approximately 30 rad of those
5 folks in that area. I submit the following,
6 sir, because it does counter what we're saying
7 here. It must be corrected.

8 **ADMIRAL ZIMBLE:** All right. Thank you.

9 **MR. CLARK:** I also -- I also would like to --
10 if I may, please. I refer now to the Green
11 Book, page 160.

12 **ADMIRAL ZIMBLE:** All right.

13 **MR. CLARK:** Page 160 speaks to skin cancer, of
14 which I'm a victim of. It says in the first
15 paragraph, it cites that skin cancer was the
16 most-cited medical issue. It continues down to
17 cite that beta dose was not routinely
18 calculated in such cases until 1998.

19 I just recently received a reply back from NTPR
20 saying denial without beta. Beta is a
21 component of skin cancer. I'd like to see that
22 in our next report, if we would, please. I
23 thank you, sir.

24 **ADMIRAL ZIMBLE:** All right. Thank you very
25 much, Mr. Clark. Any comments or questions

1 from the Board?

2 Yes, Paul.

3 **MR. VOILLEQUÉ:** I'm wondering if we can get a
4 copy of that ABCC report?

5 **ADMIRAL ZIMBLE:** I have a copy of that report
6 and I'll make it available.

7 Thank you very much, Mr. Clark.

8 **MR. CLARK:** Thank you.

9 **ADMIRAL ZIMBLE:** We appreciate it. Have a nice
10 safe trip back to Hawaii. Aloha.

11 The next speaker -- I'm going to have trouble
12 reading this last name. It's Bernie, and I --

13 **MR. B. CLARK:** (Off microphone) I'm the
14 brother.

15 **ADMIRAL ZIMBLE:** Oh, you're the brother? Okay.

16 **MR. B. CLARK:** (Off microphone) Not
17 (unintelligible)

18 **ADMIRAL ZIMBLE:** That's Clark, then. Mr.
19 Bernie Clark.

20 **MR. B. CLARK:** I am Bernie Clark, I --

21 **ADMIRAL ZIMBLE:** Okay.

22 **MR. B. CLARK:** -- I don't write too well, but I
23 thank you for addressing you.

24 I participated in the November tests in Nevada
25 as an observer, along with about two other

1 thousand soldiers and officers, including
2 General Clark. We were observers for the Shot
3 Dog test at that time. We were taken all
4 around the facility after that detonation, and
5 we got to observe all of the things that
6 occurred to animals, equipment and everything
7 else. I present to you a challenge. We did
8 not have any kind of test equipment or
9 monitoring equipment or such. I -- I challenge
10 some of the results that you have come up with.
11 I am a chemical engineer by background. In my
12 industrial career I have been involved with lot
13 -- with research and development projects, and
14 so I feel that I have a little bit of
15 background as to what is required when you are
16 doing research and information -- selection and
17 data collection. So with that as background, I
18 do challenge.

19 Now the other thing I have a more positive
20 view. We -- I hope that we can work with your
21 Advisory Board. You are -- you are setting up
22 presentations across the country. We would
23 like to get the rest of the atomic veterans
24 throughout the United States involved with
25 these programs. And I understand -- your

1 presentations. And I understand that that
2 agenda has not been fully established at this
3 time, but if we can participate with you, we
4 would like to give the opportunity to other
5 atomic veterans throughout the country to come
6 hear what you have to say.

7 **ADMIRAL ZIMBLE:** Fine, I appreciate that. Let
8 me just respond by saying that we will -- we
9 have maintained our web site, vbdr.org, and on
10 that web site will be every presentation that
11 was made tonight, as well as all testimony --
12 that will be all part of the record. And that
13 will also indicate the agenda and the schedule,
14 the calendar for our future meetings, which
15 will be quarterly from now throughout the year.
16 And -- and we appreciate -- we also will have
17 on that web site an e-mail address. Please do
18 not hesitate to apprise all the veterans -- use
19 your means of communication. We also on the
20 Board will try to -- will attempt to enhance
21 the communications, between members as well as
22 between the agencies and -- and the members, so
23 I thank you for the request and I promise you
24 that we will give you the information.
25 All right. Colonel?

1 **COLONEL TAYLOR:** I have a question of him.

2 Bernie --

3 **ADMIRAL ZIMBLE:** Colonel -- Colonel...

4 **COLONEL TAYLOR:** I'm sorry. The Clark you
5 referred to I believe was Bruce. Right?

6 **MR. B. CLARK:** Bernie Clark.

7 **COLONEL TAYLOR:** No, when you said General
8 Clark.

9 **MR. B. CLARK:** No, Mark Clark.

10 **COLONEL TAYLOR:** Okay, Mark Clark.

11 **MR. B. CLARK:** Mark Clark.

12 **COLONEL TAYLOR:** We're trying to sort them out.

13 **MR. B. CLARK:** Oh, okay.

14 **COLONEL TAYLOR:** Bruce E. was the CONARC
15 commander at that time, now TRADOC.

16 **MR. B. CLARK:** This is the -- this is the Clark
17 out of World War II.

18 **COLONEL TAYLOR:** Okay, the one with the 36th
19 Division, doesn't speak to him. But the second
20 thing I wanted to say to you was I applaud you
21 for what you've been doing to keep track of
22 this as well as you have. I've recently become
23 more involved in this and some names have come
24 to my attention as a member of this Board and a
25 veteran involved in this, and I applaud you for

1 what you've been doing. Thank you.

2 **MR. B. CLARK:** Thank you.

3 **ADMIRAL ZIMBLE:** Thank you very much, Mr.
4 Clark.

5 **UNIDENTIFIED:** Mr. Chairman?

6 **ADMIRAL ZIMBLE:** Yes? Please come to the
7 microphone. Okay, Mr. Ritter.

8 **MR. RITTER:** Mr. Chairman, I only want to ask
9 one question. That is do we have -- we would
10 like to request the permission of the VBDR to
11 add your link to our web site so that our
12 veterans who go to our web site can go on to
13 yours and see what's there.

14 **ADMIRAL ZIMBLE:** That can be done.

15 **MR. RITTER:** All right, sir.

16 **ADMIRAL ZIMBLE:** I'll make sure of that.

17 **MR. RITTER:** Thank you.

18 **ADMIRAL ZIMBLE:** All right, Mr. DeSalvo.

19 **MR. DESALVO:** Joseph DeSalvo. I was involved
20 in Upshot Knothole, series -- there were 11
21 shots. I was in shot 7, Shot Simon, April
22 25th, 1953. This shot was 51 and a half
23 kiloton on a 300-foot tower. The fallout from
24 Shot Simon was much worse than anticipated due
25 to changing weather conditions. This shot

1 caused contamination 60 miles outside of Yucca
2 Basin. I think most of you people have
3 probably read that. If you haven't, it's in
4 the records under Shot Simon. It even went
5 into New York City, across the nation. If
6 you're not aware of it, it's in the records in
7 Shot Simon.

8 Vehicles 60 miles outside of Yucca Flats had to
9 be decontaminated, automobiles and buses. I
10 was in a trench two miles from ground zero.
11 Immediately after detonation I had to advance
12 toward ground zero. According to my
13 recollection, our captain said we were within
14 300 yards of ground zero because the Geiger
15 counter soldiers told the captain continually
16 it was getting hotter and hotter, and he had
17 told the captain we supposed -- we should have
18 turned around a long time ago. Captain said
19 kept going -- keep going. And we -- we had no
20 face protection, no special clothing, and I was
21 not issued a radiation badge. In fact, I never
22 even seen one.

23 The reason I remember all this, when I got back
24 to camp, I wrote everything down and I kept it
25 all these years.

1 We had to walk back to the trench area where
2 the only decontamination process we had was to
3 sweep each other off with house brooms. When
4 we returned to Camp Desert Rock, we showered
5 and put all of our clothes into duffel bags and
6 were shipped out early the next morning by
7 troop train back to Camp Polk, Louisiana.
8 I don't know how many soldiers and military
9 were on that train, but it was a long, long
10 train. All those duffel bags had -- had to be
11 contaminated. There's no way they wouldn't be
12 -- shoes, clothing, underclothing, helmets,
13 weapons that we took with us.
14 As guinea pigs, which a lot of people do not
15 like to hear the word "guinea pig." A guinea
16 pig, to me, is an example of some little animal
17 that's being tested for something, and then
18 they check them to see what's happened to their
19 bodies. Nobody ever asked me or anyone I know
20 of if anything ever happened to our bodies.
21 Nobody in the government ever asked us
22 (unintelligible) we're guinea pigs.
23 They sent -- on our shot there were 2,200
24 soldiers there, Marines, Naval people, what
25 have you. Why -- why so many people? Why not

1 just 200 on each shot? Why thousands? It
2 don't make sense. Could have got -- they never
3 checked anybody. What -- why would they send
4 thousands of them there?

5 DD-214, I know you've heard a lot of about DD-
6 214. Why wasn't it noted on the DD-214 we were
7 atomic soldiers? Is it because they didn't
8 want anybody to know we were? You would have
9 been able to find every one of us if it had
10 been on the DD-214.

11 I suggest they put out a DD-500 or something
12 and put on there atomic soldier. Make another
13 DD-214 separate from the one we have right now.
14 My claim for dose reconstruction has been in
15 for over two years in the system. Sounds like
16 I won't be able to hear anything for a long
17 while, according to Dr. Blake. It's going to
18 be ages before I hear any-- I'm 76 years old
19 now. I'm not going to stand here and tell you
20 the multiple of problems I've had since I was
21 30 years old 'cause you don't want to hear
22 them. But they're all in the VA at Haley's
23 Hospital. And as was stated before, IRR
24 registry is not noted in these facilities, so
25 how would anybody find them?

1 Five soldiers that I -- I contacted in the last
2 year and a half, that I did not know but were
3 in my battalion, in a trench with me -- I
4 didn't know them back at camp -- they're
5 disgusted. They filed claims, some of them
6 live 200 miles from the hospitals. They've
7 been turned down. They don't care no more.
8 They're too old to care. You'll never find
9 them all. But you do have the records in D.C.
10 of all of them. They're there. I know they're
11 there 'cause I got mine. Thank you for
12 listening to me.

13 **ADMIRAL ZIMBLE:** All right, thank you very much
14 -- wait, wait, don't -- don't go away too fast.
15 I have one question.

16 **MR. DESALVO:** Yes, sir.

17 **ADMIRAL ZIMBLE:** You mentioned that you had
18 written everything down. If --

19 **MR. DESALVO:** Yes.

20 **ADMIRAL ZIMBLE:** -- it's at all possible for us
21 to give us a copy or some way get -- get to the
22 Board a copy of what you've written down --

23 **MR. DESALVO:** I could send it to you.

24 **ADMIRAL ZIMBLE:** That'd be fine.

25 **MR. DESALVO:** Somebody give me an address.

1 **ADMIRAL ZIMBLE:** All right, we'll -- we'll take
2 care of that.

3 **MR. DESALVO:** Uh-huh.

4 **ADMIRAL ZIMBLE:** Okay.

5 **COLONEL TAYLOR:** Before he leaves --

6 **ADMIRAL ZIMBLE:** Colonel Taylor.

7 **COLONEL TAYLOR:** There are two things in your -
8 -

9 **ADMIRAL ZIMBLE:** Colonel Taylor -- I'm sorry.

10 **COLONEL TAYLOR:** There are two things in your
11 thing that you -- one, I was in the Army about
12 that same time and I participated in blasts and
13 there was a reason they were doing that that
14 wasn't generally announced. It was simply that
15 we knew our potential enemies had the atomic
16 weapons --

17 **MR. DESALVO:** Yes, (unintelligible) Germany --

18 **COLONEL TAYLOR:** -- (unintelligible) the war
19 and we weren't going to leave because somebody
20 else brought those weapons on.

21 **MR. DESALVO:** That's right.

22 **COLONEL TAYLOR:** So we were doing the best job
23 we could to expose as many people as we could
24 to it. That was why you got the numbers you
25 got.

1 **MR. DESALVO:** Yes, but nobody followed us as
2 guinea pigs.

3 **COLONEL TAYLOR:** I understand that. I'm not --
4 I'm not trying to justify that.

5 **MR. DESALVO:** Okay.

6 **COLONEL TAYLOR:** I'm telling you that's how
7 some of it happened, and I was there in part of
8 it and I had something to do with that. And
9 the other thing that comes up was they tried in
10 many ways to expose people to a degree that
11 could not only -- not only let you understand
12 the awesomeness of this weapon system or these
13 weapon systems, but also not make you overly
14 afraid and concerned of it. It was a fine
15 balance going on in that regard, and I know
16 because I was an operations officer and we were
17 trying to plan that, and it made some of it.
18 You know, you come up with -- not knowing some
19 of those things, you can sometimes almost be a
20 little harsher in your judgments than you would
21 had you known.

22 **MR. DESALVO:** Two days before our shot we were
23 briefed for six hours.

24 **COLONEL TAYLOR:** Yep.

25 **MR. DESALVO:** You've got my little pamphlet.

1 **COLONEL TAYLOR:** Yeah, I've got it.

2 **MR. DESALVO:** Okay, 12-page pamphlet. It says
3 in there --

4 **COLONEL TAYLOR:** The pamphlet says atomic
5 radiation will not hurt you. You gave it to
6 me.

7 **MR. DESALVO:** It will not hurt you. I have my
8 original in the bank vaults, 52 years old.
9 Thank goodness I kept it. I kept my transfer
10 orders, and that's how I proved -- at first
11 they wouldn't believe me. That's how I proved
12 that I was there because I kept all that
13 information. And like I said, it said you
14 can't be hurt.

15 **COLONEL TAYLOR:** That's right.

16 **MR. DESALVO:** And I -- I started to have
17 problems -- I got out at 24 years old. By 30 I
18 was having problems before that. I became very
19 depressed. I didn't know why. Never gave it a
20 thought that atomic radiation was into my body.
21 By 30 and 32 I had the highest blood pressure
22 you could imagine. I've been to many, many
23 places to try and get it down. It's still not
24 down. They say high blood pressure will not
25 come from ionizing radiation. I don't know,

1 nobody could get it down.

2 **COLONEL TAYLOR:** I share your problem.

3 **MR. DESALVO:** Okay.

4 **COLONEL TAYLOR:** The same.

5 **ADMIRAL ZIMBLE:** Thank -- thank you very much.

6 **MR. DESALVO:** Okay. I could be here for hours
7 telling you -- but I'm not going to waste my
8 time or your time on it.

9 **COLONEL TAYLOR:** Thank you, Mr. --

10 **ADMIRAL ZIMBLE:** Thank you very much, Mr.
11 DeSalvo.

12 **MR. DESALVO:** (Unintelligible) give me an
13 address.

14 **ADMIRAL ZIMBLE:** Mr. Clyde Wyant? Yeah, let's
15 see if we can get you a chair. Outstanding.
16 Are you all right? Okay.

17 **MR. WYANT:** I'm Clyde Wyant. I am legally
18 blind the last nine years. I'm an atomic
19 veteran. I think there might be one or two
20 here in the last day know who I really am, but
21 I'll tell you. I'm the oldest living veteran
22 who worked in Los Alamos making the atomic
23 bomb. Bob Oppenheimer was my boss. I have a
24 letter from him thanking me for my service. He
25 picked me out of 3,500 GIs in Washington, D.C.

1 when the fellows were coming back from Europe.
2 He picked me the second day, he said. And I
3 asked him when I got down to Los Alamos, and
4 I'll tell you, that trip was something else
5 because the MPs hauled me -- they didn't take
6 me to the depot in Washington, D.C. They
7 stopped it out in the country, and when they
8 took me off of a plane, they stopped -- train,
9 they took me out in the boonies and got me off.
10 The military picked me up. It took me almost
11 three weeks to wind up in Camp Beale,
12 California -- through security. I was confined
13 to that camp for a year, for my own protection.
14 I was told -- I have been told -- up through
15 three weeks ago I was in Washington, D -- at
16 Walter Reed Hospital. I was checking in
17 because of my problems, and of course naturally
18 they asked me when I was born. I told them in
19 1921. They looked at me, says you're dead.
20 Believe me, fellas, I've got your 309, 10, 11 -
21 - there isn't anything that says anything about
22 atomic veterans. It mentions Trinity in one of
23 them. Trinity, that's all. It don't say what
24 Trinity is. They don't say anything.
25 Anyway, that's a short story and I could be

1 here for hours. I know, and I've -- can almost
2 have somebody who will verify it. I probably
3 know more about radiation than most of you
4 because I looked it up. I've lived under it
5 since 1947. I got involved with the VA in
6 1947, I think it was, when the VA was
7 established. And in Portland, Oregon we had
8 one. It was in a hotel that I was living in
9 across from the office where I worked. And a
10 fella met me over at the hot dog place at noon,
11 and I looked at him, he looked at me. He says
12 what in the hell are you doing here? Well, I
13 was in Kodiak, Alaska when they bombed Pearl
14 Harbor. You know I've been around a little
15 bit. And he said what are you doing in
16 Portland? Well, he lived here, I knew that. I
17 live in Iowa, I'm an Iowa farm boy. That's why
18 Oppenheimer caught me. He says he figured I
19 might not have any problems, and to this day I
20 still carry the highest rating that the FBI
21 will give you. I still have it. They called
22 me in January, wanted to know if I was alive.
23 Told me, he said Clyde, don't worry, it's just
24 us. We're checking to see if you're alive.
25 And I said well, you're talking to me. He says

1 well -- that's when I found out there was 240
2 in my division. I didn't know that, I -- only
3 the ten people that worked with me in the lab,
4 that were GIs. And he'd been two and a half
5 months to see how many veterans were alive. He
6 hadn't found a one. No folks, no GIs, no
7 wives, no children -- talked to some cousins,
8 some neighbors. And he finally got to me. My
9 last name is Wyant, W-y-a-n-t. I knew there
10 was no Z -- Zs, so I said to him, why are you
11 calling me? She said I want to know if you are
12 alive. First of all, he didn't believe me
13 because he talked -- all this time he hadn't
14 talked to anybody. Well, I told him I had the
15 citation from the atomic group proving it
16 because when I went there in 2000 they all said
17 what ship was you on? I said I was never on a
18 ship. He says how come you're a atomic
19 veteran? I says I worked at Los Alamos making
20 the damned thing and if it wasn't for us you
21 wouldn't have been out there. And that's the
22 fact.

23 There are a lot of things I can't say. For 65
24 years I've been under security, couldn't say a
25 word. My wife of 49 years married did not know

1 what happened. She's not here now.

2 **ADMIRAL ZIMBLE:** Mr. Wyant, could I ask --

3 **MR. WYANT:** Yes.

4 **ADMIRAL ZIMBLE:** -- do you have a -- did you
5 have a claim to the VA?

6 **MR. WYANT:** I was just going to get to that.

7 **ADMIRAL ZIMBLE:** Okay.

8 **MR. WYANT:** 1947 when the VA started, I signed
9 in and I told them. It took about four years
10 and I finally got ten percent, and that they
11 can't take away from me 'cause they already
12 told me that. They tried. Anyway, in 1957 I
13 had my first back surgery. I was wearing a
14 brace for 12 years prior t that time 'cause I
15 fell when I was in Alaska before I came home.
16 I had back surgery. So I had nothing done till
17 1957. I had my first one. In 1975 I had my
18 second one. That one I have never went back to
19 work since. I've been on disability ever
20 since. I got 100 percent when I come 65. I
21 was on industrial -- state industrial
22 compensation.

23 I have had one heck of a time trying to prove
24 that I'm an atomic veteran and I deserve
25 something. I got my 100 percent in 2000. And

1 do you know what they gave it to me for? Not
2 for my disability, nothing to do with atomic.
3 It was because it was the rule.
4 My service officer -- I know him for the
5 American Legion for 20 years. He didn't know
6 about it and he works in -- he's one of the top
7 service officers on the committee of the
8 American Legion in Washington. He got chewed
9 out and he canceled me out.
10 But anyway -- got to excuse me 'cause --
11 **ADMIRAL ZIMBLE:** Okay.
12 **MR. WYANT:** -- I'm just -- I've only seen you
13 people the last six months, that I can actually
14 see people. I can't see to read or write, but
15 I can see you, I can see this room. I can see
16 a lot of things. This -- it blows my mind. I
17 have traveled every year. Two years ago --
18 'cause last year we were all on the west coast
19 out my way, so I didn't travel very much. I
20 traveled 13,000 miles that year to conventions.
21 I belong to the Blind -- a life member in the
22 Blind Veteran (unintelligible), I'm a life
23 member here of the Atomic. I'm a life member
24 in the DAV, which trying to do things for me in
25 this year. They sent me to conventions last

1 year, to the state and national, cost them
2 \$20,000 -- \$2,000. They tried to help me get
3 electric vehicle so I could go to the grocery
4 store two miles away without having to try to
5 get someone to drive me. I never got it, but I
6 bought it so I would have it.

7 I've been told because I have 100 percent --
8 and I just heard you people say it several
9 times and yesterday -- that single now gets
10 \$2,093. Well, I get \$2,099. I used to get
11 \$2,375 when my wife was around, so I don't
12 understand the difference.

13 But the other thing, and I have been told the
14 last two or three years at different
15 conventions, talking to different people from
16 Washington, they said -- and it was said
17 something yesterday about it, one of the fellas
18 -- that radiation, we would get compensation.
19 Now I'm 100 percent, I'm legally blind and I've
20 got a lot of problems. All my fusions, three
21 of them, are coming apart -- legally,
22 deteriorating. The VA in Portland has known it
23 for over two years. There's 17 X-rays and two
24 MRIs proving that they are badly in need of
25 repair. The only one that can do it is a

1 neurosurgeon who specializes in neurospinal.
2 The VA has three and now in the general --
3 country of the United States there are three.
4 I know of one in Monterey, California. That's
5 where I joined the Army. He is supposed to be
6 one of the top notches, but one of these days
7 they're going to have to have it -- something
8 done.

9 I had a wrist done three times. It's got a
10 plate in it now. I've had a knee replaced and
11 it's got a plate in it. My shoulder on this
12 side, they just did three months ago, filled it
13 full and put my arm socket in and said well,
14 that'll last maybe three to six months. Well,
15 it's starting to bang me like mad. Now left
16 one is starting to it. I had the X-rays before
17 I left and they told me the same thing. It's
18 happening so I'm going to have to have
19 something to do that. My whole right side is
20 para-- going paralyzed if I sit like this very
21 long. My hands are numb and my whole right
22 side is numb.

23 Now, you talk about cancer. Now I'm going to
24 say this. You can have cancer -- there's 26 of
25 them on there first, and every one of them -- I

1 wouldn't have to be in the Navy, I wouldn't
2 have to be an atomic -- or any of that, I could
3 have those cancers. Yet you people are telling
4 me it's because of radiation. Well, it could
5 be. It could have caused a lot of -- my
6 problem is because of radiation. I'm losing my
7 voice now, they said. My voice box now is
8 affected because I've been trying to use a cell
9 phone and I can't because they don't understand
10 what I'm trying to say. I'm trying to get e-
11 mail, been two years. I know it's out there,
12 but I can't find anybody that says where it is
13 and what it is and get the VA to buy it for me
14 -- it talks. If any of you know, please, it
15 talks and prints when it comes in. And when I
16 send it, I talk to it and it prints it and
17 sends it. Now the good part about it is that I
18 can actually read it because I have a closed
19 circuit TV and I can read it 'cause then I can
20 read what came to me, I can know how I answer
21 it and I can file it and I could refer back to
22 it.

23 **ADMIRAL ZIMBLE:** Okay. Mr. Wyant --

24 **MR. WYANT:** I guess I'm getting close to my ten
25 minutes or so --

1 **ADMIRAL ZIMBLE:** Yeah. Well, I thank you --

2 **MR. WYANT:** -- just cut me off anywhere you
3 want, but I just want you to know that I am the
4 sole survivor.

5 **ADMIRAL ZIMBLE:** Okay.

6 **MR. WYANT:** And I bet you two to one didn't any
7 of you know about unless you were out in the
8 meeting yesterday. Thank you.

9 **COLONEL TAYLOR:** Mr. Chairman, may I ask him
10 one question?

11 **ADMIRAL ZIMBLE:** Yes.

12 **COLONEL TAYLOR:** How old are you?

13 **MR. WYANT:** Eighty-four.

14 **COLONEL TAYLOR:** Okay. Thank you.

15 **ADMIRAL ZIMBLE:** I would congratulate you.

16 **MR. WYANT:** They told me I wouldn't live to be
17 50, but I'm still here. I told them that I'm
18 going to live another 15.

19 **ADMIRAL ZIMBLE:** Thank you very much, sir.
20 Okay, Mr. -- Mr. Wilson. Mr. Wilson?

21 **UNIDENTIFIED:** (Off microphone) I think he
22 (unintelligible).

23 **ADMIRAL ZIMBLE:** Pardon me?

24 **UNIDENTIFIED:** (Off microphone) I think he
25 left.

1 **ADMIRAL ZIMBLE:** He left? Okay. Mr. Thomas
2 Daly.

3 **UNIDENTIFIED:** Before Mr. Daly gets up I'd like
4 to say that (off microphone and
5 unintelligible).

6 **ADMIRAL ZIMBLE:** Okay. Thank you very much.

7 **UNIDENTIFIED:** The gauntlet's been laid down,
8 Paul.

9 **ADMIRAL ZIMBLE:** Mr. Daly?

10 **MR. DALY:** Yes, sir.

11 **ADMIRAL ZIMBLE:** Right.

12 **MR. DALY:** I'm Thomas Daly. I served at
13 Eniwetok in 1953/'54 during Operation CASTLE.
14 I have just a procedural question, more than
15 anything, and it is -- does the reconstruction
16 require a claim to initiate it, and does a
17 claim require a sickness associated with the
18 atomic testing?

19 **ADMIRAL ZIMBLE:** I'm going to ask Mr. Pamperin
20 to answer that question.

21 **MR. PAMPERIN:** For RECA?

22 **MR. DALY:** Pardon?

23 **MR. PAMPERIN:** You're asking do you need to
24 file an application for RECA.

25 **MR. DALY:** What initiates the reconstruction of

1 the dosage?

2 **MR. PAMPERIN:** Oh, oh, oh.

3 **MR. DALY:** Do you need a claim --

4 **MR. PAMPERIN:** Yes, you do.

5 **MR. DALY:** -- before you get a reconstruction?

6 And do you need an illness before you file a
7 claim?

8 **MR. PAMPERIN:** Ye-- well, in order to -- to
9 claim VA disability benefits, you do have to
10 have an illness, yes.

11 **MR. DALY:** Yes, so -- so the reconstruction
12 depends on being sick to start with, and then
13 filing a claim.

14 **ADMIRAL ZIMBLE:** Correct.

15 **MR. PAMPERIN:** Right.

16 **MR. DALY:** Okay. How do --

17 **DR. BLAKE:** Mr. Daly, could I answer part of
18 that question for you? I'm happy to take a
19 look to see if we have any occupational
20 radiation exposure records for you. That's
21 different than performing a dose
22 reconstruction.

23 **MR. DALY:** Uh-huh.

24 **DR. BLAKE:** And if you leave that information
25 with us, we can turn that around literally in a

1 few days and get that --

2 **MR. DALY:** I see.

3 **DR. BLAKE:** -- information back to you. That's
4 different than a dose reconstruction that's
5 quite involved. But certainly looking up to
6 see if we have any occupational radiation
7 exposure, if you were monitored, we can turn
8 that around very quickly.

9 **MR. DALY:** Okay. Well, I did -- I did have
10 some data in my 201 file, and I had
11 communications with some department in '82, '86
12 where I gave them my opinions as to how
13 accurate it might, but I haven't heard anything
14 since then and I was -- I was just wondering
15 what the veterans would do to file a claim and
16 -- and get a reconstruction, so -- that was it.

17 **ADMIRAL ZIMBLE:** Okay.

18 **MR. RITTER:** I think I know where he's going
19 with that question, if I may.

20 **ADMIRAL ZIMBLE:** Good, would you stand at the
21 microphone? Okay.

22 **MR. RITTER:** I think I know where he's going
23 with that question, and that question's been
24 asked --

25 **ADMIRAL ZIMBLE:** This is Mr. Ritter.

1 **MR. RITTER:** This is Mr. Ritter again -- this
2 is R. J. Ritter again. I think the -- I know
3 where he's going with that question because
4 it's been asked of us several times, and we
5 don't really know the answer. And that is, we
6 talk about the ionizing radiation registry and
7 what does it take to get on the register. Some
8 of us are of the opinion, from what we
9 received, that you have to be sick to get on
10 the register.

11 **ADMIRAL ZIMBLE:** No.

12 **MR. RITTER:** I think the question is, if I'm an
13 atomic veteran, I haven't shown any -- or
14 exhibited any illness and signs yet with -- yet
15 might end tomorrow, and yet I want to submit a
16 request to get the information out of my file
17 that I was exposed however much. But if I was
18 exposed, it's my opinion that I should be
19 placed on an ionizing radiation register and as
20 an exposed veteran that I should be placed in
21 group six, and I think that's the question our
22 members want us to answer, and we really don't
23 have a firm answer to give them yet. So I
24 think that's where that question was leading.

25 **ADMIRAL ZIMBLE:** Now the eligibility for the

1 Ionizing Radiation Registry is participating in
2 --

3 **MR. RITTER:** Atmospheric --

4 **ADMIRAL ZIMBLE:** -- atmospheric testing or
5 being in Hiroshima or Nagasaki. That gets you
6 on the registry. You don't have to be sick to
7 get on the registry, so --

8 **MR. RITTER:** But then we got to go on to group
9 six, so if you're an exposed veteran, you may
10 not show symptoms and need -- or need
11 medication at that point in time, but if you're
12 an exposed atomic veteran and you're on the
13 register, then automatically placed in group
14 six. That's the question.

15 **ADMIRAL ZIMBLE:** You want to check that for the
16 record?

17 **MR. PAMPERIN:** We'll get you the answer to
18 that.

19 **ADMIRAL ZIMBLE:** We'll get a -- we'll get a
20 definitive answer and --

21 **MR. RITTER:** Okay, 'cause it's very important.

22 **ADMIRAL ZIMBLE:** Right. That's a generic
23 question --

24 **MR. RITTER:** A generic question.

25 **ADMIRAL ZIMBLE:** -- and we will get a

1 definitive answer and put that on the web and
2 get that information out to the NAAV and to
3 other veterans' groups.

4 **MR. RITTER:** Very well.

5 **ADMIRAL ZIMBLE:** That's very important.

6 **MR. RITTER:** Thank you.

7 **ADMIRAL ZIMBLE:** 'Cause now, if I understand
8 correctly, category six is the category that
9 gives you a level of priority above a needs
10 testing. Is that right?

11 **MR. PAMPERIN:** Yes, yes, it -- but really the
12 way it's working, quite frankly, if you get in,
13 you're in.

14 **ADMIRAL ZIMBLE:** Okay.

15 **MR. PAMPERIN:** So we'll get you a definitive
16 answer.

17 **MR. RITTER:** Thank you, sir.

18 **ADMIRAL ZIMBLE:** Okay. Thank you.

19 **MR. WYANT:** I'd just like to add a little to
20 that. They -- I -- they claim I never signed
21 in for it. Well, when they came out with Agent
22 Orange and atomic, I went to the VA hospital,
23 but they told me they only know from '50 on.
24 They know nothing about in the '40s.

25 **ADMIRAL ZIMBLE:** Okay.

1 **MR. WYANT:** I just -- I think now I am since
2 2003, but I don't know for sure. The other
3 thing is --

4 **ADMIRAL ZIMBLE:** We can get that information
5 for you.

6 **MR. WYANT:** I'm going to tell you one thing,
7 just -- and then I'm going to give you a copy.
8 My medical records are locked up in Washington
9 since '75. My discharge paper shows me in
10 Washington, D.C. The last time they told me
11 that I'm discharged in Camp Beale, California.
12 That's three years that's a blank in my
13 discharge. There's nothing there, and that's
14 what I had a real problem at first because my
15 discharge didn't say where I was during that
16 time. They thought maybe I was in the brig or
17 something, I think.

18 **ADMIRAL ZIMBLE:** Okay. Thank you.

19 **MR. WYANT:** (Off microphone) (Unintelligible)
20 right now is my citation for NAAV
21 (unintelligible) and there's a letter there
22 from Bob Oppenheimer.

23 **ADMIRAL ZIMBLE:** Okay, give it to that young
24 lady right there to your right -- right there,
25 right there, on your right. Okay. Okay, thank

1 you very much.

2 Is there any other individual who would like to
3 make a comment? I've reached the end of the --
4 oops.

5 **COLONEL TAYLOR:** Can I -- can I add a moment to
6 this?

7 **ADMIRAL ZIMBLE:** Okay, Colonel Taylor.

8 **COLONEL TAYLOR:** I don't know how many of you
9 have been exposed to an atomic weapon, but I
10 have, and it's probably one of the reasons I'm
11 on this committee. And the only thing I'll
12 tell you, it's probably one of the most awesome
13 experience you'll ever exp-- you'll ever have -
14 - the light, the strength of it. I was less
15 than a mile away in a trench dug by a pipeline
16 trencher and that first night they said the
17 weather's wrong, we'll come back the next day.
18 The next day went out, carried some stuff to
19 read, cards to play poker and all -- we're out
20 there on the desert two or three night-- two or
21 three hours. Finally they said take to the
22 trenches and they counted it down, and we were
23 in full uniform. I had a poncho and a helmet,
24 and I think I had a gas mask, I'm not certain.
25 I can go back and check and maybe I can find

1 out. But in the process, you put your hands
2 over your eyes. Some of my friends told me
3 they could see the bones in their hands. I
4 don't remember that. I do know that a few
5 minutes later they said you can come out of the
6 trenches. This PA system still was operating.
7 I don't know where they had it hidden. And all
8 around me when I went down were dummies and
9 vehicles and mess tents and things of that
10 nature. And directly across from us was some
11 buildings, and you have probably seen movies or
12 newsreels of them. They looked kind of like
13 the white barracks sort of buildings. And if
14 you remember, the flash occurred and all the
15 paint burned off, and about five seconds later
16 the buildings disappeared. (Unintelligible)
17 like I were, they were a mile away. The flash
18 the speed of light, the blast the speed of
19 sound, five seconds a mile, roughly.
20 That same thing happened. The flash was very
21 intent, and then five seconds later it was as
22 if somebody had jumped in the middle of my back
23 when the blast went over it, and you went over.
24 And then a few minutes later they called us out
25 and we were allowed to walk down to ground

1 zero, which was a concrete block where there
2 had been a winch and a balloon where they'd
3 raised this thing up to a set height so they
4 could get an exact height of the explosion and
5 not worried about the timing of the detonating
6 device.

7 I carried a film badge. To show you what can
8 happen, I didn't put this in in a VA claim
9 until a couple of years ago and they said when
10 you been working in Veterans we watch you
11 deteriorate, you need to reconsider your thing,
12 I listed that on it. I got called and notified
13 by DTRA, then DNA. They said next time you're
14 in Washington, talk to us. I went and talked
15 to Mike Schaeffer and a whole group of people
16 and they told me about what was happening and
17 asked me would I participate. Well, I'd
18 already put in an application when he first
19 brought it out. I don't know what happened to
20 it. But in the process I did that and then the
21 next day I talked to Dr. Tenforde and group of
22 his people. And having had exposure since
23 August the 6th of 1945, my 15th birthday and I
24 was at McCauley's School and we then learned
25 what Oak Ridge was about. I became interested

1 in it. I went through college, finished, went
2 in the service, became a nuclear weapons
3 employment officer, did a lot of things,
4 visited Hiroshima, went out to Desert Rock and
5 went through that blast, went to Alamogor--
6 went to several places to be renewed as a
7 nuclear weapons employment officer because we
8 at that time in the early '50s were expecting
9 to fight an atomic war, and we were not going
10 to leave the battlefield. We were teaching our
11 soldiers dispersion and decontamination and all
12 kind of things, and that's why I was saying, I
13 was an operations officer. I was put through
14 it and with volunteers.
15 DTRA told me there were 54 men on the list.
16 They found my name. First time they answered
17 to the VA and said we don't know anything about
18 him. They'd used my Social -- my serial -- my
19 Social Security number, and it was my serial
20 number. When I gave them the serial number it
21 all became clear, it's that simple. So a
22 simple mistake can do drastic things in this
23 system. You've got to understand that. You've
24 got to be persistent.
25 Then they went through it and they said we

1 would like you to consider this. And I said 25
2 million veterans, why? They said you've got an
3 interest in it that's far above the average
4 veteran. You've got a combat record includes
5 like 30 awards and three Silver Stars. You've
6 fought a lot so nobody'll question your being a
7 soldier. And for the 20 years since you
8 retired you've been involved in veterans'
9 activities, so we want you on the Board. And
10 I'm very honored to be here and I think I can
11 help understand what these guys are talking
12 about and hope that you will understand with me
13 where we're coming from because the one thing I
14 came out of that morning was I want to never
15 have anything to do with another one of those
16 things. I can tell you that very clearly, and
17 I think everybody that went through it would
18 agree with me on that. That's -- some of them
19 got three or four or five shots, and I applaud
20 them, 'cause one was enough to teach me I
21 didn't need any more of that. And hopefully
22 we'll never have to fight that battlefield, and
23 what we're doing today is trying to make it
24 even to people that were there and who
25 volunteered, who went through it, and the

1 system kind of forgot them, in my opinion.
2 That's the way I visualize what we're doing
3 here and I hope we make it work. Thank you
4 very much, sir.

5 **ADMIRAL ZIMBLE:** Thank you very much, Colonel.
6 If there are no further comments from the
7 public, if there are no further comments from
8 the Board -- wait, we have one more. Dr. (sic)
9 Groves.

10 **MR. GROVES:** Thank you very much. I just would
11 like to -- I had the pleasure of sitting next
12 to Otto Miller and his wife yesterday at the
13 meeting, and Otto had given me a copy of the
14 story of the first atomic bomb. Otto was
15 stationed at the Alamogordo Army Air Station
16 during the Trinity tests, and I had told him
17 that I would put this in the record for the
18 whole committee. So since we're at our first
19 official meeting, I want to acknowledge the
20 fact that I have this document and I'm going to
21 pass it to Isaf and it will go into our
22 database. It's a very, very interesting first
23 account of the Trinity device, and I think will
24 be very useful to the committee.

25 **ADMIRAL ZIMBLE:** Okay, thank you very much.

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We'll take care of that.

Is -- if there are no other comments, and
without objection, I'm going to call this
meeting adjourned. Thank you.

(Whereupon, the meeting was adjourned at 8:37
p.m.)

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C E R T I F I C A T E O F C O U R T R E P O R T E R**STATE OF GEORGIA****COUNTY OF FULTON**

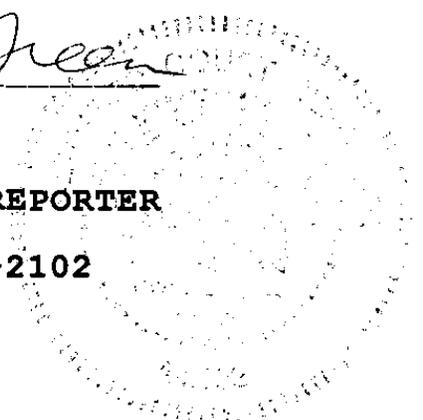
I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of August 17, 2005; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 10th day of September, 2005.



Steven Ray Green

STEVEN RAY GREEN, CCR**CERTIFIED MERIT COURT REPORTER****CERTIFICATE NUMBER: A-2102**

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