Executive Summary

The Inaugural Meeting of the Veterans' Advisory Board on Dose Reconstruction (VBDR or the Board) was held at the Hyatt Regency Tampa Hotel in Tampa, Florida on August 17-18, 2005. Members in attendance were Dr. James A. Zimble, Vice Admiral, USN, Ret., Chairman; Dr. Paul K. Blake; Mr. Harold L. Beck; Dr. John D. Boice; Mr. Kenneth L. Groves; Dr. Curt R. Reimann; Mr. Thomas J. Pamperin; Mr. Paul L. Voillequé; Dr. Gary H. Zeman; Mr. George Edwin Taylor, Colonel, USA, Ret.; and Dr. Elaine Vaughan via telephone. Dr. Kristin Swenson was present on the second day. Unable to attend due to scheduling conflicts were Dr. Ronald Blanck, Lieutenant General, USA, Ret.; Drs. John Lathrop and David E. McCurdy. Others in attendance included staff of various Federal agencies and members of the public.

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The Veterans' Advisory Board on Dose Reconstruction
Department of Defense and Department of Veterans Affairs

Summary Minutes of the Inaugural Meeting
August 17-18, 2005

The Inaugural Meeting of the Veterans' Advisory Board on Dose Reconstruction (VBDR or the Board) was held at the Hyatt Regency Tampa Hotel in Tampa, Florida on August 17 and 18, 2005. The meeting was called by the Defense Threat Reduction Agency (DTRA) and the Department of Veterans Affairs (VA). These summary minutes, as well as a verbatim transcript certified by a court reporter, are available on the internet on the Advisory Board Web site located at www.vbdr.org. Those present included the following:

VBDR Members: Dr. James A. Zimble, Chair; Dr. Paul K. Blake; Mr. Harold L. Beck; Dr. John D. Boice; Mr. Kenneth L. Groves; Dr. Curt R. Reimann; Mr. Thomas J. Pamperin; Mr. Paul G. Voillequé; Dr. Gary H. Zeman; Mr. George Edwin Taylor; and Dr. Elaine Vaughan (via telephone). Dr. Kristin Swenson was present on the second day.

Designated Federal Official: Mr. William R. Faircloth, Chief of Staff, DTRA.

Federal Agency Attendees:

Department of Defense:
Mr. Dave Algert, DTRA; Mr. Blane Lewis, DTRA; Lieutenant Commander Ralph J. Marro (USN), DTRA; Mrs. Joy Powell (USAF); Mrs. Irene Smith, DTRA; Colonel Rainer P. Stachowitz (USAF), DTRA.

National Council on Radiation Protection and Measurements Staff:

Dr. Isaf Al-Nabulsi, Ms. Patty Barnhill, Ms. Melanie Heister, Dr. David Schauer, and Dr. Thomas Tenforde.

Members of the Public:

See Registration

OPENING REMARKS

Dr. Zimble called the meeting to order. He asked that all attendees register at the front desk, and that all those who wanted to address the Board during the public comment session also add their names to the list of those who wish to make public statements.

Mr. William R. Faircloth added his welcome and explained his role as Designated Federal Official. He mentioned the basis upon which members of the Board were selected, their various areas of expertise, and invited guests to make use of the available handouts.

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CHAIRMAN'S WELCOME AND INTRODUCTION OF BOARD MEMBERS

Dr. Zimble explained that this meeting would include a review of some items which needed to be documented for the record. He noted the handouts included the Board's charter, commenting that the Board had been designed to maintain independence and did not represent the government. Describing the Board's purpose as one of oversight, **Dr. Zimble** remarked that its mandate is to assure the processes of dose reconstruction and of processing claims filed with the VA were accomplished with quality and that communication with the veterans was proper. He added that he meant two-way communication and that the Board is ready and prepared to do a lot of listening.

Dr. Zimble commented he was comfortable chairing this Board because of the professional expertise and experience of its members. Indicating their bios were available as a handout, he called upon the members to introduce themselves.

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PERSPECTIVES ON DOSE RECONSTRUCTION PROGRAMS

Dr. Paul L. Ziemer, Chairman
President's Advisory Board on Radiation and Worker Health

Dr. Ziemer explained his career area was that of health physics and radiation protection. He reflected on his career background at Oak Ridge National Laboratory, as professor of health physics at Purdue University, and his service as Assistant Secretary of Energy for Environmental Safety and Health under President George H. W. Bush.

Dr. Ziemer expressed his intent to share some of his personal views of

the similarities and differences between the VBDR and his Advisory Board on Radiation and Worker Health (ABRWH). Listing the four radiation compensation programs currently in effect, **Dr. Ziemer** indicated he would focus on just the two with which the respective advisory boards were concerned.

Dr. Ziemer provided a history of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), its enactment by Congress, effective date, its purpose, roles and responsibilities, and compensation for its members and staff. He explained the authority for establishment of ABRWH and appointment of its members by the President.

Observing that the VBDR responsibility to "conduct periodic random audits of dose reconstructions and claim adjudication procedures" is analogous to the ABRWH responsibility to "advise the Secretary of Health and Human Services on the scientific validity and quality of dose reconstruction efforts," **Dr. Ziemer** remarked that his board audits the dose reconstruction process itself. All claims decisions are made by the Department of Labor, and those decisions are not audited by his board. He explained that his board is auditing the process for patterns of procedural, calculational and other deficiencies in the system, reviewing a block of 20 cases and presenting findings in a roll-up format to the National Institute for Occupational Safety and Health (NIOSH), which performs the dose reconstructions.

Dr. Ziemer remarked on the VBDR responsibility to "assist the VA and DTRA in communicating to veterans information on mission, procedures and evidentiary requirements of dose reconstruction," noting that ABRWH has no such duty. He observed that his board is nonetheless not shy about commenting when they find areas in which they feel the involved agencies could do a better job of interacting with claimants. While those comments are often from individual board members and thus do not represent board consensus, procedures and approaches have been changed in a number of cases based on those remarks.

Dr. Ziemer also addressed the composition of the two boards. The ABRWH consists of no more than 20 members, appointed by the President. There have never been more than 13 members, and currently there are 12 members, plus the Designated Federal Official. Those members are required to represent the labor, medical, and scientific communities. The VBDR is composed of members with expertise as directed by its Charter, and has a higher percentage of technical individuals.

Dr. Ziemer went on to discuss the frequency of ABRWH meetings, the status of the program relative to cases received and cases completed, and the status of petitions for inclusion of a class of employees in the Special Exposure Cohort. He highlighted some of the

accomplishments of the Board since inception of the program.

Explaining that, as a group, the ABRWH had neither the time nor the expertise to complete its responsibilities, **Dr. Ziemer** described the use of a contractor to support the Board in those endeavors. He listed and described the tasks currently assigned to the contractor.

Dr. Ziemer offered some observations on the benefits of having an independent advisory board, which included increased public confidence in the process and the opportunity to introduce alternate views, both scientific and practical. He closed by remarking that he felt the establishment of the VBDR was a positive addition to the DoD dose reconstruction program and that it will play an important role in future compensation programs for military veterans.

Discussion Points:

1. The idea that it costs more to run a dose reconstruction program than it would to compensate the claimants is not accurate. If that should ever become the case, it would be the Board's obligation to say something about it.
2. A cost/benefit analysis of the program should be done.
3. The contractor's development of the methodologies for reviewing and assessing dose reconstruction, with modification and approval of the ABRWH, is not a secret and certainly could be shared, though how much it would apply to VBDR is unknown.
4. Exposure scenarios of workers at each facility are different, even though there may be some shared similarities, just as there are differences and similarities with the veterans. There cannot be a one-size-fits-all scenario.
5. The labor unions serve as advocates for the workers and are doing what is needed to represent them. Much has been learned from listening to workers' stories, and the unions have been helpful in ensuring that the workers are aware of the program.
6. The VBDR equivalent of unions may well be the various veterans' organizations, which can be extremely helpful in the area of communications.

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NTPR DOSE RECONSTRUCTION PROGRAM FOR VETERANS
CURRENT STATUS

Dr. Paul K. Blake, Program Manager
Nuclear Test Personnel Review Program
Defense Threat Reduction Agency

Dr. Blake indicated in his outline that his presentation would consist of an overview, historical events, recent events, radiogenic disease and the road ahead. **Dr. Blake** first thanked **Dr. Ziemer** for his presentation and mentioned that there were certainly lessons learned between the two programs. He commented that in the next week his program would have two physicists from the NIOSH program visiting, and he was hopeful the two groups could benefit from each other.

Dr. Blake explained that DTRA is a defense combat support agency consisting of more than 2,000 personnel from military services, federal civil service, universities, et cetera. DTRA performs the National Security mission of reducing the threat of weapons of mass destruction. Its roots can be traced back to the Manhattan Project.

After World War II, nuclear weapons development became the responsibility of the Atomic Energy Commission (AEC), which evolved into the Department of Energy. Since the military had a continuing need to understand the effects of nuclear weapons, both the AEC and military personnel participated in nuclear weapons tests. Those tests, between 1945 and 1962, are approximately 235 aboveground or atmospheric tests, primarily in Nevada and the Pacific, with over 400,000 DoD military and civilian participants.

In 1975, fifteen years after the last above-ground test, the VA regional office in Boise, Idaho received a claim for disability benefits from a retired Army sergeant who attributed his acute myelocytic leukemia to radiation exposure received when he was a participant in Shot Smoky of Operation PLUMBBOB. The claim was initially denied, but later that decision was reversed.

That decision initiated a series of events involving the Department of Defense (DoD), the Department of Energy (DOE), the National Academy of Sciences (NAS), the White House, and others which led to questions about possible long-term health effects resulting from radiation exposures received by atomic test participants.

To answer those questions, DoD established the Nuclear Test Personnel Review (NTPR) Program in 1978. NTPR’s mission was to provide veterans, the VA and the Department of Justice with confirmation of participation and radiation doses, when applicable, to military and DoD civilian personnel who participated in 1) atmospheric nuclear testing, 2) served in the occupation forces of Hiroshima and Nagasaki, or 3) were interned as prisoners of war near Hiroshima and Nagasaki at the end of World War II. The program objectives cover the three areas of veterans’ assistance, dose assessment and database management.

Dr. Blake noted that Congress had passed 19 laws that impact the

program, including the Freedom of Information Act and the Privacy Act. The federal agencies then determine and report on the implementation of the legislation. Three federal agencies have now published their implementation procedures in the Code of Federal Regulations. The Department of Justice in Title 28 CFR Part 79; the VA in Title 38 CFR Part 3; and DoD in Title 32 CFR Part 218. DoD's regulations provide the guidance for the determination and reporting of nuclear radiation doses for DoD participants in the atmospheric test program.

Dr. Blake noted that the environment in which they operate is fairly complex. It includes individual veteran case histories, interagency decisions, historical perspectives, and various data archives. Classified data are reviewed and declassified, and new scientific developments are monitored. Oversight and scrutiny of the NTPR operations are performed by the Government Accountability Office, the NAS and now the VBDR.

Dr. Blake explained that the NTPR Integrated Product Team consists of three board-certified health physicists as government staff, and 25 support staff and 14 scientists/engineers as contractors. The DTRA members are located at Fort Belvoir, Virginia, and the contractors are primarily located in Reston and McLean, Virginia. The program has expanded in the past year or so based on the most recent NAS review published in 2003.

In early 1977, the CDC initiated an epidemiological investigation into abnormal leukemia incidents, and found an unusual leukemia cluster. Interagency meetings between DoD, DOE, VA and the U.S. Public Health Service addressed the issue, leading to Congressional hearings in 1978.

Dr. Blake described the initial responses, including passage in 1984 of the Veterans Dioxin and Radiation Exposure Compensation Standards Act. NTPR has continued to be active in addressing veterans' concerns, having sponsored or co-sponsored eight NAS studies, some of which have included active veteran participation. Over 68 historical/technical reports are now being posted on the DTRA Web site. The toll-free line established in 1978 by the Defense Nuclear Agency, DTRA's predecessor, is still in existence today.

Originally maintained separately, the records of the Atomic Energy Commission, now DOE, and the DoD have been combined and are located at the jointly funded DOE Nuclear Test Archives in Las Vegas, Nevada.

In May of 2003 NAS released the report on "A Review of the Dose Reconstruction Program of the Defense Threat Reduction Agency." The review contained eight NAS recommendations, each of which was described by **Dr. Blake**, the impact of which was a shutdown of NTPR's operations

for a number of months in order to reorganize and rework procedures, a shutdown that resulted in a heavy backlog of cases. The NAS recommendations also forced a lengthening of the process and required more interaction with veterans.

One major challenge currently faced is how to effectively reduce the backlog under those circumstances. To illustrate, **Dr. Blake** presented a timeline illustrating non-presumptive cases where dose reconstruction required approximately 204 days from receipt of the request to completion of the process with a letter to the VA and the veteran. In discussion with the VA regarding the backlog, DTRA has proposed eliminating the backlog by September of 2006.

Dr. Blake used graphs to demonstrate the DTRA workload for the period 1988 through 2004, the pending workload by cases, and the pending workload by disease.

Addressing the history of radiogenic cancer studies, **Dr. Blake** noted that NAS and other groups first studied the large cohort which had received significant acute radiation exposure - the Japanese survivors of the Hiroshima/Nagasaki atomic bomb explosions. He described the lifespan study of the Japanese survivors and the historical veterans' radiation exposure levels and compared those doses.

Dr. Blake discussed biomarkers versus probability analysis, cancer statistics and cancer prevalence, and how to determine whether disease is due to radiation exposure. The Veterans Advisory Committee on Environmental Hazards was established by Congress in 1985 to provide advice on adverse health effects of ionizing radiation. The most recent change as result of the committee’s advice was the Veterans’ Health Administration's adoption of the Interactive RadioEpidemiological Program (IREP) software for determining the probability of causation. A variant of that program, the NIOSH-IREP, is used by the Department of Labor in administering the EEOICPA program.

Dr. Blake explained that the VA compensation decisions are based on internet-accessible software that determines the probability of causation for a disease based on occupational radiation exposure which compares the risk from radiation to the risk due to all causes. He described uncertainty analysis and how the uncertainties are applied in favor of the veteran at both DTRA and the VA.

Dr. Blake concluded by commenting that his number one priority is to serve the veterans, that he and his program continually strive to find new ways to reduce the time necessary to complete dose reconstructions, and that he looked forward to the VBDR's input and assistance in

improving their program.

Discussion Points:

1. Is there a major source of information on how data on the 400,000 atomic veterans or participants in the database had been collected?
2. Did NTPR access any of the epidemiologic investigations where the participants had been identified by NAS and others?

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VA RADIATION CLAIMS COMPENSATION PROGRAM FOR VETERANS CURRENT STATUS

Mr. Thomas Pamperin, Assistant Director for Policy
Compensation and Pension Service
Department of Veterans Affairs

Mr. Pamperin explained the role of his department in administering all the non-medical benefits, including insurance, home loan guarantees, et cetera. He specifically discussed the term, “compensation” which he described as a monetary payment for an injury or disease incurred during active duty. Injuries or diseases “incurred during active duty” does not mean “caused by”, but “coincident with” that service.

He indicated VA currently pays 3.4 million veterans and survivors compensation and pensions, 2.6 million of whom receive disability compensation. Compensation is rated at 10% increments of levels of disability from zero to 100%. Individual disabilities have a specific assignment. For example, migraine headaches cannot be rated higher than 50% while amputations of a lower leg, depending on whether below the knee or above the knee can range up to 80 or 90%.

As examples, he explained that currently a 10% disability paid $108.00 per month while a 100% disability for a veteran with no dependents pays $2,293.00 per month. In addition, special monthly compensation for very seriously disabled veterans, i.e., those who have lost use of limbs, eyes, hearing, and bowel and bladder control can approach a maximum of almost $7,000.00 per month, for a single person. This year, the Veterans Benefits Administration (VBA) will spend $31 billion, $27 billion of which will be in compensation.

Radiation induced cancers can be rated as low as zero percent, for successfully treated prostate cancer with no residual disease, to 100% for an active lethal cancer, which might qualify for as much as $2,293 per month. Such disability ratings also entitle veterans to Category One status for health care, vocational rehabilitation and employment;

the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), a health care program for families; and an opportunity to have life insurance, for which a veteran might not otherwise qualify in the private sector.

The VBA has over 12,000 employees of whom 7,200 are employees in 57 regional offices and 140 military installations in the United States, as well as Germany and Korea, to process disability claims. This fiscal year that agency will receive 800,000 claims for either initial or increased disability; overall 2.1 million awards will be processed; 300,000 letters unrelated to a specific claim will be answered; and 6.4 million phone calls from veterans regarding their claims will be taken.

As of August 15th there were 524,000 pending disability claims in the inventory, 18% over six months old, with a smaller percent more than a year old. Virtually all those over a year old are reconstructed radiation dose cases. In addition to those cases there are also 152,000 pending appeals and 123,000 other award actions pending. In other words, **Mr. Pamperin** described his department as "fairly busy."

The VBA reorganized into a Claims Process Improvement (CPI) model, with six discrete steps. By going to the model, pending inventory dropped by over 300,000 cases in two years, and processing time was cut by about 75 days. Things were going quite well until a couple of court reversals.

Under Title 38, the Secretary of Veterans Affairs is charged with both being the administrator of the program and with being the veterans' advocate. Under the Veterans Claims Assistance Act the VA is specifically charged with assisting all veterans in proving their claims. In that regard the VA will obtain any government records needed, conduct required exams, get necessary medical opinions, and assist veterans in obtaining private medical records.
The following are the six steps of the CPI: 1) the Triage Team receives the claim and begins the process that controls claims for the entire system within seven calendar days of receipt; 2)the Determination Team develops all rating-related issues; 3) the Rating Team determines disability; 4) the Post-Determination Team implements the rating and prepares the award notification; 5) the Appeals Team handles all appeal activities; and 6) the Public Contact Team maintains active communication with the public, and deals with guardianship activity for about 120,000 beneficiaries who cannot handle their own estates, et cetera.

Mr. Pamperin explained the steps for processing of radiation claims once received from the regional office, including completeness review and forwarding to the VHA for a medical opinion, before return to the

regional office. He described the three categories of veterans' exposure as participation in the military occupation of Hiroshima/Nagasaki, participation in atmospheric testing of nuclear weapons, and occupational exposure.

Mr. Pamperin remarked that in a normal year about 600 cases will be sent to DTRA for dose reconstruction. He explained how a case is developed once a specific disability is claimed, the title under which the claim will be made, and what information will then be gathered for the determination of those claims.

The NAS report on dose reconstruction contained some critical findings. The most important from the VA perspective was that upper bound ingestion doses had been underestimated. Based on that finding, the VA determined that a review of previous denials of claims based on doses that failed to establish causation would be undertaken. More than 11,000 records were reviewed to determine which claims had been denied on that basis, resulting in 1,250 claims requiring readjudication. Thus far 188 claims have completed the readjudication process, of which 126 have granted compensation.

Discussion Points:

1. What is the Ionizing Radiation Registry and what does one have to do to get included in it?
2. The four benefits a veteran receives if he is granted a 100% disability.
3. The amount a single veteran with no dependents rated 100% receives as a monthly benefit.
4. How the program interacts with benefits through other retirement-type programs?
5. The percent disability rating for skin and prostate cancers, which make up about two-thirds of the claims currently requiring dose reconstruction.
6. In an effort to shorten the process, the feasibility of making determinations of percent disability concurrently or before reconstruction of dose, so that if someone were eligible only for zero percent disability the dose reconstruction would be rendered unnecessary.
7. An important underlying issue isn't a matter of whether the veteran gets money today, but whether there is Dependent Indemnity Compensation payable later on.

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DOSE RECONSTRUCTION AND VETERANS COMMUNICATION ACTIVITIES

Dr. Paul K. Blake,
NTPR/DTRA

The topics described in the outline of **Dr. Blake**'s presentation included *P. L. 108-183*, the VA/DoD joint report to Congress, workload and pending issues. **Dr. Blake** began with background of the enactment of *P.L. 108-183* and what it required of the Secretaries of Defense and the VA, including establishment of this Board.

One requirement was a joint review to determine whether additional actions are required to ensure quality assurance and quality control mechanisms are sufficient. Also requested in the review was a determination of actions required to ensure mechanisms for communication and interactions with veterans are sufficient. The results of the review were to be conveyed in a joint report to Congress, which should include a plan of required actions and other recommendations as jointly considered appropriate by the respective Secretaries.

Dr. Blake described the activities requested of the Advisory Board and the guidelines for its composition.

The 90-day report to Congress was submitted as required in June of 2004. That report described and expanded on the eight recommendations in the NAS review of the dose reconstruction program. Twenty-three findings were summarized in the report, which will be put on line shortly on the VBDR Web site. The action plans are expected to overcome the deficiencies in the dose reconstruction and claims adjudication program.

The findings are broken down into subcategories: findings 1 through 4 address interagency actions to improve claims procedures; 5 through 14 address DTRA actions to improve NTPR program procedures; 15 through 18 address interagency actions to improve communications, and 19 through 23 address advisory board requirements and functions.

Dr. Blake specifically discussed findings 5 through 14, which were specific to NTPR. He outlined each of those findings individually and provided action plans, both completed and/or ongoing.

Addressing the workload and incoming cases, **Dr. Blake** noted that the workload changes with time. Right now the workload is actually a little less on incoming cases, which is fortunate since they are in the midst of an effort to reduce a backlog. Cases have been broken down into three different categories and **Dr. Blake** reiterated that it is DTRA's goal to have the backlog down and be back to normal by September of 2006.

Discussion Points:

1. Definition and explanation of ISO-9001 as the International Systems Organization, which is a quality assurance/quality management procedure.
2. Whether a process analysis can deal with the issues of backlog, which are typically issues of strategy, without having load-leveling capability.
3. The ISO-9001 auditors went through the DTRA procedures manual and, on the administrative side, found no problems. On the technical side the auditor, who was not a formal health physicist, simply looked to see if there were procedures in place and whether they were being followed.
4. It will be important that the types of quality being discussed are identified.
5. The frustrations of people who call upon the services of NTPR are ones that the process doesn't address in a direct way. They relate to things like the ability to manage a workload with the available staff.
6. ISO-9001 is a process for laying out the expectations in such a way that anyone can evaluate the steps and someone can then follow up and audit against the expectations. It does not measure effectiveness or efficiency, but measures whether the expected processes are being carried out.
7. The difficulties in getting best estimate or even considering best estimate were mentioned and the question was raised whether an actual organ dose is computed from the internal radionuclides that are inhaled or ingested.
8. A documented software procedure called Fallout Inhalation and Ingestion Dose to Organs is used to do an internal organ dose computation, but there are large uncertainties associated with that.
9. The need to do a dose reconstruction on radionuclides that have just minimal effects on dose to the organ in question was discussed.

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DOSE RECONSTRUCTION ACTIVITIES

Dr. Paul K. Blake
NTPR/DTRA

Dr. Blake commented that in his final presentation he would like to briefly discuss the team, the process, the timelines and a closing note.

In the integrated product team made up of both the government and contractors there are seven individual teams. **Dr. Blake** described each

one and explained the role each plays in the process, the key actions and key factors in each step.

He described the types of documents that would be sought and where that information might be located. Noting that claims may involve not only his program but other occupational radiation exposures, he then went on to describe the military service contacts to coordinate the process and help support the VA, such as the Army Surgeon General's Office, Office of Preventive Medicine, et cetera.

As for key information collected, from a technical viewpoint it includes personal identification, activity, location, unit identification, activity, location and weather, terrain, and post-test site project identification.

The veteran's response to the questionnaire is requested within 30 days. Upon receipt, it is then followed up with a phone call. If there is no response within 60 days, NTPR moves ahead without the questionnaire. Right now the average return time is 35 to 40 days.

When cases are received, triage is performed on the dose assessment. **Dr. Blake** provided the key actions and key factors involved in that step, and explained the dose reconstruction process. He described it as a time-consuming and expensive scientific estimate of the total dose received from personnel activities in a defined radiological environment.

The first step in the process is called the Scenario of Participation and Radiation Exposure (SPARE). **Dr. Blake** enumerated the key actions and key factors involved in that step of the process. The next step involves estimating the radiation dose in which the key actions and key factors were also enumerated, with the same being provided for the final processing.

The length of time to do cases has grown considerably since the NAS review. The time period now is approximately 204 days, as **Dr. Blake** had described earlier, although some cases can move much faster. He noted his program is making new efforts to facilitate the process, reduce delays, shorten the timelines and eliminate the case backlog.

Discussion Point:

1. If the search for records involves medical records or if the veteran had previously filed a claim for some other condition, the VA would have all of his military medical records.

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PERSPECTIVES OF THE NATIONAL ASSOCIATION OF ATOMIC VETERANS

Mr. R. J. Ritter, National Commander
National Association of Atomic Veterans, Inc.

Mr. Ritter announced he was grateful for the opportunity to present, on behalf of America's atomic veterans, their views and objections to the continuance of dose reconstruction by DTRA. **Mr. Ritter** provided background on the formation of the National Association of Atomic Veterans (NAAV), which was for the primary purpose of giving those veterans a single-voice platform to express frustrations related to inability to obtain service-connected compensation from the DoD and VA.

He noted there are questions related to the accuracy of the number of veterans exposed to ionizing radiation from atomic weapons tests. The DoD and the VA has officially estimated 410,000 military personnel exposed by above-ground and underwater tests from 1945 to 1962. It is estimated there may be several thousand additional veterans exposed to post-test residual radiation particles while on various maneuvers in and around the weapon detonation test sites. Studies would suggest more than one million veterans may be suffering long-term effects of ionizing radiation.

Mr. Ritter commented that for more than 45 years the U.S. Congress, along with DoD and the VA, had commissioned numerous panels and advisory boards to address the monetary and medical needs of the atomic veterans. Most of those board members possess impeccable credentials and impressive biographies. But to the sick and aging veterans, those credentials are totally meaningless. He remarked that while those veterans continued to suffer from radiation-induced illnesses, consultants continued to generate theoretical opinions and hypothetical scenarios, all of which have denied the veterans recognition and benefits.

After a review of the comments in the joint report to Congress by the DoD and VA on June 3 of 2004, **Mr. Ritter** indicated he fully understands why only 50 of the approximately 280,000 claims were approved. In fact, after being exposed to the complexities of the system, he remarked that he was amazed that 50 actually made it through the maze of theoretical assumptions and radiation exposure projection models. The process of arriving at theoretical exposure level assumptions would accurately be described as a Catch-22 situation.

Mr. Ritter highlighted some milestone events in the lives of these atomic veterans. He noted they are a tribute to those atomic veterans who have since died from radiation exposure events without receiving recognition for their sacrifices.

The events included: Operation TRINITY, test Gadget, July 16, 1945, in the desert of Alamogordo, New Mexico, the first day that America's atomic veterans were exposed to ionizing radiation; personnel present were not issued protective clothing and only a few were issued film badges; the Empire of Japan surrendered unconditionally just 28 days after the test.

In August 1945 occupation forces liberated Americans from the Prisoners of War camp on the outskirts of what was left of Nagasaki, Japan.

September 1945 additional U.S. military personnel entered the cities of Hiroshima and Nagasaki for purposes of occupation and damage assessment.

June 30, 1946 approximately 41,000 military personnel and 150 civilian scientists and technicians gathered at Bikini Atoll in the Marshall Islands for the two CROSSROADS tests. Almost all the military participants have developed radiation-induced health issues.

Shortly after the CASTLE series of tests at Bikini in February of 1954, a Japanese fishing fleet harvested 450 metric tons of irradiated tuna, causing the U.S. to ban all fish imports from Japan for one year.

During Operation WIGWAM off the coast of California in May of 1955, Captain Richard Purdy was skipper of the U.S.S. Marion County. That ship was damaged in the blast and could not be sailed in a forward motion. Captain Purdy negotiated the 480 nautical miles back to Long Beach harbor in reverse. After docking in a secured area and before leaving the ship, a technician checked Captain Purdy for evidence of radiation. His shoes were too hot to allow him to leave the vessel. A few years later Captain Purdy was diagnosed with leukemia and lung cancer and has since died.

Mr. Ritter speculated whether dose reconstruction could determine with any degree of accuracy the amount of radiation absorbed by the servicemen and technicians who participated in Operation WIGWAM.

The Operation PLUMBBOB series of tests from May 28, 1957 to March 14, 1958 included 33 fission weapon device detonations at Yucca Flats and Frenchman's Flat, Nevada. A photo of members of the 11th Airborne who were air-dropped over ground zero less than an hour after a test detonation shows the paratroopers walking through smoking ruins. None were wearing any visible protective clothing, nor were they wearing any breathing apparatus.

In keeping with the Atmospheric Nuclear Test Ban Treaty, the U.S. went underground with their atomic testing program. In October of 1964 and

December of 1966 three fission devices were detonated in a shaft penetrating a salt mine on the outskirts of Hattiesburg, Mississippi. Ninety civilian contractor compensation claims were filed for illnesses attributed to post-test radiation exposure. Only one was approved, an approval ratio of 89 to one.

If this ratio were applied to the number of claims filed by atomic veterans, the VA should have approved more than 3,000 rather than 50. But even more insulting to the veterans was then-President Clinton's compensation of government contractor employees who worked at the nuclear weapons material plant in Paducah, Kentucky without question.

Mr. Ritter suggested it is the feeling of the atomic veterans that the deck has been stacked against them for several reasons. They include the fact that these veterans were sworn to secrecy; the availability of their individual film badge readings was and still is non-existent; their DD-214 discharge document doesn't mention any connection with atomic weapons testing.

Mr. Ritter declared the current list of presumptive radiation-induced illnesses a massive concrete wall. It was supposed to be a simple method of dealing with questionable service-connected situations. He opined that implementing the wishes of Congress is often left to contractors with no background experience related to the actual events and issues. None of the experts of record were on-site participants in any atomic weapon detonation event.

Mr. Ritter observed that he'd found many key personnel at VA medical facilities have no idea there is an Ionizing Radiation Registry, let alone its purpose. VA medical facility personnel have said it is difficult to understand the current VA rules as they apply to the acceptance, disposition and treatment of atomic veterans.

Since 1979 the NAAV has developed and maintained a medical database of members who elected to submit their illness histories for such purposes. Most included comments about their children born with health anomalies. Approximately 18% of the children born to atomic veterans can be classified as genetically impaired offspring.

Mr. Ritter contended the experiences and plight of the atomic veterans are kept secret from the general public. He opined that if the American people were fully informed of how Congress continues to drag its feet in addressing the issues of these veterans, they would be outraged.

Noting that a key issue of concern to the atomic veterans is post-exposure radiation-induced genetic mutations, **Mr. Ritter** stated it is

the belief of the NAAV, as well as other veterans' associations, that dose reconstruction is a waste of taxpayer funds, results cannot be accurately substantiated, nor can they be verified as credible. Furthermore, NAAV believes all atomic veterans should be placed in the same VA medical care group as those veterans who were awarded the Purple Heart, without restrictions.

Declaring these Cold War warriors are trapped in a twilight zone of Congressional procrastination and political indecisiveness, **Mr. Ritter** closed by stating it was time for a major change on their behalf.

Dr. Zimble inquired if he were correct in assuming **Mr. Ritter** was speaking on behalf of his organization, the NAAV. **Mr. Ritter** stated he spoke for all veterans in all tests from day one. He added that NAAV now has concerns for veterans exposed to depleted uranium in the Gulf War, noting this will be another group of radioactive veterans with which the government will have to contend.

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Dr. Zimble declared the Board in recess until 7:15 p.m., at which time public comment would be received.

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PUBLIC COMMENT PERIOD

Input from the public was solicited on both days of the meeting. Veterans gave public testimony on cancers, birth defects and other debilitating illnesses they believe resulted from their participation in atmospheric nuclear testing and other occupational radiation exposures. They also expressed concerns about problems with DTRA's dose reconstruction procedures and the claims decisions made by VA.

The following is a list of the members of the public who spoke on the first day. Verbatim transcripts of the public comments are available on VBDR Web site at http://vbdr.org.

Mr. Jim Taylor, National Association of Atomic Veterans, Area Commander for northeast Florida; **Mrs. Bettie Jo Taylor**, wife of Jim Taylor; **Mr. Charles Wisner**, past Commander of the National Association of Atomic Veterans, National VA Volunteer Services representative, National VA medical representative; **Mrs. Pat Broudy**, widow of Charles Broudy, atomic veteran; **Mr. Charles Clark**, atomic veteran; **Mr. Bernie Clark**, atomic test observer; **Mr. Joseph DeSalvo**, atomic veteran; **Mr. Clyde Wyant**, atomic veteran; **Mr. Thomas Daly**, atomic veteran.

With no further comments, the Board officially recessed until the following morning.

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Thursday, August 18, 2005

Dr. Zimble called the second day of the meeting to order, welcomed **Dr. Kristin Swenson** to the table and confirmed that **Dr. Vaughan** was present by telephone. He called for any questions or unfinished business from the previous day.

Mr. Taylor indicated he would communicate with **Mr. Ritter** of NAAV and thanked his group for having stayed over a second day to speak to the Board during the public comment period.

Dr. Zimble reminded everyone to register and indicated that the first order of business for this day is to review and approve the concept of subcommittees to do the work of the Board. He outlined the creation of four subcommittees: Number one, for auditing the dose reconstructions; number two, auditing and reviewing the claims process of the Veterans Administration; number three, to review quality assurance issues and integration of the agencies involved with compensating atomic veterans; and number four, a subcommittee on communications, looking at areas of communication between agencies and the veterans.

A motion was made and seconded that the four suggested subcommittees be created. It was carried unanimously.

REVIEW AND BOARD APPROVAL OF SCOPE OF WORK AND MEMBERSHIP OF SUBCOMMITTEE 1

A motion was made and seconded that Mr. Harold Beck be named Chairman of the Subcommittee on DTRA Dose Reconstruction Procedures in light of his experience in radiation dose reconstruction. The motion carried unanimously.

Dr. Zimble called for **Mr. Beck** to discuss the statement of work for the subcommittee, its primary mission, and to nominate the members for his subcommittee.

Mr. Beck commented that he envisioned two main goals in auditing radiation dose reconstructions. One is to examine the methodology to make sure appropriate procedures are in place, are being followed, and are adequate, as well as to identify any problems with the procedures. A second, longer-term goal is to develop a continuing process to identify enough cases to obtain statistical evidence of the quality of

the dose reconstructions, occurrence of problems, occurrence of lack of documentation, et cetera.

In the initial year of the subcommittee **Mr. Beck** suggested the focus will be on identifying problems with the methodology of dose reconstructions.

Mr. Beck proposed the following members of his subcommittee: **Mr. Paul Voillequé**, **Dr. Gary Zeman** and **Dr. Paul Blake**. He noted that they were all very well qualified in both dose reconstruction and health physics.

A motion was made and seconded that the proposed members of Subcommittee Number 1 be accepted by the Board. The motion carried unanimously.

Mr. Beck added that as they review the cases they are going to discover issues that involve quality assurance and communication problems, both of which are outside his subcommittee's focus. It is, therefore, essential that his subcommittee will have to work closely with the other subcommittees to ensure that those issues are adequately addressed. He suggested they may want to consider developing some mechanism for coordination between the subcommittees.

Dr. Zimble observed that during the first day of presentations to the Board, he had found it remarkable that after dose reconstructions were completed and sent to the VA for a compensation decision, almost every claim was denied. There is a mandate that everything be in favor of the veteran, that the 95th percentile would be sought on dose reconstruction and 99th percentile on probability of causation, and despite that, very few claims in the non-presumptive category are granted. He noted that in the presumptive group of 21 cancers, claims are automatically granted. There is an apparent paradox that may be appropriate for the Board to consider. Specifically, Subcommittee 1 should be looking at that aspect of the veterans' dose reconstruction and claims compensation program.

Mr. Beck replied that the Academy's report pointed out that once the dose reconstruction is done and delivered to the medical staff at VA, they apply probability of causation tables. If the dose isn't high enough, the claim will be denied. The Academy found the upper dose limits previously reported were such that the dose was rarely high enough to assume causation; nonetheless, the Academy also found that if new rules were adopted so that the upper dose limits were more realistic, it would still be unlikely that the dose would be high enough for probable causation of most cancers. **Mr. Beck** suggested that it is most important for his subcommittee to ensure that the 95th percentile dose is a realistic estimate. Why a claim is not granted

goes beyond the scope of his subcommittee.

Dr. Zimble suggested that it might be wise to look at the cost-benefit analysis of the process that has been established for the non-presumptive cases, and **Mr. Beck** fully agreed.

Dr. Zeman commented that he was particularly interested in issues involving beta dosimetry and uncertainty analysis.

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REVIEW AND BOARD APPROVAL OF SCOPE OF WORK AND MEMBERSHIP OF SUBCOMMITTEE 2

A motion was made and seconded that Dr. Ronald Blanck be named Chairman of the Subcommittee on VA Claims Adjudication Procedures due to his long history of executive management of the medical system in the United States Army. The motion carried unanimously.

Dr. Zimble indicated that at Dr. Blanck's request, he would assume the role of acting chair of the subcommittee. In order to nominate the members of Subcommittee Number 2, this would include himself, Mr. Thomas Pamperin, and one additional member to be appointed to the Board as an expert in the field of ethics. **Dr. Zimble** asked that once the ethicist is identified, that individual be included as a member of Subcommittee Number 2.

A motion was made and seconded that the proposed members of Subcommittee Number 2 be accepted by the Board. The motion carried unanimously.

Dr. Zimble noted that the mission and scope of the subcommittee is obvious. The subcommittee will review oral and written testimony from members of the cohort of veterans within the scope of this Board's purview who are having difficulty with the VA's processing of their claims. The subcommittee hopes to find the means to establish ongoing channels of communication between the Board and the involved veterans, and that it will develop productive recommendations for the Board.

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REVIEW AND BOARD APPROVAL OF SCOPE OF WORK AND MEMBERSHIP OF SUBCOMMITTEE 3

A motion was made and seconded that Dr. Curt W. Reimann, an expert in the field of quality management and communication, be

named Chairman of the Subcommittee on Quality Management and VA Process Integration with DTRA Nuclear Test Personnel Review Program. The motion carried unanimously.

Dr. Reimann proposed the following members of his subcommittee: **Dr. Kristin Swenson**, an experienced health physicist whose background includes the military and experience in dealing with veterans' groups; **Dr. John Lathrop**, with a great involvement in decision sciences and complex interactive systems; and **Dr. David McCurdy**, who may be the most experienced person on the Board in dealing with the quality issues of operating systems related to the uses of and exposure to radiation.

A motion was made and seconded that the proposed members of Subcommittee Number 3 be accepted by the Board. The motion carried unanimously.

Dr. Reimann described how he perceives the work of the subcommittee in dealing with the quality assurance of all processes related to interactions between the VA and NTPR, communications with veterans and communication with military services. He emphasized a need for integration and frequent informal communications with subcommittees and with the VA and DTRA.

Dr. Reimann discussed a need to ultimately provide recommendations on system-wide improvements and a need to have some concept of a design on how all the parts fit together. He noted the Board should appreciate they're trying to make something work well within a prescribed policy framework. It should also be understood that some recommendations might address changes in the policy.

Dr. Reimann observed that technical quality, process quality, service and relationship quality, and operational efficiency are very different dimensions, any one of which could be made to work alone, but might not produce a high quality solution for the entire system.

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REVIEW AND BOARD APPROVAL OF SCOPE OF WORK AND MEMBERSHIP OF SUBCOMMITTEE 4

A motion was made and seconded that Mr. Kenneth Groves be named Chairman of the Subcommittee on Communication With and About Atomic Veterans. The motion carried unanimously.

Mr. Groves remarked what he considered of primary importance to his subcommittee was its potential to deal closely with the veterans, and

he looked forward to that as an honor. He noted that he also will need to receive the input of the other subcommittees and their Chairs.

Mr. Groves proposed the following members of his subcommittee: **Dr. John Boice**, whose technical expertise will be helpful in communicating issues relating to dose reconstruction and probability of causation tables to the veterans' community; **Dr. Elaine Vaughan**, who has a history of expertise in dealing with the public and lay groups on the communication of technical information; and **Mr. Edwin Taylor**, whose association with veterans' groups, particularly atomic veterans, will be of great value. **Mr. Groves** added that, with the permission of **Dr. Reimann**, he would like to be able to borrow the services of **Dr. John Lathrop** from time to time, noting that he had skills that would be very useful to the Communications Subcommittee.

A motion was made and seconded that the proposed members of Subcommittee Number 4 be accepted by the Board. The motion carried unanimously.

Mr. Groves noted there were some formal charges to the subcommittee as part of the Public Law under which the Board was formed, and that a number of issues were identified in last night's public comment period that indicated a definite need for better communications. Some of those are resolvable sooner rather than later, and will be issues for consideration by the subcommittee.

Mr. Groves observed that there are typical communication issues in improving the transmission of information and being sure it is understood. A more difficult and equally important task is finding more effective ways to communicate the complex issues associated with the law and the terminology and methodologies associated with probability of causation and other technical matters.

Commenting that he saw the Communications Subcommittee as an integrating organization among the subcommittees, **Mr. Groves** said he looked forward to working with the other subcommittee Chairs.

As a first function to be addressed, **Mr. Groves** suggested getting the word out to veterans on both the Public Law and the programs that exist at DTRA and the VA, as well as information on the formation of the advisory board. He opined there are a number of potential beneficiaries who are either unaware the programs exist or do not understand them well enough to pursue more information. To marry that need with the existence of the advisory board, its charge to work with the veterans' communities, and improving the communication processes is something that can be done early on. That step would increase the visibility of both the program and the Board, and possibly result in fewer empty

chairs at the next meeting.

Dr. Vaughan remarked that she had some concerns about the subcommittee's scope as presently written, particularly after having listened to the veterans yesterday. She noted that the basis of conflict is the potential for much broader input of the veteran, which would be useful. She cautioned against interpreting the scope of the subcommittee and the Board too narrowly.

Dr. Vaughan explained there is a potential to have much broader communication issues addressed, which needs to be done in an effort to build or restore trust. Some of these issues have to do with quality of information and validity of the scientific approaches. Beyond that, the veterans are raising issues about the threshold for compensation and the decision criteria used to say whether or not a case should be considered appropriate for compensation. She suggested discussion not be limited to one-way communication to veterans about technical and scientific aspects of their cases.

Dr. Zimble asked **Dr. Vaughan** to put her thoughts into an amendment to what has been published as the scope of work for the subcommittee so that they may be included in the overall transcript.

Mr. Groves expressed his agreement with **Dr. Vaughan**, noting that she had raised issues that would be addressed not only by the subcommittee, but by the Board as a whole. He added that he looked forward to working on those issues with the ethicist who will be joining the Board and the entire subcommittee insofar as they are critical components of the lack of trust by veterans that must overcome.

Dr. Zimble suggested frustrations usually arise when you don't feel you've been heard.

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BOARD DISCUSSION

Dr. Zimble called for input from the Board members for suggestions on how to spread the word to veterans and various veterans' organizations that the Board wants very much to hear from them.

Dr. Blake suggested DTRA may be of some help through its database of the 400,000-plus atomic veterans.

Mr. Taylor observed many members of the target group were up in years and may not all be familiar with the internet or e-mails, but the veterans' magazines might be very useful tools. Another would be the

veterans' service officers of groups such as the Elks, American Legion, et cetera.

Dr. Zimble commented that the immediate charge to the public affairs staff at VA and DTRA would be to help the Board prepare appropriate literature that could be given to various organizations' publications to communicate that the Board exists and is listening to the veterans.

Dr. Reimann cautioned that at times people are gratified that you've heard them out, but in the end they interpret "hearing them out" in terms of the answer they get.

Dr. Reimann added that there will be multiple reasons for communications, but the root cause of the current difficulties is a difference in views of the meaning of “benefit of the doubt.”

Mr. Pamperin asked that two things be kept in mind with any outreach efforts. One is to not set up unrealistic expectations and the other is to not create a situation that inundates DTRA with new claims.

Mr. Taylor offered that he'd found it interesting that people may not always get the answer they seek, but the fact that they were answered at all is very important.

Dr. Swenson observed that the target group is aging, and to use restraint in outreach to avoid overwhelming the system may not be the right approach. She noted that even if the system is overwhelmed, the contact with the veterans is probably the most important goal.

MR. Taylor suggested it wouldn't hurt to make Congress aware of the situation it had triggered.

Mr. Groves agreed with **Dr. Swenson**, noting that they'd heard from both **Dr. Blake** and **Mr. Pamperin** that the systems don't have an inherent surge capability. Since they're all hoping the outreach will be effective, DTRA and the VA will need to be prepared to handle what will be some degree of surge in the system.

Dr. Reimann commented that the literature of service quality deals with the issue of gaps between expectation and delivery. If expectations are raised, perceived quality could diminish, fueling cynicism. He noted the issue in service quality is one of perceptions and fulfillment relative to what has been laid out as possible. He cautioned that while he didn't disagree with anything that had been said, we need to be very careful about raising unrealistic expectations.

Dr. Zimble recognized that **Dr. Reimann** had communicated the risk the Board will have to deal with, agreeing that they will raise expectations by veterans, but suggesting that the Board should not lower its own expectations at the same time.

A motion was made and seconded that the mission statements of all four subcommittees, along with the amendment to the statement of Subcommittee Number 4, be accepted by the Board.

Discussion Points:

2. Are there other modifications that might be submitted?
3. All Board actions are subject to modification.

A vote was called for and the motion carried unanimously.

Dr. Zimble asked that each subcommittee chair look to when they might get their groups together for meetings. He noted **Dr. Al-Nabulsi** had provided them with windows of opportunity to meet at the Bethesda offices of NCRP. **Dr. Zimble** also reminded them that there are resources available if help is needed beyond the membership of the subcommittees in order to carry out their responsibilities. He stressed the need to see something accomplished by the next meeting of the full Board in January.

Noting that Subcommittee Number 2, which deals with the claims process, will meet November 28 through 30, **Dr. Zimble** asked that the other chairs get some sense of when they will meet and provide that information to the staff.

Dr. Al-Nabulsi mentioned that the next annual meeting of NAAV is scheduled for September of 2006 in New Orleans, and that the Board might want to keep that in mind when scheduling its future meetings.

Mr. Taylor commented the NAAV was one of several veterans' groups and he felt one of his immediate roles is to determine what and where others may be and their contact points.

Dr. Reimann offered that he had experienced from similar situations that there are often rivalries and other issues in dealing with such groups. They may take different positions or jockey for influence, so there is a need to be aware of the special interests of potentially competing groups within the larger community of veterans.

A motion was made and seconded that the Board take a two and one-half hour lunch recess.

Discussion Points:

1. Why is such a long recess being suggested?
2. The *Federal Register* noticed a public comment session at 2:00 p.m. and the Board should be available for that to see if there is any public turnout. The Board has to decide how to handle the period from 2:00 to 4:00 p.m.

The motion carried unanimously.

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MECHANISMS FOR CONTACTING VBDR AND THE ROLE OF NCRP

Dr. Isaf Al-Nabulsi
Program Administrator

Dr. Al-Nabulsi, Program Administrator of the VBDR and a member of the NCRP staff, explained that her responsibilities are to provide technical and administrative support and to ensure efficiency and quality of all NCRP operations related to the VBDR. She noted that NCRP is not affiliated with the government, but is a private, non-profit organization. The NCRP involvement with veterans began after publication of the NAS report on the review of DTRA's dose reconstruction program, for which she was the study director.

One recommendation included in the report was the need to establish an independent advisory board to provide oversight of radiation dose reconstruction and claims compensation programs for veterans. As a result, DTRA and the VA took actions to meet the report's recommendation.

Dr. Al-Nabulsi provided a chronology of NCRP's actions to assist with forming the Advisory Board, and the signing of NCRP'S contract with DTRA and new staff to assist with operations of the Board. She outlined the areas in which NCRP will provide assistance to DTRA in facilitating Board meetings and activities, provide technical assistance, and prepare reports to be published over the coming five to six years.

She noted that the Board will operate under Federal Advisory Committee Act rules, which means there are open records of all activities and the meetings will be transcribed. A court reporter will keep a record of all Board meetings.

Dr. Al-Nabulsi observed there are also responsibilities the Advisory

Board does not have, such as providing a service by reviewing dose reconstructions for particular individuals, serving as an appeals board, helping a claimant with his or her claim, or changing or revising the provisions of the Radiation-Exposed Veterans' Compensation Act law.

Stressing that the Board would like to hear from veterans on issues or problems that may be claims-related, **Dr. Al-Nabulsi** discussed several ways the veterans can communicate with the Board. They include written communication, telephone, e-mail, and visiting the VBDR Web site. Addresses and phone numbers were provided each method.

Discussion Points:

1. A link to each of the subcommittee Chairs and their membership will be provided.
2. No personal e-mail addresses will be released.
3. Inclusion of an information page for the subcommittees on the Web site, such as Frequently Asked Questions, would not be a problem.
4. A hit count for the Web site will be provided.
5. **Dr. Al-Nabulsi** has the ability to keep the Board informed of other important committees or information regarding compensation issues.
6. **Dr. Al-Nabulsi** will soon release a new NAS report on radiation screening and compensation for downwinders, and it might be useful for the Board to have that report and related materials available.
7. The Ionizing Radiation Registry has generated some interest among veterans, who are asking how to find out if they are included.
8. That information is available by calling the 800 number **Dr. Al-Nabulsi** just provided.
9. The Board should avoid being viewed as an ombudsman-like entity, so it may be wise to consider providing various points of contact on the VBDR Web site.

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Dr. Zimble announced that he was very disappointed in the lack of members of the public during the comment periods. He noted that one of the most important things the Board must do is gather the information that can only come from the statements of the veterans. He called on the DFO to provide advice on how to handle the *Federal Register* notice of public comment when there are no members of the public present.

Mr. Faircloth proposed that he would stay in the meeting room, along with the court reporter and any other Board members who wished to do so, so that any statements that may be made during the public comment period.

Dr. Zimble and **Dr. Al-Nabulsi** both indicated they would remain. **Dr. Zimble** observed there was no need to maintain a quorum insofar as there were no additional official Board decisions to be made.

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FUTURE VBDR MEETINGS

Dr. Isaf Al-Nabulsi,
Program Administrator

Dr. Al-Nabulsi explained the Board will hold its public meetings at locations throughout the United States where large numbers of atomic veterans have filed compensation claims. Transcripts and minutes of each meeting will be prepared and posted on the VBDR Web site, vbdr.org.

The meetings are open to the public and anyone can attend. Date, time, location and proposed agenda for upcoming meetings will be announced in the *Federal Register* and can also be found on the VBDR Web site. News releases announcing each meeting will be provided to news media and veterans' groups. All veterans are encouraged to attend Board meetings.

The next two meetings are tentatively scheduled for the weeks of January 9 to 15 and June 5 to 9, 2006, to be located either in California or Texas. Proposed agendas will include review and approval of minutes of the preceding meeting; Board discussion and reporting on ongoing activities and the future schedule of actions; subcommittee discussion on ongoing activities and the completion schedule; and public comment.

Dr. Al-Nabulsi noted that the dates had been recommended based on the schedules of Board members, and that all members appeared to be available for those dates. She added that subcommittee meetings can be held before the Board meeting.

Following discussion by the Board, it was agreed that the second meeting of the VBDR will be held on January 12 and 13, 2006, and the third meeting on June 8 and 9, 2006.

Dr. Zimble announced the areas of Waco, Texas and either Oakland, California or midway between San Diego and Los Angeles, California have the highest concentration of claims-filing atomic veterans. Following a short discussion, **Dr. Zimble** asked the communications subcommittee to make a recommendation as to the best sites, noting the Board wanted to be in a position to get the greatest turnout of veterans. He added

that the Board would then obtain a better sense of where it can provide recommendations.

Mr. Groves confirmed it was the consensus to meet in California in January and Texas in June. **Dr. Zimble** observed that if it was found to be more appropriate to go to Texas before California, the schedule can be modified.

Dr. Zeman suggested that if the Board intends to pursue the possibility of meeting in New Orleans in September to coincide with the 2006 NAAV meeting, it might make sense to go to Texas in January.

Dr. Zimble agreed it would be a nice follow-up to the NAAV meeting to have the Board there in September, but that date hasn't been finalized yet. He suggested the decision should wait until the potential for California and Texas has been explored.

Mr. Groves commented that the issue was worthy of further discussion, but suggested it be deferred until after the Board heard from some members of the public who had just arrived.

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PUBLIC COMMENT PERIOD

The following is a list of the members of the public who spoke on the second day. Verbatim transcripts of the public comment are available on VBDR Web site at http://vbdr.org.

Mr. Paul DeGunther, atomic veteran; **Mrs. Betty DeGunther**, wife of Paul DeGunther.

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FUTURE VBDR MEETINGS (Continued)

Mr. Groves commented he would like to discuss some other communication-related issues that directly impact on meetings. He announced his subcommittee had met at lunch and they see one of their responsibilities as the need to address communication issues within the Board, hopefully enhancing the communications between the Board and the veterans' community.

Noting there seems to be a sizeable number of potential beneficiaries for the program, **Mr. Groves** commented that there are a large number of places to spread the word. If the Board agreed, it might consider having a member of the Communications Subcommittee attend gatherings of

potential beneficiaries to brief them on the fact that the Board is in place and active. The outreach program might be increased to include a member of the Board making a presentation on behalf of the Board.

Dr. Zimble inquired of **Mr. Pamperin** if the Board could become engaged with any VA outreach programs (or other similar activities). **Mr. Pamperin** responded there was no organized national effort, but reunions in areas supported by a VA Regional Office are usually attended by someone from that Regional Office. He added there are a number of things that can be done in terms of service organizations, and he could provide the subcommittee with names of people in San Diego, Los Angeles and San Francisco.

Mr. Pamperin also noted that the people coming to the Regional Offices tend to be those who are receiving benefits. There's an entirely different population at the VA medical centers and the Board needs to put up posters at those facilities.

Dr. Zimble observed that many of the comments and suggestions are worthy of major recommendations at the next Board meeting.

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The Board assembled for a group photograph needed for the Web site and future publications, following which **Dr. Zimble** remarked that a reasonable amount of business had been carried out for an inaugural meeting. He thanked the Board for their efforts and called for a motion to adjourn.

A motion was made and seconded that the inaugural meeting of the Veterans' Advisory Board on Dose Reconstruction adjourn. Without objection and with no further business to come before the Board, the meeting adjourned at 2:58 p.m.

End of Summary Minutes

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I hereby confirm these Summary Minutes are accurate to the best of my knowledge.

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Vice Admiral James A. Zimble MC, USN, Ret., Chair

Date: December 20, 2005