SUMMARY OF MINUTES OF THE THIRD PUBLIC MEETING OF THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

The third meeting of the Veterans' Advisory Board on Dose Reconstruction (VBDR or the Board) was held at the Omni Hotel Downtown, Austin, Texas on June 8-9, 2006.

In accordance with the provisions of the Federal Advisory Committee Act, *P.L. 92-463*, which sets forth standards for the formation and conduct of government advisory committees, the meeting was open to the public.

ATTENDANCE

Board Members Present: Dr. James Zimble (Chairman), Dr. Paul K. Blake, Mr. Harold L. Beck, Dr. Ronald R. Blanck, Mr. Kenneth L. Groves, Dr. David E. McCurdy, Dr. John Lathrop, Mr. Thomas J. Pamperin, Dr. Curt W. Reimann, Dr. Kristin Swenson, Mr. George Edwin Taylor, Mr. Paul G. Voillequé, and Dr. Gary H. Zeman (via telephone).
Board Members Absent: Dr. John Boice and Dr. Elaine Vaughan.
Quorum present: Yes.

OPENING REMARKS

Dr. Zimble (Chairman) called the meeting to order and introduced Ms. Shari Durand as the Designated Federal Officer (DFO).

Ms. Shari Durand (DFO) welcomed everyone to the third meeting of the Board, and explained her role as DFO.

SUMMARY OF THIRD PUBLIC MEETING OF THE BOARD

The primary topics of the two-day VBDR meeting included briefings on Biological Effects of Ionizing Radiation (BEIR) VII: epidemiology and models for estimating cancer risks by **Dr. Ethel Gilbert**, a summary of findings on beta dosimetry from the National Research Council's report on dose reconstructions for atomic veterans by **Dr. Thomas Gesell,** a presentation on the current status and activities of the Nuclear Test Personnel Review (NTPR) dose reconstruction program for veterans by **Dr. Paul Blake**, as well as a presentation on the Department of Veterans Affairs' (VA) Compensation Program by **Mr. Thomas Pamperin**. The activities and accomplishments of the four VBDR subcommittees (Dose Reconstruction, VA Claims, Quality Management, and Communications and Outreach) were also presented.

During the meeting, veterans gave public testimony regarding cancers and other debilitating illnesses they believe resulted from their participation in atmospheric nuclear testing and other radiation-related occupational exposures. Veterans expressed concerns

about problems with the Defense Threat Reduction Agency's (DTRA) dose reconstruction procedures and some claims decisions made by the VA.

Verbatim transcripts of each presentation, session, and public comment are available on the VBDR Web site at http://vbdr.org.

SUMMARY OF PRESENTATIONS TO VBDR

Dr. Ethel Gilbert's presentation:

The presentation emphasized that new data had appeared since the BEIR V report was published in 1990. BEIR VII includes a comprehensive review of studies in four areas: Japanese atomic-bomb survivors, medical radiation, occupational radiation, and environmental radiation.

Beginning with the Japanese atomic-bomb survivors study, the cohort included 87,000 Hiroshima/Nagasaki survivors with individual dose estimates and has been the primary data source for radiation health risk assessments. Studies of disease in the Japanese atomic-bomb survivors have provided the most reliable information for risk assessments for several reasons: 1) large numbers of subjects, 2) well-defined cohorts involving all ages and both sexes, 3) long term follow-up for mortality and cancer incidence, 4) whole body exposure, 5) well-characterized dose estimates for each member of the cohort as a result of in-depth dosimetry studies, and 6) the population received a wide range of doses.

Following publication of the BEIR V report, a major international effort was made to reassess and improve dose estimates for the members of the Japanese atomic-bomb survivors; however, the impact of improved dose estimates has had a minor effect on risk estimates.

Cancer incidence data obtained from Hiroshima/Nagasaki was the most important development, especially for estimating site-specific risks. Moreover, for cancers that have a fairly good prognosis of recovery such as colon, female breast, and bladder cancer, the number of cases is far greater than the number of deaths, thus providing a much stronger basis for risk assessments.

Regarding occupational studies, the nuclear industry workers were addressed because the strength of these studies is that dose estimates are available from dosimeters worn by the workers. There also have been many studies of workers at various facilities and combined analyses have been conducted on a national and international scale. Two of the most important studies were the International Agency for Research on Cancer (IARC) 3-country study, covering about 100,000 workers in the United States, the United Kingdom and Canada; and the National Registry of Radiation Workers study covering over 100,000 workers in the United Kingdom.

The largest worker study ever conducted was the IARC 15-country study, which involved about 400,000 workers, among whom there were 6,500 cancer deaths. Details on the countries involved and the number of cancer deaths from each country were provided.

The 15-country study also led to a higher risk estimate that was statistically significant. However, the confidence limits were very wide. These estimates were adjusted for socioeconomic status aimed at taking into account lifestyle factors such as smoking.

Although these studies have advantages of providing a direct assessment at low doses and low dose rates, they are subject to limitations. Even with large studies, small risk estimates cannot be estimated with great precision. Those studies also have a great potential for confounding and are subject to a high percentage of bias, consequently it is difficult to estimate risks at the two or three percent level.

Environmental studies are of limited usefulness for quantitative risk assessment because they lack dose estimates, and most of the doses would be very low. Studies showing promise are radiation exposures from the Chernobyl accident and the releases from the Mayak facility.

Quoting from BEIR VII report, the primary objective was developing the best possible risk estimates for exposure to low dose, low-linear energy transfer radiation in human subjects. The BEIR VII committee defined low dose as below one tenth of a gray.

The objective also was to estimate the lifetime risk of developing cancer, considering variables such as dose, sex, and age at exposure. The BEIR VII report gave equal attention to cancer incidence and mortality, and provided separate estimates for leukemia, solid cancers, and cancers of specific sites. Uterine and prostate cancers were included as separate categories to get them out of the "all solid cancer" category. However, skin cancer was not included as a separate category of solid cancers.

The two approaches that have been used regarding the issue of transporting risks from Japanese to U.S. populations are: 1) absolute risk transport assumes that radiation risks are independent of the baseline rates with regard to country, and 2) relative risk transport assumes that the radiation risks are proportional to the baseline risks. Intermediate approaches have also been used. Although none provides a definitive answer, it is thought there is slightly more support for relative risk transport than for absolute risk transport.

The BEIR VII approach to developing transport models for stomach cancer in males was discussed. Lifetime risks were expressed as number of cases per 100,000 persons exposed to a tenth of a gray.

Lung cancer estimates used a slightly different approach than other cancers because of the effect of smoking. An example of a risk estimate was provided showing that if 100 people were exposed to a tenth of a gray, one cancer from the exposure and 42 cancers from other causes would be expected.

Lifetime risk estimates for cancer incidence and mortality in females were also presented. The data presented had been for people exposed at specific ages for one exposure of one milligray per year to reflect an environmental exposure, or ten milligray per year to reflect an occupational exposure.

Since all the estimates have an uncertainty factor of at least 2, there is not a great deal of difference among them. Those differences that do appear can be accounted for by differences in dose and dose rate effectiveness factor and a different approach to risk transport. A summary of the major features of BEIR VII and its contrast with BEIR V was also discussed.

Dr. Thomas Gesell's presentation:

Observations and findings of the National Research Council's (NRC) review of the dose reconstruction program of the Defense Threat Reduction Agency were presented. Dr. Gesell recognized that there have been many changes, improvements and updates since the NRC committee's review.

External beta doses from contaminated surfaces were calculated by applying a beta-to-gamma ratio to an estimated upper-bound gamma dose, measured by film badge or estimated by dose reconstruction. Different ratios were used for fallout and activation products. Variables affecting ratios were location of the test (Pacific or Nevada), time after detonation, and the height of detonation above ground. Dose to skin would be the sum of the beta and gamma doses.

The beta dose coefficient changes as a function of time after detonation. The gamma dose from skin contamination is not an indicator of beta dose skin contamination. Consequently, film badge data are not applicable.

Though uncertainties of beta-to-gamma ratios were not estimated, there are a number of other variables upon which the beta-to-gamma ratios depend—time since detonation, distance from source, and height above ground—where errors would be intrinsic to the estimates of beta-to-gamma ratios. Therefore, the NRC review raised two concerns: 1) that the gamma doses may have been underestimated in some cases, and 2) that uncertainties in the beta-to-gamma ratios were not explicitly recognized. These concerns led the NRC committee to conclude that the beta components of skin doses are questionable.

Moving to the uncertainty phase of the NRC review, NTPR did not perform uncertainty calculations for beta-particle dosimetry. It was thought such calculations would require enormous resources to quantify the uncertainties in model parameters and propagate the uncertainty of each parameter to the model to obtain an overall uncertainty. It was assumed the measurements were, at worst, overestimated by a factor of 2 to 3 in favor of the participants. There was generally no discussion of uncertainty.

Shifting to procedures and quality assurance, the Standard Operating Procedures (SOPs) were more a statement of approach and general principles than a manual of procedures that were used to reconstruct dose. SOPs reviewed by the NRC committee contained provisions for review and updating, but in 2003 no reviews had been performed since 1997. Quality assurance (QA) was not discussed in any detail in any of the SOPs.

The overall conclusion of the NRC committee was that, because of the foregoing findings, there were inconsistencies in the dose reconstructions.

Dr. Paul Blake's presentation:

The presentation addressed two items as recommended from the last VBDR meeting in Los Angeles. The first item was an update on the June 2004 report to Congress. The second item was discussion of a point paper on skin cancer. This cancer comprises more than 50 percent of the cases being reviewed by NTPR.

The publication of the NRC report on the dose reconstruction program had a major impact on the NTPR program, resulting in procedural changes and a halt to dose reconstructions for six months while those changes were made. Additionally, the VA returned over 1,200 cases to be reevaluated. Thus, a tremendous backlog was created.

The veterans' frustrations, as a result of this situation, were acknowledged, but it was stated that dose reconstruction is a tedious and expensive process. NTPR has brought additional contractors on board and allocated an additional $4 million.

The cost of a dose reconstruction ranges from $9,000 to $15,000 each. New cases are coming in at the rate of about 35 per month. More than 50 percent of dose reconstruction cases deal with skin cancer or a skin-related disease.

Turning to the report to Congress, there were 23 findings and a number of action plans. Some action plans have been completed and DTRA hoped to have all of them completed in two years. Findings 5 through 14 related to DTRA actions to improve NTPR program procedures. These were discussed briefly.

Finding 5: *Inadequate and inconsistent application of benefit of the doubt in favor of the veteran*. DTRA's response was development of the Scenario of Participation and Radiation Exposure (SPARE).

Finding 6: *Several pathways were frequently neglected in exposure scenarios; specifically 1) contamination resuspended by shock wave; 2) dermal exposure from skin contamination; 3) exposure from ingestion of contaminated materials*. DTRA's response was to revise procedures to ensure these pathways are considered.

Finding 7: *External gamma dose upper bounds were often underestimated*. DTRA's response was to issue interim guidance and revised procedures for calculating the dose. This procedure needs a follow-up and further scientific review.

Finding 8: *Estimates of internal dose may not always be high-sided as intended*. DTRA has since issued an interim adjustment factor of 10.

Finding 9: *Upper bound on neutron dose component was always underestimated*. DTRA has produced a draft report that should address this problem effectively (pending peer review and publication).

Finding 10: *VA adds upper bound estimate of the external dose to reported high-sided inhalation dose and/or beta skin dose*. The VA has minimized this issue by using the Interactive RadioEpidemiological Program (IREP) exclusively. A report will be forthcoming at a future VBDR meeting.

Finding 11: *Correlations are often not properly accounted for by combining various doses to arrive at a total organ dose*. NTPR has initiated an investigation of correlations between different exposure pathways, such as between: 1) prompt neutron and gamma doses; 2) residual gamma and beta doses; 3) internal doses from different radionuclides.

Finding 12: *DTRA's documentation of specific methodology for reconstructing doses was criticized*. A four-tiered approach has been developed and work continues on SOPs and quality assurance. This activity is ongoing and will require considerable investment of time and money.

Finding 13: *Suggested DTRA needs to develop, implement, and maintain an auditable documentation system*. DTRA is implementing controls for different templates and manuals, some of which are still being developed.

Finding 14: *Recommended DTRA develop a comprehensive quality management system that covers all aspects of the dose reconstruction program*. A draft manual has been provided to VBDR Subcommittee 3 and feedback is expected soon.

DTRA Skin Cancer Point Paper entitled "An Analysis of Service Connection for Radiation-Induced Skin Cancer in Veteran Compensation Claims", was prepared in response to a request from the Board at the January 2006 meeting. The paper introduces background and discussion material, concluding with three recommendations for the Board's consideration.

DTRA currently has a backlog of 789 skin radiation dose assessments (RDAs), with 160 new cases projected per year. Uncertainty associated with DTRA's skin RDAs is potentially significant. Beta dosimetry is the biggest challenge as to how well the reconstructions are done. Upper bounds are compared to a screening dose generated through IREP. For some scenarios, basal cell carcinoma and malignant melanoma screening doses are smaller than 20 to 30 percent of DTRA's RDA upper-bound doses. For the overall population of

veterans, it is 20 percent. If the Hiroshima/Nagasaki population of veterans is excluded, it is about 30 percent.

The Hiroshima/Nagasaki detonations were unique in that they were detonated some 500 meters above ground, thereby producing little radioactive fallout. Test detonations closer to the ground did produce significant fallout; therefore it is more difficult to make a case for skin cancers developed from radiation in the Hiroshima/Nagasaki scenario.

Reiterating that dose reconstructions for skin cancer cost between $9,000 and $15,000 per case, this cost is often greater than the compensation obtained by the veteran. Thus, Recommendation 1 is the elimination of the requirement for non-Hiroshima/Nagasaki basal cell carcinoma and malignant melanoma RDAs as a matter of policy; grant service-connected compensation without calculating a skin dose.

Recommendation 2 is to eliminate the requirement to perform all non-Hiroshima/Nagasaki squamous cell carcinoma RDAs by establishing internal VA policy to grant service connection without calculating a skin dose.

Recommendation 3 does not depend on the VA. It can be acted on by the VBDR in that it is a recommendation to "Implement various efficiency measures that enable DTRA to perform expedited processing, provide worst-case skin doses to VA, and discontinue central dose estimates for skin RDAs." Thus, this recommendation would expedite certain cases.

Dr. Blake concluded by requesting that VBDR and VA endorse the recommendations in the DTRA Point Paper.

Mr. Thomas Pamperin's presentation:

The interface between VA disability compensation for radiation activities and the award of benefits under the Radiation Employees Compensation Act was discussed. The governing regulations, 38 CFR 3.309 and 3.311 were also cited. 38 CFR 3.309 provides for the 21 presumptive disabilities and was amended four years ago to come in line with the Radiation Employees Act and added four more presumptive disabilities, the most important of which are lung cancer and colon cancer.

There are three kinds of claims: presumptive (38 CFR 3.309) claims, the reconstructed dose (38 CFR 3.3.311) claims, and occupational claims. The process for each of these claims was discussed

As a result of 2003 NRC repot, some 1,251 cases were referred by VA to DTRA for reevaluation of dose reconstruction. Service-connected status has been granted thus far to 136 veterans, 124 of whom fall into the category of the four cancers that had previously required dose reconstruction. Twelve cases, all skin cancer, have been granted compensation under 38 CFR 3.311.

Figures from surveys that have been conducted by the VA were provided. They surveyed 11,843 records from DTRA and identified 39.2 percent of veterans that were still living. Of those, 44.8 percent receive compensation. Of the deceased veterans, 1,667 surviving spouses are receiving Dependency and Indemnity Compensation (25.7 percent). Comparative figures were provided for the entire veteran population. Atomic veterans receive compensation at a significantly higher rate than the veteran population in general.

Regarding dose reconstruction, skin cancer and prostate cancer make up the vast majority of requests. Moreover, cost estimates have been reviewed anticipating that basal cell carcinoma will be classified presumptive, with similar estimates being developed for squamous cell carcinoma and melanoma.

An outreach effort to atomic veterans will be made with an article to be included in the atomic veterans' flyer that goes out to all on the registration list. The VA is continuing efforts to locate additional atomic veterans through the various service organizations, Veterans Health hotlines and other outreach activities.

VBDR SUBCOMMITTEES

The Board was mandated by Congress to audit dose reconstruction and VA claims decisions for service connection of radiogenic diseases and improve communication with veterans. The Board's mission is also to address veterans concerns about the possibility of an elevated risk of cancer and other illnesses in veterans who were exposed to radiation or fallout from nuclear weapons testing, and the validity of their dose reconstructions.

To accomplish its task, the Board approved the formation of these four subcommittees (SCs), their scope of work and their membership. The work of these subcommittees will meet specific requirements of Public Law 108-183.

Subcommittee 1 report presented by Mr. Harold Beck, VBDR SC1 Chairman

The task of SC1 is to assess the dose reconstruction procedures, and to audit a random sample of NTPR dose reconstructions. Thus, additional six cases had been chosen for assessment from a stratified random sample to emphasize skin and prostate cancers.

SC1 has interviewed the analyst who prepared RDAs of each case to be sure the subcommittee understands his reasoning, methodology and conclusions. This has proved useful to both the subcommittee and the contractor. As a result of such interviews, changes have often been initiated before a subcommittee recommendation was made to the Board.

A number of topics have been discussed in these interview meetings. They include methods for expediting skin dose assessments, uncertainty analysis, uncertainties in assessing skin doses, and a need for NTPR to perform technical analyses to validate or replace interim upper-bound dose uncertainty factors established in 2003.

The review of the six new cases is not complete, but Board members can expect draft audits within the next month.

The following is a summary of the preliminary findings of SC1.

1. NTPR is generally providing benefit of the doubt to the veteran in development of the SPARE; however, this is not always done in a consistent manner.
2. The prime contractor has a great depth of personal knowledge of the issues, an excellent library, and access to background data.
3. The documentation of dose assessment procedures and consistency of dose reconstruction methodology can be improved.
4. Case file documentation can be improved, even though improvement was evident from a comparison of the first six cases to the second six.
5. The RDA memorandum sent to the VA and to the veteran often contains technical information and/or references not available to the veteran.
6. SC1 recognizes that contractors are developing new templates to perform dose assessments more rapidly for certain veterans.
7. SC1 audits confirm that skin dose calculations are complicated and the analyses are not consistent. There is a major concern with respect to skin dose uncertainty factors. Some calculations may be wrong, and it is not possible to evaluate the calculations because NTPR has not formalized the methodology. Some doses may be unquantifiable.
8. NTPR still has not issued a formal technical analysis demonstrating that the upper-bound factors recommended in the NRC report are at the 95th percentile.
9. SC1 has confirmed that some of the findings of the 2004 report to Congress have yet to be implemented and some have not been addressed.
10. Though there are inconsistencies in methodology and documentation, in only one case was an error found that might have affected the VA decision on how to adjudicate a veteran's claim. In that case, the error benefited the veteran.
11. NTPR is not being informed by VA of the outcome of each claim; therefore, no statistical data is available at NTPR to evaluate the percentage of successful non-presumptive claims.

Mr. Beck described future plans for SC1, including six new cases to be analyzed prior to the November meeting. They will be recent cases and one or two will be from the new NTPR contractor in order to evaluate consistency between contractors. Meetings with analysts will continue. Technical reports will be prepared by NTPR and SC1 has been asked to review them. SC1 will continue assessments of methods, both established and new, especially the SPAREs and templates developed by NTPR. Findings will be reported at future VBDR meetings.

Recommendations from SC1 follow:

1. SC1 recommends that a procedure be established and implemented by the VA to provide case outcomes to NTPR.

2. SC1 recommends that NTPR undertake a realistic analysis of uncertainties for all beta dose exposure scenarios.
3. SC1 recommends that the VBDR endorse Dr. Blake's proposal to develop an expedited screening procedure for certain dose assessments. The assessment of uncertainties in beta dosimetry must be accomplished first to determine worst case upper bounds to be used in this screening procedure.
4. SC1 recommends that NTPR develop a screening procedure for prostate cancer cases that would allow expedited processing of those cases for which the doses are well below 20 rem.

Mr. Beck explained that Dr. Blake, as the NTPR representative, does not take positions on the subcommittee's findings. However, he is a valuable member of the subcommittee.

Subcommittee 2 report presented by Dr. Ronald Blanck, VBDR SC2 Chairman

SC2 is charged to provide audits of the procedures and policies used by the VA and the decisions made on claims. Toward that end, 12 cases were reviewed by SC2. The reviews were complicated and time-consuming.

While SC2 noted some errors and delays in various areas, they opined that the complexity of the cases was the cause of most of the delays, amounting to months and even years. SC2 also noted that the VHA made timely decisions once they were provided with the DTRA dose reconstructions.

The process in place at the VA could be shortened with a centralized claims processing location. SC2 emphasized that it takes such a long time to obtain reasonably predictable results for the vast majority of cases, new models should be sought that would shorten the process for many of the veterans.

Recommendations from SC2 follow:

1. VA should select out radiation issues of claims and centralize those issues to a single site staffed with trained and experienced personnel.
2. VA should establish a centralized database to track radiation issues with both input and output information readily available.
3. VA should automatically place all validated radiation issues claimants into the Ionizing Radiation Registry.
4. Basal cell skin cancer and melanoma, as conditions claimed to be a result of participation in above ground nuclear tests and occupation of Hiroshima and Nagasaki, should be granted service connection for veterans whose participation in these activities has been verified by DoD.
5. All current and future radiation risk activity conditions held to be presumptively service connected under 38 CFR 3.309 that previously required a reconstructed dose estimate under 38 CFR 3.311 should be awarded service connection retroactive to the initial date of the claim that now requires a reconstructed dose estimate.

Dr. Blanck pointed out that the key recommendations are the last two. He noted that Mr. Pamperin, the VA liaison to SC2, took no position on the recommendations.

Subcommittee 3 report presented by Dr. Curt Reimann, VBDR SC3 Chairman

SC3's observations were discussed after an introduction covering SC3's approach, goals and activities.

NTPR's overall quality management system is not adequate. Though work on it is proceeding, the draft plan provided to SC3 focuses on the narrower and partial aspects of the overall plan, and is not a full QA plan.

SC3 studied SC1's audit findings and generally agreed with them, especially with the need for greater consistency in operating procedures. In four of the six cases SC1 noted that there were modifications in the calculated dose. This reflects uncertainty and lack of clarity in procedures.

It is evident that analysts apply the principle of benefit of the doubt in favor of the veteran. However, the lack of consistency in application of this principle when there are so many factors to consider in its application makes quality assurance difficult to conduct in a routine way.

Final SOPs, quality metrics, and quality assessments need to be built upon a clear and efficient case handling strategy.

SC3 pointed out that whatever approach is adopted to expedite cases, it should ensure that there are no disadvantages to the veteran. SC3 noted that all the steps in the process are high-sided and this reduces errors which would penalize the veteran. However, it is important to ensure that money and time are used to maximum benefit.

SC3 observed that NTPR is using a metrics report. However, the report deals more with case types and case throughput than specific quality indicators. This fact is important to SC3 because in order to make needed improvements, it is important to measure a number of performance dimensions, such as accuracy, response time, and costs. Such quality indicators are important to ensure the work is carried out properly and to indicate the specific processes that need to be improved. With multiple contractors, this issue is more critical than it would be if everything were accomplished by one organization.

SC3 supports the SC2 recommendation to direct all radiation-related claims to one VA office. This should improve accuracy, timeliness, and provide a better quality assessment within VA's overall quality assurance program.

Recommendations from SC3 follow:

1. NTPR should move quickly to complete the QA plan. This is especially important to

ensure that each contractor uses the same procedures.
2. NTPR should hire a consultant to write a QA plan. The present plan is insufficient. The revised plan should be completed by September 30, 2006.
3. In accord with that QA plan, NTPR should develop a QA implementation plan.
4. The QA plan implementation should be included in the Statement of Work for NTPR Program Support as an evaluation criterion to be used in the Award Fee Plan for the RDA contractor; this will assure continued quality in the RDAs.
5. VA should provide SC3 a timetable and status of development of the broader QA plan that is to be prepared.

Subcommittee 4 report presented by Mr. Kenneth Groves, VBDR SC4 Chairman

The presentation included a description of the purposes of SC4 and a summary of its activities since the previous Board meeting, including joining SC3 in their meeting with the VA. A number of conference calls were made among subcommittee members to discuss issues related to SC4's task. One of those issues was the location of the next Board meeting, to be held in Hampton, Virginia.

Actions proposed by SC4 follow:

1. Meet with other subcommittees to identify issues related to communication that SC4 can help resolve or improve.
2. Provide a final draft of the brochure prepared by SC4 to VA and DTRA with the intent of distributing the final product at VA facilities.
3. Complete the list of Frequently Asked Questions (FAQ) for the web site for final review by VBDR.
4. Work with the other subcommittees to ensure consistent messages are sent to the stakeholder community.
5. Analyze the calls made to the VBDR and "hits" on the web site to better understand veteran issues and how to effectively answer their questions.
6. Continue public meetings with stakeholders to assess and collect information needed by VA and NTPR to better serve the veteran community.
7. Identify steps to be taken to improve communications with individual claimants and veterans' groups.
8. Provide VA with a proposed letter to be included with the veteran's claim package that places the process in perspective and helps to establish reasonable expectations relative to processing time and historical results of similar claims.
9. With establishment of a central review office for radiation-related claims, the VA would become the sole source of information exchange with the veteran on these claims.

Dr. Zimble noted that items 1-8 of the report are essentially internal to the Board and recommended they be accepted without comment by the Board. Without objection, they were accepted.

BOARD'S RECOMMENDATIONS

See Addendum A for a full set of the Board's recommendations that was transmitted to VA and DTRA on July 5, 2006.

PUBLIC COMMENT PERIOD

Prior to opening the meeting for public comments, attendees were reminded that the Board had two objectives. The first is oversight of dose reconstruction and the filing and processing of veterans' claims dealing with ionizing radiation. The second is to assist DTRA, specifically NTPR, and the VA in communicating with the veteran and keeping the veteran informed.

The Board is not responsible for reviewing individual dose reconstructions nor does it serve as an appeals board. If the system is not working the Board needs to know, but the Board has no legislative power.

Input from the public was solicited on both days of the meeting and is reported in the meeting transcripts. The following is a list of the members of the public who addressed the Board at the meeting. Verbatim transcripts of the public comments are available on the VBDR Web site at http://vbdr.org.

Mr. Carlos R. Contreras, Atomic Veterans of America; **Mr. Clyde Want**, veteran; **Mr. R. J. Ritter**, NAAV National Commander; **Mr. Joe Faulkner,** atomic veteran**; Mr. Thomas Caffarello,** atomic veteran; **Mr. Bernard Tschoerner**, atomic veteran; **Mr. Joe Terry**, atomic veteran; **Mr. Ray Mullins**; **Mr. Herschel McFarland**; **Mr. James Patrick Piersol**; **Captain Will Brown**

FUTURE VBDR MEETINGS

Following discussion by the Board, it was agreed to hold the fourth meeting on November 8-9, 2006 and a fifth meeting during the week of March 5-9, 2007. Details about meeting locations will be announced in the federal register and on the VBDR Web site.

Dr. Zimble remarked that a reasonable amount of business had been carried out. He thanked the Board and the staff for their efforts, the public for their comments, and called for a motion to adjourn.

The motion was made, seconded and carried.

A SUMMARY OF VBDR DISCUSSION POINTS

The following list summarizes the main points of discussion by the Board during the course of the meeting:

1. How the methodology of BEIR VII might affect the IREP methodology for determining risk estimate, and to what degree the report addressed skin and prostate cancers.
2. How BEIR VII addressed the effect of radiation on incidence of non-cancer diseases reported by many atomic veterans.
3. NTPR has made progress in improving management of claims. There is still room for improvement, especially in dose reconstructions, and in explaining the dose reconstruction process to veterans.
4. SPARE has been a positive step in assisting atomic veterans recollect their experiences.
5. The difference between "to grant service connection" and "eligible for compensation."
6. The categories of "eligibility" and "entitlement" and the meaning of "service-connected" versus "presumptive" and the advantages accruing to veterans with these classifications.
7. "Expediting" versus "service-connected" will not eliminate all the work, but using "service-connected" would speed up the process.
8. Possible benefits of providing copies of subcommittee 1's audit reports to the contractors to check for factual errors.
9. Endorsement of Dr. Blake's skin cancer point paper.
10. Subcommittees' recommendations are for the Board's consideration and are based on equity and an effort to expedite cases. However, the Board has no authority to tell an agency what to do.
11. It is important that the Board does not make recommendations that require agencies to spend money and effort on wasteful projects.
12. The Board's recommendations regarding quality assurance/quality management and documentation should be to ensure proper documentation, review and quality management.
13. Centralization of the VA claims with radiation issues would not affect the process, but would make it more uniform, and is intended to reduce the veteran's confusion. The system should be simplified to help the veterans get answers, probably by having the Veteran Service Office as the point of contact.

ADDENDUM A

BOARD'S RECOMMENDATIONS

The Board offered the following recommendations:

For the Defense Threat Reduction Agency (DTRA):

1. The VBDR recommends that NTPR develop a screening procedure for skin radiation dose assessments that would allow expedited processing of those cases for which the doses are well below or well above the level likely to result in a successful claim. Worst case upper bounds should be used in this screening procedure to provide the veteran the maximum benefit of the doubt.
2. The VBDR recommends that NTPR also develop a screening procedure for prostate cancer cases that would allow expedited processing of those cases for which the doses are well below the level likely to result in a successful claim.
3. The VBDR recommends that NTPR undertake a comprehensive analysis of uncertainties for all beta dose exposure scenarios.
4. The VBDR recommends that NTPR hire a consultant to write a quality assurance (QA) plan. The VBDR further recommends that NTPR develop and implement a QA program on a schedule that allows it to be integrated into the contracting process now ongoing, and the development of a comprehensive manual of standard operating procedures (SOPs) that address the necessary QA elements, including metrics.

For the Department of Veterans Affairs (VA):

1. The VBDR recommends that VA provides the adjudication case outcomes to NTPR.
2. The VBDR recommends that VA grant service connection without regard to dose for those atomic veterans whose basal cell skin cancers and melanomas are claimed to be as a result of participation in aboveground nuclear test and service in Hiroshima and Nagasaki, and whose participation in these activities has been verified by DoD.
3. The VBDR recommends that VA centralize claims with radiation issues to a single site staffed with trained and experienced personnel, and that the Veterans Benefits Administration (VBA) should establish a centralized database to track radiation issues with both input and output information readily available. The VBDR further recommends that VA provides the Board with a timetable and status for the development of a QA plan and program, including metrics, in the radiation exposure claims adjudication process.
4. The VBDR recommends that VA recognize and automatically place all validated radiation issues claimants into the Ionizing Radiation Registry.

5. The VBDR recommends that VA award service connection retroactively to the date of the initial claim for all current and future radiation risk activity conditions held to be presumptively service connected under 38 CFR 3.309 which previously required a RDA under 38 CFR 3.311
6. The VBDR recommends that VA improve interaction and communication with the atomic veterans. More effective approaches should be established to communicate the general meaning of information on radiation risk. In addition to presenting general information on radiation risk, information should be communicated to claimants about the significance of their doses in relation to their diseases.