COMMONWEALTH ENVIRONMENTAL SERVICES, LLC
"A Native American Woman Owned Company"

Fax Cover Sheet

To:	Hilda Solis & Mr. Bibeault	From:	Gary S. Vander Boegh
Fax:	(904) 357-4704 (202) 693-6111	Date:	~~11-2-10~~ 11-19-10
Phone:		Pages:	___Pages including the Cover Sheet
Re:	Melvin L Spraggs	CC:	Attention Jim Bibeault and David Miller

☐ Urgent X For Review ☐ Please Comment X Please Reply ☐ Please Recycle

Comments:

COMMONWEALTH ENVIRONMENTAL SERVICES, LLC
"A Native American - Woman Owned Company"

Gary Vander Boegh, Vice President
Commonwealth Environmental Services, LLC
4645 Village Square Drive, St. F
Paducah, Kentucky 42001
Telephone: (270) 450-0850
Facsimile: (270) 450-0858

November 19, 2010

U. S. Department of Labor,
Frances Perkins Building, 200 Constitution Ave., NW
Room S-2018
Washington, DC 20210

Attention: Madam Secretary Hilda Solis & Jim Bibeault

Employee: Melvin L. Spraggs
File Number: XXXXX8940

Dear Ms Solis,

The Paducah Gaseous Diffusion Plant was a DOE facility from 1952 to July 28, 1998 and July 29, 1998 to present (remediation) where radioactive and beryllium material were present, according to the Department of Energy Office of Worker Advocacy Facility List (http://www.hss.energy.gov/HealthSafety/FWSP/Advocacy/faclist/findfacility.cfm). As "Authorized Representative" (AR) for claimants, Mary A. Davis, Sharon R. Holt, and Jerry L. Spraggs, children of Melvin L. Spraggs, deceased, I hereby submit the attached EE-2 form for Chronic Beryllium Disease (CBD) based on statutory requirements 42 USC § 7384l (13) (B) as follows:

(B) For diagnoses before January 1, 1993, the presence of—
(i) occupational or environmental history, or epidemiologic evidence of beryllium exposure; and
(iii) any three of the following criteria:
(I) Characteristic chest radiographic (or computed tomography (CT)) abnormalities.
(II) Restrictive or obstructive lung physiology testing or diffusing lung capacity defect.
(III) Lung pathology consistent with chronic beryllium disease.

(IV) Clinical course consistent with a chronic respiratory disorder.
(V) Immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred).

The Department of Labor has further stated, "***For beryllium disease prior to January 1, 1993, a specific diagnosis of CBD IS NOT REQUIRED (emphasis added.)"***....

Per Chapter 2-700.4 (September 2004) of the Federal (EEOICPA) Procedure Manual, "***To determine whether to use the Pre or Post 1993 CBD criteria,*** the medical evidence must demonstrate that the employee was **either treated for**, **tested** or **diagnosed with lung cancer**. **If the earliest dated document is prior to January 1, 1993, the pre-1993 CBD criteria may be used**. Once it is established that the employee had a chronic respiratory disorder prior to 1993, **the CE is not limited to use of medical reports prior to 1993 to meet the three of five criteria."**

(Excerpt)

DOCKET NUMBER: 57973-2005
Decision Date: January 7, 2005

NOTICE OF FINAL DECISION

This is the decision of the Final Adjudication Branch concerning your claim for compensation under Part B of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 *et seq.* (EEOICPA or the Act). This decision affirms the recommended acceptance issued on November 30, 2004.

STATEMENT OF THE CASE

On May 28, 2004, you filed a claim for survivor benefits, as the widow of **[Employee]**, Form EE-2, under Part B of the EEOICPA. **YOU IDENTIFIED 'BREATHING PROBLEMS" AND CHRONIC BERYLLIUM DISEASE (CBD) AS THE CLAIMED CONDITIONS. (emphasis added)...**

...."Based upon the DOE response that F.H. McGraw held a number of contracts from 1951 to 1954 and the security Q clearance notification, the district concluded that the DOE had a business or contractual arrangement with F.H. McGraw. **THE DISTRICT OFFICE FURTHER CONCLUDED THAT YOUR HUSBAND WORKED WITH F.H. MCGRAW AT THE PADUCAH GASEOUS DIFFUSION PLANT FOR AT LEAST ONE DAY ON DECEMBER 17, 1954 (emphasis added)** based upon the reduction in force notice.[2]...."

....."You submitted a medical report dated February 23, 1991, from Lowell F. Roberts, M.D., which indicates a history of chronic obstructive pulmonary disease (COPD), shortness of breath, and dyspnea. A February 23, 1991 X-ray report, from D.R. Hatfield, M.D., indicates a diagnosis of COPD. A February 25, 1991 CT-scan, from Barry F. Riggs, M.D., indicates abnormal nodular densities of the right lower lobe and a diagnosis of COPD. A February 26, 1991 medical report from M.Y. Jarfar, M.D. indicated that pulmonary function tests showed mild obstructive defects and mild diffusing lung capacity defects. You also submitted an X-ray report dated September 6, 1994, from Robert A. Garneau, M.D., that indicated

diagnoses of COPD and Interstitial Fibrosis. A November 27, 1994 medical report from David Saxon, M.D., indicated findings of rales and wheezing. A December 2, 1994 medical report from Dr. Saxon, indicates hypoxemia to the left lower lung. A December 2, 1994 medical report from Lowell F. Roberts, M.D., indicated diagnoses of shortness of breath, congestive heart failure, dyspnea and cough, and rales in the lung base. An August 13, 1995 X-ray report from Charles Bea, M.D., indicates a diagnoses of bibasilar infiltrates. A December 30, 1996 X-ray report from Sharron Butler, M.D., indicates an increase of lung markings since the September 14, 1992 study. In the March 1, 1998 X-ray report from Dr. Butler diagnoses of "advanced chronic lung changes, mild interstitial prominence diffusely, and patch density of the posterior right lung" are indicated. An August 19, 1998 CT-scan from James D. Van Hoose, indicates diagnoses of pleural thickening and pulmonary calcifications. **AN AUGUST 6, 1999 PULMONARY FUNCTION TEST FROM WILLIAM CULBERSON, M.D. INDICATES A DIAGNOSIS OF MODERATELY SEVERE RESTRICTIVE DISEASE(emphasis added).** An October 12, 1999 discharge summary from Eric B. Scowden, M.D. indicates diagnoses of progressive shortness of breath, congestive heart disease, COPD, and history of right-sided empyema complicating pneumonia necessitating prolonged chest tube drainage with a continued open sinus tract." Based upon these reports the district office concluded that you had CBD prior to January 1, 1993.[3]

On November 30, 2004, the district office issued a recommended decision concluding that your husband was a covered beryllium employee, that he was exposed to beryllium, and that he had symptoms and a clinical history similar to CBD prior to January 1, 1993. They further concluded that you are entitled to 30.316(a) of the EEOICPA implementing regulations provides that, "if the claimant does not file a written statement that objects to the recommended decision and/or requests a hearing within the period of time allotted in 20 C.F.R. § 30.310, or if the claimant waives any objection to all or part of the recommended decision, the Final Adjudication Branch (FAB) will issue a decision accepting the recommendation of the district office, either whole or in part." 20 C.F.R. § 30.316(a). On December 1, 2004, the FAB received your signed waiver of any and all objections to the recommended decision. After considering the evidence of record, your waiver of objection, and the NIOSH report, the FAB hereby makes the following:

FINDINGS OF FACT

1. You filed a claim for benefits under Part B of the EEOICPA on May 28, 2004.

2. YOUR HUSBAND WAS EMPLOYED AT THE PADUCAH GASEOUS DIFFUSION PLANT FOR AT LEAST ONE DAY ON DECEMBER 17, 1954.

....."You submitted a medical rep

(III) Lung pathology consistent with chronic beryllium disease.

(IV) Clinical course consistent with a chronic respiratory disorder.

(V) Immunologic tests showing beryllium sensitivity (skin patch test or beryllium blood test preferred).

The Department of Labor has further stated, "***For beryllium disease prior to January 1, 1993, a specific diagnosis of CBD IS NOT REQUIRED (emphasis added.)"***....

CONCLUSIONS OF LAW

Section 7384s of the Act provides for the payment of benefits to a covered employee, or his survivor, with an "occupational illness," which is defined in § 7384l(15) of the EEOICPA as "a covered beryllium illness, cancer. . .or chronic silicosis, as the case may be." 42 U.S.C. §§ 7384l(15) and 7384s. 42 U.S.C. § 7384l.

PURSUANT TO § 7384L(13)(B) OF THE EEOICPA, TO ESTABLISH A DIAGNOSIS OF CBD BEFORE JANUARY 1, 1993, THE EMPLOYEE MUST HAVE HAD "AN OCCUPATIONAL OR ENVIRONMENTAL HISTORY, OR EPIDEMIOLOGIC EVIDENCE OF BERYLLIUM EXPOSURE; AND (III) ANY THREE OF THE FOLLOWING CRITERIA: (I) CHARACTERISTIC CHEST RADIOGRAPHIC (OR COMPUTED TOMOGRAPHY (CT)) ABNORMALITIES. (II) RESTRICTIVE OR OBSTRUCTIVE LUNG PHYSIOLOGY TESTING OR DIFFUSING LUNG CAPACITY DEFECT. (III) LUNG PATHOLOGY CONSISTENT WITH CHRONIC BERYLLIUM DISEASE. (IV) CLINICAL COURSE CONSISTENT WITH A CHRONIC RESPIRATORY DISORDER. (V) IMMUNOLOGIC TESTS SHOWING BERYLLIUM SENSITIVITY (SKIN PATCH TEST OR BERYLLIUM BLOOD TEST PREFERRED)." 42 U.S.C. § 7384L(13)(B). (emphasis added)

The evidence of record establishes that the employee was a covered beryllium employee who had at least three of the five necessary medical criteria to establish pre-1993 CBD under the EEOICPA. Therefore, you have provided sufficient evidence to establish that your husband was diagnosed with pre-1993 CBD, pursuant to § 7384l(13)(B) of the EEOICPA.

The undersigned has reviewed the facts and the district office's November 30, 2004 recommended decision and finds that you are entitled to $150,000 in compensation.

The decision on the claim that you filed under Part E of the EEOICPA is being deferred until issuance of the Interim Final Regulations.

Washington, DC

Tom Daugherty
Hearing Representative
Final Adjudication Branch

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[1] The Paducah Gaseous Diffusion Plant was a DOE facility from 1952 to July 28, 1998 and July 29, 1998 to present (remediation) where radioactive and beryllium material were present, according to the Department of Energy Office of Worker Advocacy Facility List (http://www.hss.energy.gov/HealthSafety/FWSP/Advocacy/faclist/findfacility.cfm).

[2] Per Chapter 2-100.3h (January 2002) of the Federal (EEOICPA) Procedure Manual, "The OWCP may receive evidence from other sources such as other state and federal agencies" to support a claim under the EEOICPA.

[3] Per Chapter 2-700.4 (September 2004) of the Federal (EEOICPA) Procedure Manual, **"To determine whether to use the Pre or Post 1993 CBD criteria, THE MEDICAL EVIDENCE MUST DEMONSTRATE THAT THE EMPLOYEE WAS EITHER TREATED FOR, TESTED OR DIAGNOSED WITH A CHRONIC RESPIRATORY DISORDER. (emphasis added)** If the earliest dated document is prior to January 1, 1993, the pre-1993 CBD criteria may be used. **ONCE IT IS ESTABLISHED THAT THE EMPLOYEE HAD A CHRONIC RESPIRATORY DISORDER PRIOR TO 1993, THE CE IS NOT LIMITED TO USE OF MEDICAL**

REPORTS PRIOR TO 1993 TO MEET THE THREE OF FIVE CRITERIA."
(emphasis added)

Melvin L. Spraggs Lung Disease and Chronic Obstructive Pulmonary Disease (COPD) Reflect Compliance With Pre-1993 CBD Criteria

1/ CA-001, pages 1-7, D.R. Hatfield, MD provides evidence in the x-ray report dated 6/14/1976 that, "Front and lateral views, show chronic obstructive airway disease is present. Multiple defects are present throughout the right and left lungs. Scarring within both the left and right lungs is noted."..."Impression: COPD". X-ray reports from Dr. V. P. Semogas dated February 19, 1986, diagnosing Mr.Spraggs with calcified granuloma right upper lobe. X-ray report from Dr. C. Dale Brown dated 2/03/1989, "A film is obtained demonstrating moderate chronic obstructive airway disease." C. Dale Brown on 12/29/1990 states in the x-ray report, "Severe chronic obstructive pulmonary airway disease is present."..."Impression: Severe COPD." The X-ray report dated 4/13/1990 performed by Dr. R.A. Davis indicated "The lung fields are hyperaerated consistent with obstructive pulmonary disease." William E. Adams, MD x-ray report dated 7/12/1991 reflects "area of infiltrate within the right lung base which was not present previously", and multiple defects are present throughout the right lung, with much greater involvement s compared to the minimal right basilar infiltrate."..." Overall Impression: Underlying COPD

Conclusion: Compliance pursuit with § 7384L(13)(B), Criteria's I & IV .

2/ CA-002, pages 1-12, Medical reports include consultation/ progress notes, discharge summaries, pulmonary function tests showing deficits, histories confirming chronic COPD and severe emphysema.

Conclusion: Compliance pursuit with § 7384L(13)(B), Criteria's 1, II & IV.

3/ October 19, 2005 Final Decision that includes "Findings of Facts and Conclusions of Law" that confirms, "Since the employee met only two of the criteria (II & IV)."... X-rays reflecting "Scarring of the lungs confirm compliance with Criteria I.

Conclusion: Compliance pursuit with § 7384L(13)(B), Criteria I

CA-004: "Memorandum from DEEOICP Director Peter Turic" dated 8/25/05 regarding casual relationship between respiratory disorders and CBD.

Conclusion: Compliance pursuit with § 7384L(13)(B), Criteria's I.

Request for Approval of Part B Compensation for Chronic Beryllium Disease (CBD)

Based on the above medical evidence that the claimants for Melvin L. Spraggs have met the statutory and regulatory burden of proof for his EEOICPA Part B CBD claim for compensation in the amount of $150,000.

Please feel free to contact me at 270-559-1752 or 270-450-0850.

Sincerely,

Gary S. Vander Boegh
"Authorized Representative"
Vice President- Commonwealth Environmental Services, LLC.

Cc. Honorable Secretary of Labor Hilda Solis w/Attachments (202) 693-6111

U.S. Department of Labor
200 Constitution Avenue, NW
Room S-2018
Washington, DC 20210

Claim for Survivor Benefits Under the Energy Employees Occupational Illness Compensation Program Act

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Note: Provide all information requested below. Do not write in the shaded areas.

OMB Number: 1215-0197
Expiration Date: 08/31/2010

Deceased Employee Information (Please Print Clearly)

1. Name (Last, First, Middle Initial)
Spraggs Melvin

2. Sex
☒ Male ☐ Female

3. Social Security Number
[redacted]

4. Date of Birth
[redacted] Month [redacted] Day [redacted] Year

5. Date of Death
[redacted] Month [redacted] Day [redacted] Year

6. Was an autopsy performed on the employee?
☐ YES - List Medical Facility: _____
☐ NO ☒ DON'T KNOW

Survivor Information (Please Print Clearly)

7. Name (Last, First, Middle Initial)
[redacted]

8. Sex
☐ Male ☒ Female

9. Social Security Number

10. Date of Birth
[redacted] Month [redacted] Day [redacted] Year

11. Your relationship to the deceased employee
☐ spouse ☒ child ☐ step-child ☐ parent
☐ grandparent ☐ grandchild ☐ Other:

12. Address (Street, Apt. #, P.O. Box)
[redacted]

(City, State, ZIP Code)
[redacted]

13. Telephone Numbers
a. Home: ([redacted]) [redacted] - [redacted]
b. Other: ( ) -

14. Identify the Diagnosed Condition(s) Being Claimed as Work-Related (check box and list specific diagnosis)

		15. Date of Diagnosis Month	Day	Year
☐	**Cancer** (List Specific Diagnosis Below)			
	a.			
	b.			
	c.			
☐	**Beryllium Sensitivity**			
☒	**Chronic Beryllium Disease** (CBD)			
☐	**Chronic Silicosis**			
☐	**Other Work-Related Condition(s) due to exposure to toxic substances or radiation** (List Specific Diagnosis Below)			
	a.			
	b.			
	c.			

Awards and Other Information

16. Did the employee work at a location designated as a Special Exposure Cohort (SEC)?	☒ YES ☐ NO
17. Have you or the deceased employee filed a lawsuit seeking either money or medical coverage for the claimed condition(s)?	☐ YES ☒ NO
18. Have you or the deceased employee filed any workers' compensation claims in connection with the claimed condition(s)?	☐ YES ☒ NO
19. Have you, the deceased employee, or another person received a settlement or other award in connection with the above claimed condition(s)?	☐ YES ☒ NO
20. Have you either pled guilty or been convicted of any charges connected with an application for or receipt of federal or state workers' compensation?	☐ YES ☒ NO
21. Have you or the employee applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)? **If yes, provide RECA Claim #:**	☐ YES ☒ NO
22. Have you or the employee applied for an award under Section 4 of the Radiation Exposure Compensation Act?	☐ YES ☒ NO

Other Potential Survivors

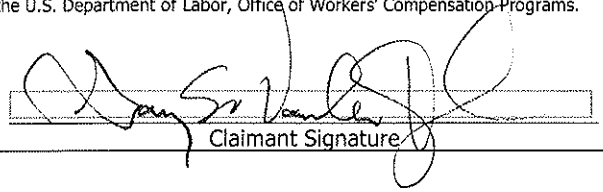
23. Are you aware of any person(s) who may also qualify as a survivor of the deceased employee? ☒YES ☐NO

If YES, please provide the following:

	Name	Relationship to the deceased employee	Address	Phone Number(s)
a.	[redacted]	[redacted]	[redacted]	Home: Other:
b.	[redacted]	[redacted]	[redacted]	Home: [redacted] Other:
c.			†	Home: Other:
d.			†	Home: Other:
e.			†	Home: Other:
f.			†	Home: Other:
g.			†	Home: Other:
h.			†	Home: Other:
i.			†	Home: Other:
j.			†	Home: Other:

Survivor Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided under EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both. Any change to the information provided on this form once it is submitted must be reported immediately to the District Office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. If applicable, I authorize the Department of Justice to release any requested information, including information related to my RECA claim, to the U.S. Department of Labor, Office of Workers' Compensation Programs (OWCP). Furthermore, I authorize any physician or hospital (or any other person, institution, corporation, or government agency, including the Social Security Administration) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.



Claimant Signature

11/19/2010

Date

Resource Center Date Stamp

EX 6

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ROOM: ER
DOB: 4/20/20

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
COPD
PNEUMONIA

DATE:
6/14/76

CHEST:
Frontal and lateral views show chronic obstructive airway disease is present. Multiple defects are present throughout the right and left lungs. Scarring within both the left and right lungs is noted.

Patient could not tolerate a ventilation scan.

IMPRESSION:
1. COPD

CLAIMANT ATTACHMENT 001
PAGE NO. 187

D. R. Hatfield, M. D.

RT)

IX

CHART COPY

NAME: Spraggs, Melvin [redacted]
CHART: ~~774397-103~~
DOCTOR: Barlow
ADM:
DIS:
ROOM: ER

KPRO #:
XRAY #: 24581

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
~~short of breath, mid chest pain started 2/18~~

DATE:
2/19/86

CHEST:
Hyperinflated lungs with advanced emphysema. Calcified granuloma right upper lobe.

No acute pulmonary process. No pneumonia.

The heart is normal in size.

CLAIMANT ATTACHMENT 001
PAGE NO. 287

VPS

V. P. Samogas, M.D.

VPS/021986

WP41.021986.3X

FINAL COPY

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

NAME: [redacted] C.
CHART: [redacted]
DOCTOR: Wallace
ROOM: GK
DOB: 4/20/20

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
PNEUMONIA
COPD
PROSTATIC CARCINOMA

DATE:
7/12/91

DOSAGE:
4 mCi 99mTc MAA

CHEST, FRONTAL:
Chronic obstructive airway disease is present as noted on the preceding study from 3/27/91. There is a small area of infiltrate within the right lung base which was not present previously. There is no other definite involvement. There is no significant effusion. The heart is normal in size.

The patient is obtundent and could not tolerate a ventilation scan.

PERFUSION LUNG SCAN:
Perfusion images are obtained after the injection of four millicuries of technetium 99m labeled MAA. Multiple defects are present throughout the right lung, with much greater involvement as compared to the minimal right basilar infiltrate. Several peripheral defects are present felt to be segmental. There is no definite significant lesion involving the left lung although there is a question of left lower lobe involvement.

OVERALL IMPRESSION:
Inward development of some right basilar infiltrate, small amount noted.

Underlying COPD.

Multiple perfusion defects on the right, with much greater involvement as noted by chest X-ray resulting a high probability of pulmonary embolus.

CLAIMANT ATTACHMENT 001
PAGE NO. 387

William E. Adams, M.D.

WEA/071291
(X-RAY REPORT)
WP38.071291.2X

PRELIMINARY REPORT

NAME: Spragge, Melvin C.
CHART: [redacted]
DOCTOR: Wallace
ROOM: ER
DOB: 4/20/20

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
PNEUMONIA
COPD
PROSTATIC CARCINOMA

DATE:
7/12/91

DOSAGE:
4 mCi 99mTc MAA

CHEST, FRONTAL:
Chronic obstructive airway disease is present as noted on the preceding study from 3/27/91. There is a small area of infiltrate within the right lung base which was not present previously. There is no other definite involvement. There is no significant effusion. The heart is normal in size.

The patient is obtunded and could not tolerate a ventilation scan.

PERFUSION LUNG SCAN:
Perfusion images are obtained after the injection of four millicuries of technetium 99m labeled MAA. Multiple defects are present throughout the right lung, with much greater involvement as compared to the minimal right basilar infiltrate. Several peripheral defects are present felt to be segmental. There is no definite significant lesion involving the left lung although there is a question of left lower lobe involvement.

OVERALL IMPRESSION:
Interval development of some right basilar infiltrate, small amount noted.

Underlying COPD.

Multiple perfusion defects on the right, with much greater involvement as noted by chest X-ray resulting a high probability of pulmonary embolus.

William E. Adams, M.D.

WEA/071291
(X-RAY REPORT)

CHART COPY

WP38.071291.2X

CLAIMANT ATTACHMENT .001
PAGE NO. 4 8 7

435

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Sanders
ROOM: ER 457-2
XRAY #: 774397
DOB: 04/20/20

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
SOB.

DATE:
02/03/89

CHEST:
A film is obtained demonstrating moderate chronic obstructive airway disease. The trachea is midline and the heart normal. No other lesions are seen.

IMPRESSION:
COPD.

CLAIMANT ATTACHMENT 002
PAGE NO. 5887

CDB/020389
(X-RAY REPORT)

WP32.020389.1X

DBB/km
C. Dale Brown, M.D.

CHART COPY

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ROOM: ~~ER~~ 3C10-2
DOB: 04/20/20

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
Chest pain.

DATE:
12/29/90

PORTABLE CHEST:
Severe chronic obstructive airway disease is present. The trachea is midline and the heart normal. No active process is seen. The mediastinal structures are normal.

IMPRESSION:
Severe COPD.

CLAIMANT ATTACHMENT 601
PAGE NO. 6 of 7

CBH
C. Dale Brown, M.D.

CDB/wp32/123090
(XRAY REPORT)

WP32.123090.3X

CHART COPY

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42003

NAME: Spraces, Melvin L.
CHART: [redacted]
DOCTOR: Barlow
ROOM: ~~ER~~ 454 Ballard
XRAY #: 774391
DOB: 04/20/20

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
COPD, chest pain, shortness of breath.

DATE:
04/13/90

CHEST:
Single AP semiupright portable radiograph dated 04/13/90 at 16:50 hours. The lung fields are hyperaerated consistent with obstructive pulmonary disease. There are no acute infiltrates seen. Heart and mediastinum are unremarkable.

Some mild infiltrate present on 02/03/89 has cleared.

IMPRESSION:
COPD. No acute infiltration seen.

CLAIMANT ATTACHMENT ~~0001~~ 001
PAGE NO. 0787

RAD/WP32/0401490
(XRAY REPORT)

R. A. Davis, M.D.

CHART COPY

WP32.041490.2X

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ADM: 02/21/86 KPRO #:
DIS: 02/28/86
ROOM: XRAY #:
PAGE: 1

DISCHARGE SUMMARY

FINAL DIAGNOSIS:
Decompensated chronic obstructive lung disease.

This [redacted] year old white male was referred by Dr. Hunt of Wickliffe because of worsening lung congestion.

In the past he was told of emphysema and has continued to smoke until recently. Several days ago, he came to the ER with weakness, shortness of breath, chest pressure and pain. Treatment was started with Keflex and Theo-Dur and he was sent home. However, he did not improve. He became more and more short of breath and was admitted for further evaluation.

ALLERGIES:
Penicillin.

PAST HISTORY:
Kidney stones, metal plate placed in skull after construction accident. In addition, the patient has had an appendectomy.

PHYSICAL EXAMINATION:
Dyspneic, thin white male. Respiratory rate, 24 with prolonged expirations. Temperature, 99. Pulse, 92. Blood pressure, 120/70. Weight, 114 lb. Pupils equally round and reactive to light.
NECK: Negative.
CHEST: Increased AP diameter. Breath sounds are diminished, but diffuse wheezing on expiration is noted.
CARDIAC: S1 and S2 are normal. There is no murmur, gallop or rub.
ABDOMEN: Bloated with gas. No organomegaly was detected.
EXTREMITIES: Mild clubbing with nicotine stains on several fingers. Dorsalis pedis pulses are 2+. There is no edema or cyanosis.

LABORATORY DATA:
Sputum cultures showed Hemophilus influenza sensitive to Ampicillin, Chloramphenicol, Erythromycin, Gentamicin, Tetracycline, and Trimethaphan Sulfa. White count, 12,400. Hematocrit, 45. Platelet count, 259,000. Initial glucose was 149 after steroids, but repeat was 85. SMA 12 was negative. Electrolytes were unremarkable. Blood gases on room air showed pH of 7.44, pCO2 of 41, and pO2 of 60. Chest X-ray showed pulmonary emphysema. Pulmonary function showed severe obstructive lung disease, severe hyperinflation with air trapping, severe impairment and diffuse incapacity. EKG showed nonspecific ST-T wave changes.

CONTINUED:
(HISTORY & PHYSICAL)

CLAIMANT ATTACHMENT 002
PAGE NO. 1 of 2

WP32.022886.1 CHART COPY

NAME: Spraggs, Melvin [redacted]
CHART: ~~774397-103~~
DOCTOR: Barlow
ADM:
DIS:
ROOM: ER

KPRO #:

XRAY #: 24581

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

A

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
short of breath, mid chest pain started 2/18

DATE:
2/19/86

CHEST:
Hyperinflated lungs with advanced emphysema. Calcified granuloma right upper lobe.

No acute pulmonary process. No pneumonia.

The heart is normal in size.

CLAIMANT ATTACHMENT 002
PAGE NO. 2 of 12

VPS/021986

WP41.021986.3X

VRS
V. P. Semogas, M.D.

CHART COPY

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Ransler/Culbertson
ADM: 09/17/90
ROOM: 292-1

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

CONSULTATION

ADMITTING PHYSICIAN: C. Ransler, M.D.

DATE OF CONSULTATION: 09/17/90

HISTORY:
This is a white male with known cancer of the prostate, who has a previous history of severe COPD. He has dyspnea on minimal exertion, of approximately 30-40', and has basically lived a bed-n-chair existence over the past several years.

He has been on a number of medications and has been seeing Dr. Wallace as his regular medical physician. He takes chlorpromazine, Efedron, theophylline, Tagamet, Atrovent, and has been on Restoril, as well, in the past.

He has a history of anemia and severe chronic obstructive lung disease. He has had both bronchitis and prostatitis in the past, and now has cancer of the prostate.

Because of his significant chronic lung disease, I am asked to see the patient pre- and postoperatively.

PHYSICAL EXAMINATION:
GENERAL IMPRESSION: He is a somewhat weak-appearing white male.
HEAD AND NECK: No palpable adenopathy, jugular venous distention or carotid bruits.
CHEST: Reveals markedly diminished breath sounds throughout, with prolongation of expiration throughout.
CARDIAC: No murmurs or gallops.
ABDOMEN: Soft, without palpable masses.
EXTREMITIES: No clubbing, cyanosis or edema.

ASSESSMENT:
(1) Severe COPD.
(2) Cancer of the prostate.

RECOMMENDATIONS:
(1) Proceed with the surgery planned. I would prefer low spinal anesthesia, if possible.
(2) Treatment with bronchodilators in the postoperative period.

Thank you for allowing me to see this consultation with you.

W. H. Culbertson, M.D.

William H. Culbertson, Jr. MD

WHC/091790
(CONSULTATION)

WP31.092090.4

CHART COPY

CLAIMANT ATTACHMENT 002

PAGE NO. 38/2

WESTERN BAPTIST HOSPITAL
2501 Kentucky Avenue
Paducah, Kentucky 42001

NAME: Spraggs, Melvin
CHART: [redacted]
DOCTOR: Jesse Wallace, M.D.
ADM: 07/11/91
DIS: 07/17/91 (Expired)
ROOM:

DISCHARGE SUMMARY

FINAL DIAGNOSIS:
1. Pulmonary emboli.
2. Chronic obstructive pulmonary disease.
3. Carcinoma of the prostate.
4. Anemia.
5. Ileus.
6. Hyponatremia.

CONSULTING PHYSICIAN:
WALLY O. MONTGOMERY, M.D.

Mr. Spraggs is known to have severe chronic obstructive pulmonary disease with worsening chest congestion and difficulty clearing his secretions. He had chest pain and he was found to have evidence of pneumonia initially but a lung scan was compatible for multiple pulmonary emboli. Heparin therapy was started and chest xray showed slight improvement. Patient was placed on heparin therapy with PT maximum of 52. Initial WBC was 11,000, rising to as high as 25,000 but dropping to as low as 15,000. Hematocrit ranged from 34 up to 36 but down to 31. Platelet counts were negative. U/A was negative. Glucose was 118. Liver functions were negative. Sodium was 139 but was as low as 116. CPK was 27. Theophylline level was maximum of 15. p02 was 69 with pC02 of 40. Blood cultures were negative. Rhythm strips showed sinus rhythm and sinus tachycardia.

HOSPITAL COURSE:
Initial management was that of treating pneumonia, chronic obstructive pulmonary disease and pulmonary emboli with Heparin, antibiotics and pulmonary toilet. Patient developed gaseous bloating and ileus pattern. The rectal exam showed no impaction. Patient did have several bowel movements but still remained bloated. he was having no bleeding. His abdomen became softer and less problematic. However, on 07/17/91, he looked worse with pallor and worsening abdominal distention and bloating. A nasogastric tube was placed with 1800 cc of bilious material suctioned. Abdomen was not rigid or tender and occasional bowel sounds were noted. Rectal showed large prostate but no stool present. I discussed the case with the family and we consulted Dr. Montgomery. Patient however continued to decline and subsequently had cardiopulmonary arrest and resuscitation

CONTINUED...

CLAIMANT ATTACHMENT 0002
PAGE NO. 48/12

NAME: Spraggs, Melvin
CHART: [redacted]
ROOM:

DISCHARGE SUMMARY

was unsuccessful and he was pronounced dead at 3:48 p.m., may he rest in peace.

It is felt that his terminal event may have been some type of abdominal catastrophe. However, the patient overall was in severe medically compromised state due to his underlying lung disease and recent pulmonary emboli. He was felt not to be an operative candidate for an acute laparotomy.

Jesse Wallace, M.D.

JW/lw
DD: 08/14/91
DT: 08/19/91

DISCHARGE SUMMARY

CLAIMANT ATTACHMENT 502
PAGE NO. 58 of 2

EX12

Chronic Beryllium

For diagnoses before January 1, 1993, the presence of-
Any three of the following criteria:

a. Restrictive or obstructive lung physiology testing or diffusing lung capacity defect
    1. Dr. Kalnas says: Yes the ABG tests or pulmonary function tests reflect an obstructive defect and a ventilation- perfusion abnormality.

b. Clinical course consistent with chronic respiratory disorder.

1. Dr. Glazer: Yes, the records clearly indicate that Mr. Spraggs suffered from a chronic respiratory disorder. As stated in [in the Dr's summary] the clinical course seen in the records is consistent with clinical diagnosis he received from his physicians of severe COPD.

2. Dr. Kalnas says: Yes, the medical records reflect a clinical course consistent with a chronic respiratory disease.

These are two of the three that are required for proof.

Characteristic chest radiographic(or computed tomography (CT) abnormalities.

1. First the doctors only based their report on X-ray reports and not X-rays.
2. Discharge report from Dr. Wallace on 2/28/86 says chest x-ray showed pulmonary emphysema. Pulmonary function showed severe obstructive lung disease, severe hyperinflation with air trapping, severe impairment and diffuse incapacity.
3. Dr. Wallace reported decompensated COPD 2/28/86 –
4. 2/24/86 lab work said the following
    a. Severe obstructive lung disease present
    b. Severe hyperinflation air trapping
    c. Borderline oxygen tension without any significant hypoxemia
    d. Severe impairment in diffusion capacity
5. 7/12/91 Other etiologies such as infraction are not excluded.
    a. Could be other things present
6. 2/19/86 Dr. Barlow reports that calcified granuloma in right upper lobe.
    a. Present in CBD
7. Report from WebMD health says "Chronic berylliosis is characterized by the abnormal formation of inflammatory masses or nodules (granulomas) within certain tissues and organs and widespread scarring and thickening of deep lung tissues.
    a. X-rays showing scarring of the lungs that were not read.

Summary: We feel the above information and the doctor records that have not been looked at is more than enough to prove our case. We feel our case should not be decided on two doctors looking at X-ray reports and not actual X-rays considering all of the other information supporting our claim.

CLAIMANT ATTACHMENT 002
PAGE NO. 68/12

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ADM: 04/13/90
ROOM: 454-2

HISTORY & PHYSICAL

Mr. Spraggs is a [redacted]-year-old white male, who presented to the ER with shortness of breath and dull substernal diffuse chest aches. He has had at least one week of shortness of breath, with cough and congestion. He has a diagnosis of severe emphysema in the past. In addition, the patient states he has had such difficulty breathing and coughing, he has "pulled a muscle" in his abdomen.

PAST HISTORY:
Includes no known heart disease, but known emphysema. The patient still continues to smoke.

MEDICATIONS:
Efedron, theophylline, Tagamet, and Atrovent inhaler.

ALLERGIES:
Penicillin.

PHYSICAL EXAMINATION:
Temperature 99.3, pulse 110, respiratory rate 30, blood pressure 118/70, weight 106.
HEENT: The face is symmetrical. The pupils are round and reactive to light. The EOMs are intact.
NECK: Supple, without masses. There is coarse upper airway sounds.
CHEST: Increased AP diameter, with scattered rhonchi and faint expiratory wheezing.
CARDIAC: Shows S-1 and S-2 to be normal. There is no murmur, gallop, or rub.
ABDOMEN: Soft, nontender, without masses, bruits, or organomegaly.
EXTREMITIES: Early clubbing, but no edema or cyanosis. Pedal pulses are 1+.

LABORATORY DATA:
Chest x-ray pending. EKG shows sinus rhythm, pulmonary disease pattern, and nonspecific T-wave changes. White count 8,100, hematocrit 40.9. Electrolytes negative. Amylase 68. Theophylline level 2.9.

DIAGNOSIS:
(1) Severe bronchitis.
(2) COPD.
(3) Chest pain.
(4) Anemia.

Jesse Wallace, M.D.

JW/041490
(HISTORY & PHYSICAL)

WP31.041590.2

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CES 0085

CLAIMANT ATTACHMENT 002
PAGE NO. 7 of 12

WESTERN BAPTIST HOSPITAL
WHERE YOUR NEEDS COME FIRST
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ADM: 02/03/89
DIS:
ROOM: 452-2

HISTORY AND PHYSICAL

Mr. Spraggs is a [redacted] year old white male who was in the emergency room with severe chest congestion, left side chest pain and great difficulty handling his secretions and dry cough. It was very painful and very severe. He was noted to be febrile and tachypneic in the emergency room and it was felt best to admit him for further evaluation and therapy.

PAST HISTORY:
Chronic obstructive pulmonary disease, ~~bronchitis~~, lumbar radiculitis, anemia, and osteoarthritis of the spine.

ALLERGIES:
Penicillin.

MEDICATIONS AT HOME:
To be listed.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature 100.3°, pulse 75 and regular, respiratory rate 26 with prolonged expiration. Weight 115.
HEENT: Pupils are round and reactive to light.
NECK: Supple without masses, thyromegaly or venous distenaion.
CHEST: Increased AP diameter, possible rub at the left lateral base. Breath sounds are remarkable for rhonchi and faint expiratory wheezing.
CARDIAC: S1 and S2 are normal. There is no murmur, gallop, rub or click.
ABDOMEN: Soft, nontender, without masses or organomegaly.
EXTREMITIES: Early clubbing with diminished pedal pulses. No edema or signs of phlebitis.

LAB DATA:
Chest X-ray shows sinus tachycardia. STT wave changes are nonspecific at this time.

INITIAL IMPRESSION:
1. Severe bronchitis and COPD.
2. Chest pain -- likely pleurisy.

Jesse Wallace, M.D.

JW/020489
(HISTORY AND PHYSICAL)

WP33.020689.1

CHART COPY

CLAIMANT ATTACHMENT 002
PAGE NO. 88/12

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Wallace
ADM: 01/19/85
DIS: 01/23/85

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVE.
PADUCAH, KENTUCKY 42001

DISCHARGE SUMMARY

FINAL DIAGNOSIS:
Decompensated chronic obstructive lung disease

This [redacted] year old white male was referred by Dr. Hunt of Wickliffe because Of worsening lung congestion.

In the past he was told of emphysema. He came to the ER with weakness and shortness of breath. He was treated with Keflex and Theo-Dur and he was sent home. He did not improve. He became more and more short of breath. He was admitted for further evaluation.

ALLERGIES:
Penicillin.

PAST HISTORY:
Kidney stones, metal plate placed in skull after construction accident. He has had an appendectomy.

PHYSICAL EXAMINATION:
Thin white male, dyspneic. Respiratory rate, 24 with prolonged expirations. Temperature, 101. Pulse, 96. Blood pressure, 130/86. Weight, 115 lb.

NECK: Negative
CHEST: Increased AP diameter, Breath sounds diminished, but diffuse wheezing is noted on expiration.
CARDIAC: S1 and S2 are normal.
ABDOMEN: No organomegaly detected.
EXTREMITIES: No edema or cyanosis

LABORATORY DATA:
Chest x-ray showed severe obstructive lung disease, severe hyperinflation with air trapping, severe impairment and diffuse incapacity. EKG showed nonspecific ST-T wave changes.

CLAIMANT ATTACHMENT 002
PAGE NO. 9 of 12

WP32.011985

NAME: Spraggs, Melvin L.
CHART: [redacted]
DOCTOR: Seabury
ADM: 09/30/84 KPRO #:
DIS:
ROOM: 381-1 X-RAY #:24581
PAGE:

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVE
PADUCAH, KENTUCKY 42001

X-RAY REPORT

ADMITTING PROBLEM/HISTORY:
R. ureteral stone

DATE:
10-02-84

CHEST:
The lungs show hyperinflation. There is also evidence of hyperlucency of the lungs suggesting oligemia. A calcified granuloma is present in the right upper lung field, indicating old healed granulomatous disease. Minimal spurring is seen in the thoracic spine.

IMPRESSION:
Hyperinflation, suggesting chronic obstructive pulmonary disease.

CP

OR - Oligemia - deficiency in amt of blood in body or any organ or tissue
hyperlucency of lungs - dark areas.

CB/100284

Collins Baber, M.D.

WP30.100284.5X

CLAIMANT ATTACHMENT 2 2
PAGE 10 of 12

CHART COPY

2-24-86

SPRAGGS, MELVIN - RM 443 -2

[redacted]

Age 65; HT 67"; WT 115

DR. WALLA

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVENUE
PADUCAH, KENTUCKY 42001

PULMONARY FUNCTION LAB

BLOODGAS

	OBS	%PRED	PREDICTED
FIO2:	021		
PO2 (TORR)	060.0	69	86.7
A-aDO2 (TORR)	41	253	16.2
PCO2 (TORR)	41.00		35-45
HCO3 (MEQ/L)	26.6	111	24
PH	7.44		7.35-7.45

INTERPRETATION:

1. Severe obstructive lung disease present.
2. Severe hyperinflation air trapping.
3. Borderline oxygen tension without any significant hypoxemia.
4. Severe impairment in diffusion capacity.
5. These results are comparable with severe emphysema.

Yaser Jaafar, m.D

M.Y.JAAFAR, MD.

CLAIMANT ATTACHMENT 002

PAGE NO. 11 of 12

2-24-86

SPRAGGS, MELVIN - RM 3-2

[redacted]

Age 65; HT 67"; WT 115

DR. WALLACE

WESTERN BAPTIST HOSPITAL
2501 KENTUCKY AVENUE
PADUCAH, KENTUCKY 42001

PULMONARY FUNCTION REPORT

SPIROMETRY

		PREBRONCHODILATOR OBS	%PRED	PREDICTED
FEV.5	(L)	.63	31	2.03
FEV 1	(L)	.82	29	2.82
FEV 3	(L)	1.37	35	3.93
FVC	(L)	1.88	46	4.05
FEV.5/FVC	(%)	34	68	50
FEV1/FVC	(%)	44	63	70
FEF200-1200	(L/SEC)	.56	9	6.26
MMEF	(L/SEC)	.31	11	2.74
PEAK FLOW	(L/SEC)	3.21	39	8.31
FEF25	(L/SEC)	.55	7	7.48
FEF50	(L/SEC)	.31	6	4.79
FEF75	(L/SEC)	.16	9	1.69

MAXIMUM VOLUNTARY VENTILATION

	PREBRONCHODILATOR OBS	%PRED	PREDICTED
(L) 10 SEC	040	32	124

LUNG VOLUMES

		OBS	%PRED	PREDICTED
TV	(L)	.78		
MV	(L)	15.94		
ERV	(L)	.90		
IC	(L)	1.56		
VC	(L)	2.46	61	4.05
TLC	(L)	7.48	125	5.97
RV/TLC	(%)	67	223	30
FRC	(L)	5.92	238	2.49
EQUILBRATION TIME		15.00		
RV	(L)	5.02	280	1.79

DIFFUSION

		OBS	%PRED	PREDICTED
VOLUME	(L)	1.69		
TIME		11.52		
HE	(%)	39		
CO	(%)	33		
DLCO	(ML/MIN/MMHG)	4	20	20

CLAIMANT ATTACHMENT 002

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U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
FINAL ADJUDICATION BRANCH

EMPLOYEE: Melvin L. Spraggs

CLAIMANTS: Mary A. Davis
Sharon R. Holt
Jerry L. Spraggs

FILE NUMBER: [redacted]

DOCKET NUMBERS: 51667-2005
51669-2005
51808-2005

DECISION DATE: October 19, 2005

NOTICE OF FINAL DECISION FOLLOWING A HEARING

This is the decision of the Final Adjudication Branch concerning your claims for compensation under 42 U.S.C. § 7384s of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 *et seq.* (EEOICPA or the Act). For the reasons set forth below, your claims are denied.

STATEMENT OF THE CASE

On November 26 and December 1, 2003, you filed forms EE-2, Claim for Survivor Benefits under the EEOICPA, as the children of the employee. The claimed conditions were metastatic cancer of the prostate and testicles and possible CBD (chronic beryllium disease). You submitted birth, marriage and death certificates confirming that you are children of the employee, that he died on July 17, 1991, of atherosclerotic heart disease, at the age of 71, and that his surviving spouse died on September 18, 1998.

Medical records, including August 22, 1990 and September 18, 1990 pathology reports, confirmed that your father had prostate cancer, which spread to other parts of the body, including the bladder, for which he underwent an orchiectomy. You also submitted records of treatment he received, from July 10, 1973 until his death, for other medical conditions, particularly pulmonary illnesses. The records were reviewed by physicians acting as office medical consultants on January 19, 2004 and June 1, 2004.

The EE-3 form stated that the employee worked for F.H. McGraw at the Paducah Gaseous Diffusion Plant from 1951 to 1954. The Department of Energy (DOE) could not confirm his employment, but did support that F.H. McGraw was a DOE contractor at the Paducah Gaseous Diffusion Plant during the claimed period. Affidavits (EE-4 forms) from a neighbor and two co-workers supported that your father worked at the Paducah Gaseous Diffusion Plant between 1951 and 1954. Social Security records established that he was employed by F.H. McGraw from

CLAIMANT ATTACHMENT 003
PAGE NO. 185

the second quarter of 1952 to the first quarter of 1955. The Paducah Gaseous Diffusion Plant has been a DOE facility, where radioactive materials and beryllium were present, since 1951, according to the Department of Energy (DOE) Office of Worker Advocacy Facility List website (at: http://tis.eh.doe.gov/advocacy/faclist/findfacility.cfm).

In order to determine the probability that your father sustained his cancer in the performance of duty, the Jacksonville district office referred your application package to the National Institute for Occupational Safety and Health (NIOSH) for radiation dose reconstruction, in accordance with 20 C.F.R. § 30.115 of the regulations implementing the EEOICPA. External and internal dose reconstruction was performed, utilizing, Dose Reconstruction Implementation Guidelines, Technical Information Bulletins, Technical Basis Documents and the computer assisted telephone interview. The dose reconstruction was done on the basis that your father was employed at the Paducah Gaseous Diffusion Plant from April 1, 1952 to March 31, 1955. On October 20, 21 and 25, 2004, you signed OCAS-1 Forms, indicating that you had reviewed the NIOSH Draft Report of Dose Reconstruction and agreed that it identified all of the relevant information you provided to NIOSH

Pursuant to 42 C.F.R. § 81.20 of the implementing Department of Health and Human Services (HHS) regulations, the district office used the information provided in this report to determine that there was no more than a 24.66% probability that the employee's cancer was caused by radiation exposure at the Paducah Gaseous Diffusion Plant.

On January 18, 2005, the district office issued a recommended decision finding that your father's cancer was not "at least as likely as not" caused by his employment at the Paducah Gaseous Diffusion Plant, within the meaning of 42 U.S.C. § 7384n of the EEOICPA. It also concluded that the medical evidence did not support that he had chronic beryllium disease, as defined in 42 U.S.C. § 7384l(13) of the EEOICPA. Therefore, it concluded, you are not entitled to compensation under 42 U.S.C. § 7384s of the Act.

By a letter dated February 2, 2005, Sharon Holt objected to the recommended decision and requested a hearing. A hearing was held in Paducah, Kentucky on April 14, 2005, during which the three of you explained why you disagreed with the recommended decision, and submitted some documents which you felt supported your decision.

OBJECTIONS

You made the following objections to recommendation to deny benefits for cancer: (1) you questioned the NIOSH findings, stating "I don't think they could have reasonable knowledge of where my father worked and what he could have been exposed to at PGDP." Your father worked in eight different areas of the plant and should probably have been monitored. [hearing transcript, page 21], (2) you questioned how claimant-favorable and maximum doses were obtained and whether monitored workers received higher doses. [hearing transcript, page 24], (3) you stated that your father car pooled "... 30 miles every day with two people that have already been awarded claims." Potential exposure from the work clothing was posited as a pathway, [hearing transcript, pages 17 and 26], (4) you stated that medical evidence supported that his cancer spread to his bladder, resulting in his undergoing an orchiectomy [hearing transcript, pages 22-23 and 25].

NIOSH reviewed your father's employment records, and no records of bioassay monitoring results were found. Internal monitoring programs are applied to individuals who are likely to be exposed to radiation from internally-deposited radioactive material. Personnel who are not selected for internal dose monitoring programs are less likely to be exposed. However, to account for any incidental dose that may have been received but not documented, internal dose was assigned based on a hypothetical intake assuming an intake of 28 radionuclides. This results in an intake that greatly exceeds any possible actual intake by the employee because this level of activity would be expected to be detectable by workplace indicators. Additionally, these nuclides would not all be found in a single location on site.

For the purposes of the dose reconstruction, NIOSH assigned your father the highest reasonably possible radiation dose related to radiation exposure and intake using maximizing assumptions in the absence of documented exposures. The discussion above demonstrates that NIOSH used maximizing and claimant-favorable assumptions in the dose reconstruction, which addresses the issue raised in the first objection. The NIOSH approach is based on current science, documented experience and relevant data. These objections are challenges of the dose reconstruction methodology and cannot be addressed by the FAB per 20 C.F.R. 30.318(b).

The third objection suggests that radiological exposure from the contaminated clothing of other workers in his car pool could have been a potential exposure pathway. Site practices were such that workers were monitored for contamination prior to leaving a contaminated area, and other site practices and procedures would indicate if contamination was present in non-radiation areas such as administrative areas, exit points form the site, and lunch rooms. It is unlikely that the potential transfer of contamination from other workers to your father by hand-to-hand contact or by inhalation of contamination from clothing, if present, would be significant in light of the maximized dose assigned by NIOSH. The internal dose from the hypothetical intake and the external ambient dose assigned are more than adequate to account for dose from the types of situations proposed in your objection. This is a challenge of the dose reconstruction methodology and cannot be addressed by the FAB per 20 C.F.R. 30.318(b).

Concerning the fourth objection, it should be noted that the recommended decision did not deny, and the medical evidence does support, that the prostate cancer spread to the bladder and that your father underwent an orchiectomy. However, the evidence does not support that he had any primary cancer, other than the prostate cancer.

You also objected to the denial of benefits for chronic beryllium disease (CBD). Specifically, (1) you noted that even brief exposures to beryllium can be dangerous, (2) you questioned a difference in the reports of two consultants who reviewed the file, and, (3) you reviewed some of the medical evidence in the file, including x-ray reports, and explained why you believed it demonstrated that your father had a severe pulmonary condition which may have been CBD.

It is undisputed that your father did have exposure to beryllium during his employment at the Paducah Gaseous Diffusion Plant. The basis for the recommendation to deny benefits was that the medical evidence did not support that he had CBD, as that condition is defined in the EEOICPA.

The consultant who reviewed the case on January 19, 2004, Dr. Craig Glazer, was asked if blood gas tests showed results consistent with CBD. He responded that, considered in context with the other evidence, they did not. Dr. Jonas Kalnas, the consultant who reviewed the case on June 1,

2004, was asked (more appropriately, given the language of the Act) if the blood gas and pulmonary function tests showed obstructions, restrictions or a diffusing capacity defect, and he responded that they did. As you were informed at the hearing [page 32 of the transcript], they were asked different questions and gave different answers. It should also be noted that Dr. Kalnas was able to review additional medical reports which you submitted after the review of Dr. Glazer.

Dr. Glazer and Dr. Kalnas agreed that the evidence supported a clinical course consistent with a chronic respiratory disorder, and this is clearly indicated by the medical evidence in the case file. A report of August 25, 1979 indicated that your father had been disabled by emphysema for eight years, and an admission note of April 13, 1990 stated that he had severe emphysema, bronchitis and COPD, adding that he "continues to smoke."

Chest x-rays of October 2, 1984, February 19, 1986 and October 10, 1988 stated that your father had a calcified granuloma of the right upper lobe, indicative of an old healed granulomatous disease. However, no x-rays supported that he had multiple granulomas, or a granuloma in any other part of the lungs. Both Dr. Glazer and Dr. Kalnas reviewed the evidence and concluded that the x-rays reports did not show abnormalities consistent with CBD. At the bottom of page two of his report, Dr. Kalnas described the type of x-ray findings which are consistent with CBD.

It should be noted that the file does not support that your father ever underwent a beryllium lymphocyte proliferation test (LPT), or other immunologic test, showing he had beryllium sensitivity. The evidence also does not include any pathology report showing findings in the lungs consistent with CBD.

Upon review of the case record, the undersigned makes the following:

FINDINGS OF FACT

You filed claims for survivor benefits on November 26 and December 1, 2003, under the EEOICPA.

You are children of the employee, who died on July 17, 1991, of atherosclerotic heart disease, at the age of 71. His surviving spouse died on September 18, 1998.

He worked for a Department of Energy (DOE) contractor, at the Paducah Gaseous Diffusion Plant between April 1, 1952 and March 31, 1955. During that time, it was a Department of Energy facility where radioactive material was being processed, and where beryllium was present.

The employee had prostate cancer, confirmed by an August 22, 1990 pathology report. He also had a clinical course consistent with a chronic respiratory disorder and pulmonary function tests showing an obstructive defect. His chest radiographs did not show abnormalities characteristic of CBD. He had no lung pathology reports consistent with CBD and did not undergo any abnormal LPT or other immunologic test demonstrating beryllium sensitivity.

NIOSH reported annual dose estimates for prostate cancer from the date of initial radiation exposure during covered employment, to the date the cancer was first diagnosed. A summary

Section 7384l(13)(B) of the EEOICPA provides that, for diagnoses made before 1993, chronic beryllium disease may be established by "any three of the following...(I)Characteristic chest radiographic...abnormalities...(II)Restrictive or obstructive lung physiology testing or diffusing lung capacity defect. (III)Lung pathology consistent with chronic beryllium disease...(IV)Clinical course consistent with a chronic respiratory disorder...(V)Immunologic tests showing beryllium sensitivity". As noted above, the medical evidence includes pulmonary testing showing obstruction and records indicating a clinical course consistent with a chronic respiratory disorder. However, the evidence does not include chest radiographs with abnormalities characteristic of CBD, lung pathology consistent with CBD or immunologic tests showing beryllium sensitivity. Since the employee met only two of the criteria (II and IV) the evidence does not establish chronic beryllium disease, as defined in 42 U.S.C. § 7384l(13)(B) of the Act.

It should be noted that your father also could not meet the definition of CBD diagnosed after January 1, 1993, since that would require an abnormal beryllium LPT, as stated in 42 U.S.C. § 7384l(8)(A),(13)(A) of the EEOICPA.

For the foregoing reasons, the undersigned hereby denies your claims for compensation under 42 U.S.C. § 7384s of the EEOICPA. Adjudication of your claims under 42 U.S.C. § 7385s is deferred pending further development.

Washington, DC

Richard Koretz
Hearing Representative
Final Adjudication Branch

CLAIMANT ATTACHMENT 003
PAGE NO. 585

Judy Vander Boegh

From: "Saved by Windows Internet Explorer 7"
Sent: Wednesday, November 25, 2009 8:02 AM
Subject: Chapter 2-1000 Exhibit 1

Memorandum from DEEOIC Medical Director
Regarding Causal Relationship Between
Established CBD and Other Respiratory Disorders

Memorandum

Date: 08/25/2005

To: Peter Turcic, Director of DEEOIC, Department of Labor

From: Sylvie I Cohen, MD, MPH

RE: Chronic Pulmonary Diseases

This memo is to address the rationale between the accepted medical condition under part B of the program for Chronic Beryllium Disease (CBD) and its contribution and aggravation of other chronic pulmonary diseases

CBD is considered to be a disease that is involved with the destruction of viable pulmonary tissue that normally aides an individual in the process of gas exchange and blood oxygenation

There are other chronic pulmonary diseases that are involved with lung tissue destruction or replacement that for the purpose of this memo we shall call "Other Chronic Pulmonary Diseases." Diseases that should be considered as members of this set are: asbestosis, silicosis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, and pulmonary fibrosis

Since both CBD and Other Chronic Pulmonary Diseases share in the destruction and or replacement of viable lung tissue, it can be concluded that the presence of CBD contributed or aggravated one of the illnesses named in the list of Other Chronic Pulmonary Diseases which led to an individual's death

CLAIMANT ATTACHMENT 004
PAGE NO. 181

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From: Gary S. Vander Boegh

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