

Fax Cover Sheet

To: Rachel Leiton, Jim Bibeault,
Hon. Secretary of Labor
Hilda Solis

From: Gary S. Vander Boegh

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Date: 4-7-10

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Pages: ___ Pages including the Cover Sheet

Re: Ezra Freeman
File: xxx-xx-4418

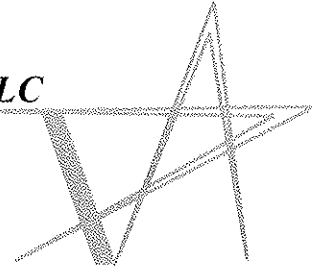
CC: Attention Ms. Leiton

Urgent For Review Please Comment 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
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April 5, 2011

U. S. Department of Labor,
Frances Perkins Building, 200 Constitution Ave., NW
Room S-2018
Washington, DC 20210
Facsimile (904) 357-4704
Attention: Jim Bibeault & Madam Secretary Hilda Solis

**RE: Request for Reopening/ Approval of CBD Claim Due to New Evidence of Beryllium/
Neutron Exposure at Paducah Gaseous Diffusion Plant.**

Employee: Ezra Freeman
File Number: XXX-XX-4428
Claimant: Lynda L. Freeman

Dear Ms. Leiton, Mr. Bibeault and Madam Secretary Solis,

As "Authorized Representative" (AR) for claimant's daughter Lynda L. Freeman, I hereby respectfully submit the attached "EE-1 form" and "Claimant Attachments" that support the claimant's Part B claim for compensation for Chronic Beryllium Disease (CBD). Per the statutes and the regulations, a claimant is required to provide the appropriate documentation in support of the claim for compensation for Parts B and E of the Energy Employee Occupational Illness Compensation Program (EEOICP) ("the Act).

Recently Commonwealth Environmental Services, LLC presented evidence to the Paducah Citizens' Advisory board (CAB) that confirmed the presence of **radioactive beryllium** from nuclear reactor fuel received from Hanford, Washington. Therefore, the claimant Lynda L. Freeman respectfully requests reopening of her for CBD since she now provides "new evidence of toxic chemical (radioactive beryllium) exposure in support of her pre-1993 CBD criteria. Mrs. Freeman has met her "burden of proof" per the statutes and regulations for re-opening of her CBD claim and subsequent approval based on meeting 4 of 5 statutory criteria for Part B compensation in the amount of \$150,000.

The pre-1993 CBD criteria qualifies the claimant Lynda Lou Freeman since her father's medical records confirm her father's respiratory disease diagnosis prior to January 1, 1993 and allows his Energy Employee Occupational Illness Compensation Program (EEOICP) CBD claim to be evaluated per the pre-1993 criteria based on statutory requirements 42 USC § 73841 (13) (B) set forth 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 a chronic respiratory disorder. 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.**"

PRIOR DOL CASE DECISION PRECEDENT

(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 compensation in the amount of \$150,000 pursuant to § 7384s of the EEOICPA.

Section 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. (emphasis added)**
3. Medical evidence has been submitted establishing a diagnosis of chronic beryllium disease before January 1, 1993.
4. You were married to the employee from March 23, 1940, until his death on October 12, 1999.

Based on these facts, the undersigned makes the following:

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 § 73841(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

[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)

Ezra Freeman Medical Reports, Radiology Report, Tissue Analysis Report Established Lung Diseases Reflecting Hyperinflation, Chronic Obstructive Pulmonary Disease, Emphysema, Fibrosis, & Lung Cancer Reflecting Compliance With 4 of 5 Pre-1993 CBD Criteria

Lynda Lou Freeman provides Claimant Attachment (CA) – 001 (Q/A #1 – Q/A #5) – That confirms both claims examiner Judy K. Allen and District Medical Consultant (DMC) William Wright have acknowledge compliance with the pre-1993 statues.

1/ CA-001, (Q/A #1, On a DMC report dated December 17, 2008 it is noted that Mr. Freeman had multiple chest X-rays showing lung abnormalities. On a X-ray dated December 17, 1979 shows both lungs show some linear fibrosis. 3/15/86 shows very hyper inflated lungs indicating advanced emphysema. 3/09/88 shows hyper aerated lung fields consistent with obstruction.

5/01/88 shows hyper inflated lungs consistent with obstructive lung disease. 5/04/88 hyper expansion consistent with COPD. 7/18/88 advanced COPD with markedly hyper inflated lungs. 12/21/89 left perhilar mass. Chest CT on 12/22/89 left upper lobe mass, slight soft tissue, prominence in the left hilum. 1/26/90 left perihilar mass. 5/17/90 left perhilar mass. 11/01/90 left hilar fullness and probable fibrosis in that area. 1/01/91 left hilar mass, enlarging. 3/07/91 left hilar mass.

Conclusion: Compliance pursuit with § 7384L(13)(B) , Criteria I, “Characteristic chest radiographic (or computed tomography (CT)) abnormalities.”

2/ CA-001, Q/A #2 – Arterial blood gas (ABG) at 93% while breathing 2L/min supplemental oxygen on May 3, 1988. On July 6, 1988 ABG’s dropped to 90-91% on room air. In December 1989, oxygen saturations dropped to 82-85% on room air. On April 17, 1991, ABG normal on 2L/min supplemental oxygen. On October 1, 1991, oxygen saturation was at 82% on room air that was corrected to 93-95% respectively with 2L/min supplied oxygen. The DMC summarizes his findings by documenting that Mr. Freeman hs oxygen “de-saturation” that is “corrected with supplemental oxygen.

Reports indicate that Dr. Clarke admitted Mr. Freeman to a hospital on July 2, 1988 for shortness of breath and chest congestion, an exacerbation of COPD and possible pneumonia; ...”He was discharged on July 7, 1988 by Dr. Culbertson for respiratory failure, COPD, with infection, and **COR PULMONALE (emphasis added).** (Reference CBD Chart PM 2-700).

On page 4 of 5, of the DMC, Dr. Wright hospitalizes Mr. Freeman for exacerbation of COPD on January 1, 1991 where he is diagnosed with pneumonia, received treatments including antibiotics, corticosteroids, and bronchodialators.

Dr. Locken on June 13, 1991 reported that radiation treatments of the lung cancer were completed on February 15, 1990.

The death certificate dated August 5, 1991, confirms the immediate cause of death as cardiac arrest, as a “consequence of cancer of lung.”

Conclusion: Compliance pursuit with § 7384L(13)(B), Criteria I, “Characteristic chest radiographic (or computed tomography (CT)) abnormalities.”, Criteria II, “Restrictive or obstructive lung physiology testing or diffusing lung capacity defect”, Criteria III, “Lung pathology consistent with chronic beryllium disease” & Criteria IV, “Clinical course consistent with a chronic respiratory disorder.”

3/ The PFT (page 5 of 5) on 5/03/88 shows FEV 1.26L (43%) with FEV /FVC 55% **and no improvement after bronchodilator treatment.** Total lung capacity was 105% , residual volume 217%, diffusion capacity 17%..

Compliance pursuit with § 7384L(13)(B), Criteria II, “Restrictive or obstructive lung physiology testing or diffusing lung capacity defect.”

4/ CA-002, "Statement of Accepted Facts" (SOAF) signed by Senior Claims Examiner Judy Allen on November 20, 2008 that confirms Mr. Freeman has met his burden of proof established for the pre-1993 CBC criteria per 42 USC § 7384l (13) (B).

Conclusion: Compliance pursuant with § 7384L(13)(B), Criteria I, "Characteristic chest radiographic (or computed tomography (CT)) abnormalities.", Criteria II, "Restrictive or obstructive lung physiology testing or diffusing lung capacity defect", Criteria III, "Lung pathology consistent with chronic beryllium disease" & Criteria IV, "Clinical course consistent with a chronic respiratory disorder."

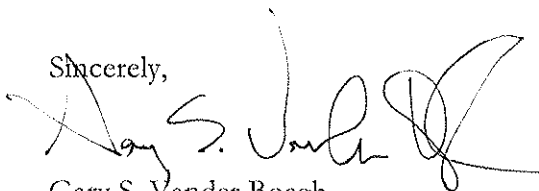
5/ CA-003, Robert Jessing statement that confirms radioactive beryllium producing "neutrons" distributed in the nuclear reactor feed received from Hanford and Savannah River sited were allowed to expose the workers causing their death and illnesses.

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

Based on the above medical evidence, Lynda Freeman has met her statutory burden of proof for EEOICPA Part B lump sum 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 by facsimile (202) 693-6111

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

President Barack Obama by facsimile!
Malcolm Nelson, EEOICP Ombudsman (by email and facsimile)

CLAIMANT ATTACHMENT 001
PAGE NO. 5 PAGES

WorkWright, Inc.
for occupational health services

P.O. Box 1142
McLean, Virginia 22101-1142
Phone: 703-556-0092

Date: December 17, 2008

To: Judy K. Allen
Claims Examiner

From: William E. Wright, MD, MSPH
President, WorkWright, Inc. *WEW*
VA#0101038882
District Medical Consultant
Jacksonville District Office

Re: Mr. Ezra A. Freeman
File #: XXXXXXXXXX

Thank you for your inquiry. I reviewed the Statement of Accepted Facts (SOAF), the entire case file, and your questions.

QUESTION#1: Do the chest x-rays/CT scans show characteristic abnormalities of CBD?

ANSWER#1: No. Please see discussion for details.

QUESTION#2: Are the arterial blood gas tests indicative of restrictive or obstructive lung physiology?

ANSWER#2: No. Please see discussion for details.

QUESTION#3: Do the records reflect a clinical course consistent with a chronic respiratory disorder?

ANSWER#3: Yes. Please see discussion for details.

QUESTION#4: Do the pulmonary function tests (PFTs) show a restrictive or obstructive lung physiology or diffusion lung capacity defect that is consistent with CBD?

ANSWER#4: Yes. Please see discussion for details.

QUESTION#5: Do the pathology reports show findings consistent with CBD?

ANSWER#5: No. Please see discussion for details.

DISCUSSION: #1. Chest radiograph and CT scan reports. The reports in the file are

DISCUSSION: #1, **Chest radiograph and CT scan reports:** The reports in the file are cited chronologically. Listings are for conventional chest radiographs (non-CT) unless stated otherwise:

- 01/20/70: normal
- 01/18/77: normal except for increased density near the junction of the heart and diaphragm on the right thought to be either "chronic change" or subsegmental pneumonia.
- 02/06/79: early hyper-expansion consistent with emphysema, mild fibrosis right middle lobe (Dr. Boom) – (NOTE: admission film after a chlorine inhalation injury – Dr. Shields referred to this chest radiograph as normal – see notes in clinical course, below).
- 02/07/79: normally expanded and aerated lungs with no sign of active parenchymal disease, no detectable change from yesterday's film (Dr. Chumley).
- 12/17/79: both lungs show some linear fibrosis and no definite acute parenchymal disease.
- 03/15/86: very hyperinflated lungs indicating advanced emphysema, small calcified granuloma in right lower lobe.
- 03/09/88: hyperaerated lung fields consistent with obstruction, no acute infiltration.
- 05/01/88: hyperinflated lungs consistent with obstructive lung disease; left and right lungs clear except for some very minimal interstitial infiltration in the medial aspect of the right lung base – probably mild interstitial pneumonitis, right medial base. (NOTE: portable film technique – treated for COPD with infection, see clinical course notes)
- 05/04/88: hyperexpansion consistent with COPD, no active infiltrate, density right base is less prominent – appears to be pulmonary blood vessels.
- 07/02/88: interstitial lung disease is present with what appears to be some basilar fibrosis, no definite pneumonia; chronic lung disease with basilar fibrosis. (NOTE: was treated with antibiotics for possible pneumonia – see notes in clinical course section; also – this film was done with a portable chest radiograph machine – can be suboptimal technically).
- 07/18/88: advanced COPD with markedly hyperinflated lungs, no acute pulmonary infiltrate.
- 12/21/89: hyper-expanded lungs, left perihilar mass, no other lesions of the lung fields.
- Chest CT 12/22/89: left upper lobe mass, no other lung nodules, slight soft tissue prominence in the left hilum, no other abnormalities noted.
- 01/26/90: left perihilar mass, hyper-expansion of lungs indicating COPD.
- 05/17/90: left perihilar mass, hyperaerated lung fields.
- 08/02/90: no sign of recurrent tumor in left anterior upper hilum, scarring seen (prior radiation therapy), diffuse signs of chronic lung disease present (pulmonary emphysema).
- 11/01/90: over-expanded lungs, left hilar fullness and probable fibrosis in that area.
- 01/01/91: hyper expanded indicating COPD, left hilar mass, enlarging.
- Chest CT 01/02/91: left perihilar mass smaller; tiny stellate parenchymal scar right upper lobe, focal area of scar at left heart border.
- 03/07/91: COPD, left hilar mass, lingular pneumonia.

Chest CT 03/19/91: enlarging lingular mass with signs of obstructive pneumonitis; remainder of lungs well inflated with no other abnormalities noted, "No other significant pathologic process" (Dr. Riggs).

04/17/91: markedly hyperaerated lungs, large left suprahilar mass, left lower lung field pneumonia (acute infiltrate) with a small pleural effusion.

In summary, the chest radiograph reports evolve from normal to showing hyper-expansion/hyperinflation of COPD/emphysema. A few readings of conventional chest radiographs refer to signs of fibrosis in several areas of lung – these findings are not consistently present and correlate with occurrence of a chlorine inhalation injury, complication of COPD with infection and/or pneumonia, and post-radiation treatments for lung cancer. The reports of the chest CT scans, which are more sensitive to the presence of fibrosis, have reports that do not mention focal scars likely related to healed infection, but no interstitial fibrosis, diffuse interstitial fibrosis, scattered round opacities or nodular densities, ground glass opacities, scattered reticular-nodular densities, or septal lines, consistent with or characteristic of CBD¹. In my opinion with a reasonable medical certainty, the available chest radiography does not show characteristic abnormalities of CBD, even on an at least as likely as not basis.

#2, Arterial blood gas (ABG) tests: The following test reports were found in the file:

01/23/77 ABG normal;

05/03/88: ABG with 93% saturation while breathing 2L/min supplemental oxygen.

07/02 and 7/06/88: ABGs with 90-91% on room air.

12/89: three serial ABGs with pO₂s 50-59mmHg, oxygen saturations 82-85% on room air.

04/17/91: ABG normal on 2L/min supplemental oxygen.

10/01/91: two ABGs; pO₂ 55, saturation 82% on room air – corrects to 93 and 95 respectively with 2L/min supplemental oxygen.

In summary, the reports range from normal to showing arterial oxygen desaturation, corrected well with supplemental oxygen treatment, and correlate well with Mr. Freeman's infectious exacerbations of his COPD. In my opinion with a reasonable medical certainty the ABG results are too non-specific to support presence of restrictive or obstructive lung physiology, even on an at least as likely as not basis.

#3, Clinical course consistent with a chronic respiratory disorder: The records show the following, which in my opinion with a reasonable medical certainty reflect presence of chronic respiratory disorder of COPD/emphysema from 1977 until his death, and of lung cancer from 1989 until his death:

Dr. Coyer's 01/17/77 hospital admission note refers to a history of cigarette smoking and having been told he has early emphysema; no cough, phlegm, wheezing; lung exam hyperresonant with reduced breath sounds at the bases – diagnosis of COPD listed. A 03/10/77 note from Dr. Coyer states his pulmonary function test showed mild small

airways obstruction and he was felt to have severe emphysema with pulmonary artery hypertension; discharge diagnoses included COPD/emphysema.
hypertension; discharge diagnoses included COPD/emphysema.

02/06/79: admitted to the hospital with a chlorine gas inhalation injury – had shortness of breath, tightness in chest, difficulty breathing, and wheezing; admission chest radiograph normal, had bilateral wheezing on exam; symptoms and physical exam of the lung improved and he was discharged the next day (Dr. Shields).

On 12/17/79 Dr. Brigance noted smoking three quarters packs of cigarettes daily; has chronic lung disease with mild emphysema and shortness of breath on exertion; lung exam with increased chest diameter and rhonchi.

On 03/18/86 Dr. Shields noted emphysema.

On 05/01/88 he was hospitalized for treatment of COPD with infection. On admission, Dr. Culbertson noted past history of smoking, current respiratory failure, severe COPD; pO₂ was 47; he received multiple treatments including bronchodilators, corticosteroids, antibiotics, and supplemental oxygen.

Dr. Jaafar interpreted the 05/03/88 PFTs as showing moderate to severe obstructive lung disease with severe hyperinflation air trapping, severe impairment in diffusion, adequate oxygen tension on supplemental oxygen without any significant desaturation; results compatible with emphysema.

Dr. Clarke admitted Mr. Freeman to a hospital 07/02/88 for shortness of breath and chest congestion, an exacerbation of COPD and possible pneumonia; treated with modalities as in May. He was discharged 07/07/88 by Dr. Culbertson for respiratory failure, COPD with infection, and cor pulmonale.

Admitted to the hospital 12/21/89 for exacerbation of COPD with cough, phlegm, and trouble breathing; found to have a left lung mass. Treated for COPD with infection (*Hemophilus*), respiratory failure, and cor pulmonale, and had bronchial washings and lung biopsy (anterior segment left upper lobe) showing poorly differentiated large cell adenocarcinoma of the lung; signs of acute and chronic bronchitis were found on bronchoscopy, but no bronchiectasis.

Hospitalized for exacerbation of COPD 01/01/91; found to have pneumonia, received treatments including antibiotics, corticosteroids, and bronchodilators.

Dr. Locken on 06/13/91 reported that radiation treatments of the lung cancer (6000R) were completed 02/15/90; records show that the lung mass decreased in size but Dr. Locken reported that on a 03/19/91 CT the lung mass was felt to have increased in size.

Death certificate 08/05/91: immediate cause of death listed as cardiac arrest, as a consequence of cancer of lung. No other consequential or other significant conditions listed.

#4, Pulmonary function tests (PFTs): The file contains the following PFT:

PFT 05/03/88 shows FEV₁ 1.26L (43%) with FEV₁ /FVC 55% and no improvement after bronchodilator treatment. Total lung capacity was 105%, residual volume 217%; diffusion capacity 17%.

The test report confirms obstructive physiology and excludes the presence of restrictive physiology. CBD can occur with either normal, obstructive, restrictive, or mixed obstructive/restrictive physiology; diffusion capacity can be normal or reduced. In my opinion with a reasonable medical certainty the PFT report shows obstructive physiology and a diffusion capacity defect that are consistent with CBD.

#5, Lung pathology: The file contains the following lung pathology reports:

12/23/89: bronchial washings: mixed epithelial cells with macrophages and neutrophils, many malignant cells.

12/23/89: bronchial biopsies: some normal epithelium and some fragments with extensive invasion by poorly differentiated adenocarcinoma; no fungi on special stains.

12/26/89: 24 hour sputum collection: smears and cell blocks showed acute inflammation with polymorphonuclear cells, superficial squamous cells, and histiocytes; no malignancy identified.

In summary, the reports do not show any diffuse interstitial fibrosis, lymphocytosis, or non-caseating granulomas². In my opinion with a reasonable medical certainty, the available lung pathology reports do not show findings consistent with CBD, even on an at least as likely as not basis.

References:

1. Copley S, Hansell DM. Imaging, chapter 31 in: Hendrick DJ, Burge PS, Beckett WS, et. al. (eds). Occupational Disorders of the Lung. WB Saunders, London, 2002:498.
2. *Ibid.*, 168.

As required by the U.S. Department of Labor EEOICP Guidance for District Medical Consultants (DMC Handbook) issued 08/28/08, the following statement is made: "I certify that I am an expert in the required areas of medical expertise for the issues raised in this case and this is my objective medical opinion provided in accordance with the DEEOIC program procedures and guidelines. I also certify that I neither have now, nor have had in the past, any relationship with the claimant, his/her physicians, their attorneys, representatives or any employee, employer, manufacturer or entity that may be connected with this case that would influence my opinion in any way. I also certify that my opinion was not influence by any financial consideration that may benefit me, my family or my heirs".

CLAIMANT ATTACHMENT 002
PAGE NO. 2 PAGES

STATEMENT OF ACCEPTED FACTS

Ezra A. Freeman
File Number [REDACTED]

Mr. Ezra A. Freeman was born on [REDACTED]. He died on August 5, 1991. Cause of death is listed as cardiac arrest and cancer of the lung (diagnosed 1.5 years prior to death)

Mr. Freeman worked at the Paducah Gaseous Diffusion Plant (GDP) as a laborer and electrician for various subcontractors during the following employment periods:

07/01/1951 to 12/31/1951
07/01/1953 to 10/31/1953
10/01/1953 to 12/01/1953

Employment dates were verified using Social Security earning records and affidavits. There are no Department of Energy (DOE) records.

The condition being claimed is pre 1993 chronic beryllium disease.

As a laborer and electrician, the employee was exposed to radiation, beryllium, asbestos and other toxic chemicals.

Medical evidence included the following:

- History of COPD and emphysema
- ABG dated 01/23/1977 and 04/19/1991
- Chest x-ray dated 02/06/1979 – indicating mild fibrosis
- Chest x-ray dated 12/17/1979 – indicating linear fibrosis
- Chest x-ray dated 03/15/1986 – indicating advanced emphysema, small calcified granuloma in right lower lobe
- PFT performed on 05/3/1988
- Chest x-ray dated 05/01/1988 and 05/04/1988
- Chest x-ray dated 07/02/1988 – indicating chronic lung disease with basilar fibrosis
- Discharge Summary dated 07/07/1988 indicates the employee was diagnosed with respiratory failure, COPD with infection, cor pulmonale and hypercholesterolemia.
- Chest x-ray dated 12/21/1989 and 12/22/1989
- Bronchoscopy on 12/23/1989
- Pathology Report dated 12/23/1989 – diagnosed lung cancer
- Discharge Summary dated 12/26/1989 indicates left upper lobe large cell carcinoma and severe COPD
- Pathology Report dated 12/26/1989

- Chest x-rays performed on 01/26/1990, 05/17/1990, 08/02/1990, 11/01/1990 (probably fibrosis), 03/07/1991, 03/22/1991, 04/17/1991
- Pathology report dated 01/03/1991 – fiberoptic bronchoscopy with biopsy
- CT Scan of the chest dated 03/19/1991

Medications:

- Sinemet, Procardia, Trental, Ceclor, Persantine, Theo-Dur, Atrovent inhaler, and other drugs

Judy K. Allen
Judy K. Allen
Senior Claims Examiner

11-20-2008
Date

To whom it mt concern

August 24- 2008

Mr. Green worked in the c 340 building most of the time he was in operations . I was the building supervisor, Mr Green reported direct to me or through his shift foreman .

Dave worked mostly in the "Metals area " where UF4 was converted from powder to uranium metal. Some of the metal was then cast and sawed into parts need by the coustermer.

The most radioactivs operation was to clean the graphite crucible after each pour. Most of the radation did not reach the monitors as it was normally wore over the heart area . cleaning of the crucible required an arm and head inside the crucible to reach the bottom but the monitor did not get inside.

As reactor fuel was returned for reprocessing several trace elements such as beryllium got into the cascade and then into the urnium metel . Exposure to these " trace " elements were in the metal when sawed and processed bty theoperators

These elements were not identified to us do to security reasons , but only referred as trace elements.

I hope this clears up some what Mr. Green worked with in c 340.

Robert Jessing Building Supervisor



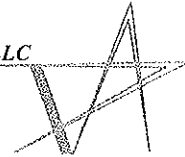
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COMMONWEALTH ENVIRONMENTAL SERVICES, LLC

"A Native American - Woman Owned Company"



Fax Cover Sheet

To: Rachel Leiton, Jim Bibeault,
Hon. Secretary of Labor
Hilda Solis

From: Gary S. Vander Boegh

Fax: (202) 693-1465
(904) 357-4704
(202) 693-6111

Date: 4-7-11

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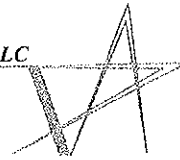
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