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DEPARTMENT OF HEALTH, BUREAU OF RADIATION CONTROL
ADVISORY COUNCIL ON RADIATION PROTECTION

(Pages 1 - 136)

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APPEARANCES

ADVISORY COUNCIL MEMBERS:

WARREN JANOWITZ, Chairman
ALBERT TINEO
CAROL BONNANO
EFSTRATIOS LAGOUTARIS
KATHLEEN DROTAR
MARK SEDDON
PATRICIA DYCUS
PAUL BURRESS
RANDY SCHENKMAN
TIM RICHARDSON
TIMOTHY WILLIAMS
WILLIAM ATHERTON

DEPARTMENT OF HEALTH MEMBERS:

JANET COOKSEY
JAMES FUTCH
BRENDA ANDREWS
VICTOR JOHNSON
GAIL CURRY
YVETTE FORREST
JERRY BAI

P R O C E E D I N G S

* * * * *

THE CHAIRPERSON: Good morning.

ATTENDEES: Good morning.

THE CHAIRPERSON: We have full council here today.

I think we should probably start off again by everybody introducing themselves. Go around the table.

DR. LAGOUTARIS: Good morning. I'm Stratis Lagoutaris. I'm a podiatrist in Jacksonville Beach.

MR. RICHARDSON: Good morning. Tim Richardson. I represent the Florida Society of Radiologic Technologists.

MR. SEDDON: Mark Seddon. I'm a medical physicist. I represent the -- public --

MR. BURRESS: Paul Burress, health physicist, representing the Florida Chapter of Health Physicians.

MS. DROTAR: Kathleen Drotar. I'm the radiologic technology therapy member, and I work at Keiser University.

MS. COOKSEY: Janet Cooksey for the Bureau.

1 MS. ANDREWS: Brenda Andrews with the
2 Bureau of Radiation Control.

3 DR. SCHENKMAN: Randy Schenkman,
4 radiologist, now retired.

5 MR. FUTCH: James Futch, Bureau of
6 Radiation Control.

7 MR. JANOWITZ: Warren Janowitz, nuclear
8 medicine physician, Baptist Hospital, Miami.

9 MR. JOHNSON: Victor Johnson, director of the
10 Division of Emergency Preparedness & Community
11 Support.

12 MR. BAI: Jerry Bai, field operations for
13 Bureau of Radiation Control.

14 MS. FORREST: Yvette Forrest, Bureau of
15 Radiation Control, radiation machine program.

16 MS. BONNANO: Carol Bonnano, representing
17 the Florida Nuclear Medicine Technologists.

18 MS. CURRY: Gail Curry, medical quality
19 assurance. We do the licensing.

20 MR. WILLIAMS: Tim Williams, Oncology,
21 Boca Raton, Florida Radiologic Society.

22 MS. DYCUS: Patty Dycus, registered
23 radiologist assistant.

24 MR. TINEO: Albert Tineo, Halifax Medical
25 Center in Daytona Beach.

1 MR. ATHERTON: Bill Atherton, chiropractic
2 radiologist in Miami.

3 THE CHAIRPERSON: Well, thank you all for
4 being here. I guess the first order of
5 business this morning is the approval of the
6 minutes from the last meeting.

7 Has everyone had a chance to look at that?
8 Do we have any corrections or changes?

9 (No response.)

10 MR. WILLIAMS: Move to accept.

11 THE CHAIRPERSON: Second?

12 MS. BONNANO: Second.

13 THE CHAIRPERSON: All in favor?

14 EVERYONE: Aye.

15 THE CHAIRPERSON: Okay. I guess we can
16 move along relatively quickly.

17 Janet Cooksey?

18 MS. COOKSEY: Good morning. Cindy
19 couldn't be here today, so she asked me to give
20 you a couple updates.

21 The two biggest ones are: We hired two
22 administrators. The radiation machine
23 administrator is Yvette Forrest, and we've got
24 the time later on the agenda for her to go into
25 her background.

1 And the administrator for our field
2 operations and training and quality assurance
3 is Jerry Bai. And he'll be also giving us more
4 updates.

5 We also have with us Victor Johnson, our
6 division director. And we moved into -- with
7 the reorg last year, we moved into the new
8 division, and he came on as director.

9 Do you have anything you want to say,
10 Victor?

11 MR. JOHNSON: Good morning. This is the
12 first time I've been able to make it to
13 advisory council meeting. Thank you for
14 letting me join you. And I'm hoping to learn a
15 lot today, and I'm sure

16 MS. COOKSEY: The other thing, if you
17 look, we have the org chart which just shows
18 those changes, but we also -- in the next part
19 of the tab, we have a couple of rule updates.
20 And the first one is our general definitions.
21 We -- and the second part is our fluoro rule.
22 We made some changes.

23 We talked about those probably a couple of
24 years ago now, some things that we needed to
25 clarify. And we made those changes in the

1 definitions. We updated numbers 187 and 188,
2 and we added 193 and 194.

3 (Pause.)

4 MR. FUTCH: Tab B?

5 MS. COOKSEY: Tab B. And they all have to
6 do with the fluoroscopy systems. And then in
7 the fluoroscopy updates, we provided -- wanted
8 to provide some clarification on requirements
9 for the facilities. Part of this was the
10 manufacturers trying to make it easier without
11 losing any of the safety requirements.

12 THE CHAIRPERSON: Anybody else we need to
13 discuss about this? Anyone have any questions
14 about this?

15 MR. BURRESS: No.

16 MS. COOKSEY: We also have some other rule
17 changes that we're working on right now.
18 Several of them were in the promulgation
19 process, so we can't actually discuss the
20 contents of the rules, but I can give you the
21 status of the updates on them.

22 In the 64E-5 in the RAM, radioactive
23 materials part of the rules, we are making some
24 NRC-compatibility changes, and that is
25 currently under review by the Joint

1 Administrative Procedures Committee, and we
2 hope that that'll be moving along soon to be
3 adopted.

4 The specialty tech rules have been taken
5 to the Department of State for adoption, and we
6 hope that those are final around June 11th.

7 And we received the PET standards and have
8 now started that part of the specialty tech
9 rules in the system. Those haven't been
10 published yet, but they've been sent through
11 the Department for review of those forms.

12 We also on -- James, do you want to talk
13 about the Nonionizing rules?

14 MR. FUTCH: Sure. 64E-4 is Control of
15 Nonionizing Radiation, and it governs lasers
16 predominantly at this point. And the Joint
17 Administrative Procedures Committee sometime, I
18 think it was last year, had identified certain
19 parts of that rule that needed to be corrected
20 or updated.

21 There's some places where the address for
22 reporting some incidents was on the
23 registration form, but it wasn't actually in
24 the text of the rule itself, so we've added
25 that, basically our address and phone number

1 and contact information, into the body of the
2 rule itself.

3 There are other references to Title 21 of
4 the Code of Federal Regulations, which is the
5 FDA laser manufacturer, laser device standards
6 at the federal level.

7 The way we had referenced 21 CFR, we
8 didn't quite like the way we did that, so JAPC
9 went back and changed the reference to what
10 they thought was proper and correct. None of
11 it really changed anything of substance in
12 64E-4. It was just what we considered to be
13 technical changes, but JAPC wanted us to go
14 through the full promulgation process, so
15 that's where it's gone now.

16 MS. COOKSEY: And then the last one is --
17 the Department is working on an initiative to
18 reduce regulations, and so we have been
19 reviewing all of our rules and looking at the
20 statutory cites of the law implemented, making
21 sure everything's up to date, going through,
22 making sure our incorporated documents and
23 forms are all up to date. Anything that might
24 be repeated that's in the statute repeated in
25 the rule, we're reducing those so it's not

1 confusing, and just kind of cleaning them up.
2 And that process will be ongoing for a while,
3 'cause -- well, the whole Department's going
4 through it, and then, of course, it's now in
5 Legal for them to review. But just our
6 Bureau's rules alone, we have 330, so it's
7 taking some time.

8 MR. FUTCH: All the state agencies are
9 going through that.

10 MS. COOKSEY: As far as I know.

11 THE CHAIRPERSON: This is for reducing
12 radiation exposures, right?

13 MR. FUTCH: No, this is reducing
14 regulatory burden. And this one is a line --
15 recounting -- I don't know if you remember this
16 or not, but back in the '90s, during the Chiles
17 administration, we went through something
18 similar. And, at that point in time, it was a
19 rule reduction. And rule reduction back then
20 meant actually eliminating rules. So
21 64E-3.001 -- that's one of the rules -- .002,
22 that's two rules.

23 This one is not looking at the rule
24 numbering. They're looking at the number of
25 lines of text. And if anybody has ever seen

1 64E-5 in its entirety, it looks like the New
2 York City phone book. It's a little on the
3 thick side. So there's lots of areas to look
4 at, and that can be reduced to -- to achieve --
5 anybody knows what the goal is, the stated
6 goal?

7 MR. JOHNSON: Fifteen percent.

8 MR. FUTCH: Which is better than the '90s.
9 I think it was 33 percent back then.

10 MR. JOHNSON: I just want to applaud
11 everybody's efforts on this. This was not --
12 no easy -- not an easy task. They went through
13 every single rule that was on the books and
14 made some very, very good recommendations that
15 had no negative effects that we could perceive
16 for the program. So I was very impressed on
17 how well it was done.

18 MS. COOKSEY: That's it.

19 THE CHAIRPERSON: Okay. The next item on
20 the agenda is introduction of my
21 administrators.

22 So, Yvette, you want to go first?

23 MS. FORREST: Okay. As I was introduced
24 before, my name is Yvette Forrest. I am the
25 newbie on the block, so to speak. I've been

1 with the Bureau a whopping 23 minutes, so to
2 speak. I came on board in February. I just
3 got back a few days ago from the CRCPD
4 conference in Oregon, and it was absolutely
5 fabulous. Had a great time. Met a lot of
6 wonderful people and sat through some really
7 engaging seminars. So ... other than that, a
8 little bit of background about me.

9 I am a radiological technologist from a
10 thousand years ago, where I graduated from
11 Riverside School of Radiologic Technology in
12 Hampton Roads, Virginia, where I was born and
13 raised in Poquoson, Virginia.

14 My professional career, I've been a
15 radiologic technologist, a radiology
16 coordinator, and most recently, before joining
17 the Bureau, I had stepped out of the field of
18 radiology for many years and owned my own
19 business which I sold last year. So -- gosh,
20 couple of months ago, actually, not all of it
21 was last year. But, anyway -- and last year I
22 was the Jacksonville business -- small leader
23 business -- small business leader of the year
24 for the council.

25 I kind of have an unusual skill set to

1 bring to the Bureau, and I think that's kind of
2 what made me attractive to them. I know that I
3 have enjoyed my time with the Bureau, and can't
4 really retire, because I have an 18-year-old
5 going off to college, the same year as I have a
6 kindergartener. So they're stuck with me. So
7 you guys will see me a lot.

8 I look forward to the advisory council
9 meeting today simply because I have a lot to
10 learn, as this is a growing process for me.

11 One thing I'll tell you about the program,
12 though, we are in a stage of flux, but it's an
13 exciting change. I'm looking forward to the
14 challenges and things that we've already
15 implemented.

16 We are tackling some training issues, some
17 program issues, training with both staff and
18 with processes, and also with equipment. So we
19 are kind of taking all -- all challenges head
20 on, and making some vast improvements to make
21 the program the best that it can be.

22 We've got a few other states that we're
23 going to -- we're determined to beat, so within
24 the next two years, Florida's machine program
25 is going to be the best. And that's not just

1 fluff. That's a fact.

2 So with that being said, I'm going to let
3 Jerry take it over.

4 MR. BAI: I guess a lot of you I've met at
5 one time or another, or many times in the past.
6 And just about every one of you have dealt with
7 field operations for radiation control, which
8 being an inspector for that, come into your
9 facility. But they made me administrator for
10 field operations.

11 Now, I was ... area manager for the
12 central inspection office prior to that, but my
13 main functions would be coordination of all
14 x-ray inspections, all radioactive license
15 inspections, incident response in the field,
16 and any type of support for any other Bureau
17 radiation control programs we have. That's me
18 up there.

19 So, any type of dealings with inspection
20 staff, that would be through me. And if you go
21 to the next slide there. We would also
22 coordinate all the field investigations through
23 the area offices and support for programs and
24 agencies could be anything and almost
25 anybody -- anyone from FDA to FBI to Yvette's

1 programs to James' program. And then we also
2 perform the power plant exercises.

3 Next slide. Basically, we represent about
4 11 regions around the state. Some of these
5 regions are represented by one person,
6 depending on the population and density of the
7 area. Usually, industrial licensees coincide
8 really close to the population density in that
9 area.

10 We have five main offices and,
11 additionally, we have two county programs.
12 That would be Broward and Polk counties.

13 And, in addition to that, each of the
14 field office inspectors is equipped with a
15 vehicle, and they each have a full load-out of
16 emergency equipment so that they can respond at
17 any time.

18 We have on-call staff who are on duty
19 24-7. They're -- that emergency number you see
20 on -- when you call that, one of the inspectors
21 gets called. And that's at any time, even
22 holidays.

23 My background ... I've been with the
24 Bureau approximately about 16 years, something
25 like that. I forget. It's a long time ago.

1 But my background, I've got a radiological
2 technology background, Bachelor's in that.
3 I've got an engineering background. I've
4 pretty much been with the Bureau ever since.

5 I got an e-mail inviting me to the
6 meeting. I'm here, and hopefully I'll pick up
7 some stuff.

8 MR. FUTCH: Jerry, how many inspectors do
9 you have statewide?

10 MR. BAI: Just get a -- approximately --
11 well, it depends. I mean, do you -- do you
12 still consider me an inspector? I mean -- and
13 the managers, are they still inspectors?

14 MR. FUTCH: Yeah. We'll count them, too.

15 MR. BAI: Yeah. Approximately 30
16 full-time inspectors, somewhere around there,
17 plus you got the area offices with the
18 managers, and we have some other additional
19 staff who are non-inspectors. We think the
20 numbers came out, we perform 17,000 tube
21 inspections annually. I think we additionally
22 perform around 700 or so radioactive license
23 inspections annually, as well. Depending on
24 the year, if it's a good year, 200 plus
25 incident response, anywhere from junkyards to

1 somebody lost a source.

2 And I'm not sure, we -- investigations,
3 probably along the same order as the incident
4 response. Investigations would be anything
5 that is not involved in the radioactive
6 material.

7 Ecology, somebody just had a concern.
8 Could be anything.

9 MR. FUTCH: Any questions?

10 (No response.)

11 THE CHAIRPERSON: How often do you
12 inspect

13 MR. BAI: Well -- you're talking about
14 radioactive materials?

15 THE CHAIRPERSON: Oh, both.

16 MR. BAI: Different types of inspections
17 or different frequency. Accelerators would be
18 every year. HDR's would be every year. Food
19 irradiators would be annual. Most radiographic
20 x-ray facilities are ... every other year.
21 Veterinarians would be every three years.
22 Dental, every five years. Depends.

23 THE CHAIRPERSON: Okay. Thank you.

24 MR. JOHNSON: Like I said, I'm Victor Johnson.
25 I'm the director of the Division of Emergency

1 Preparedness & Community Support. I've been
2 with the State of Florida for 20 years, and
3 I've been with the Department of Health since
4 January of 1997, so that's part of the group
5 that actually joined when we were first forming
6 the Department. We were -- I helped with the
7 Division administration for six months prior to
8 coming into the Department.

9 My last position was with the Division of
10 Emergency Medical Operations, and that
11 eventually turned into the Division of
12 Emergency Preparedness and Community Support.

13 We have five Bureaus in our division. We
14 have the -- of course, the Bureau of Radiation
15 Control, the Bureau of Public Health
16 Pharmacies, the Bureau of Public Health
17 Laboratories, the Bureau of Emergency Medical
18 Oversight, and the Bureau of Preparedness and
19 Response.

20 And one of the main reasons why we are all
21 together is that preparedness and response are
22 linked. We very often are working together
23 when it comes to any type of radiological
24 issue, when it comes to preparedness or
25 response, and we've been partners for many,

1 many years, and I'm very happy to be part of
2 the team with the Bureau of Radiation Control.

3 I've been very impressed just by every
4 time -- the different products that we've been
5 able to work on since July of last year. And
6 I'm looking forward to continuing partnerships,
7 and hope that us being part of the same
8 division, we can really do some things that
9 will enhance the capabilities and protection
10 for the State of Florida. Thank you for
11 inviting me here.

12 (Pause.)

13 THE CHAIRPERSON: Anyone else?

14 Okay. The next item on the agenda is the
15 MQA update.

16 MS. CURRY: Good morning, everyone. It's
17 very nice to be here again. I always enjoy
18 coming to these meetings.

19 I was just going to give you some numbers
20 and some things that are happening with MQA. I
21 ran some numbers from January 1st until May --
22 I don't remember, but it was Thursday. And in
23 that time we've received 2,912 applications
24 online. We received 1,356 applications by
25 mail, for a total of 4,268 applications. Now,

1 that's just since January 1st.

2 As you-all know, if you are in education,
3 we are now in the middle of graduation. Well,
4 we're actually tapering down, but we are also
5 licensing paramedics in our office, along with
6 the rad techs, so we're quite busy right now.

7 Our online applications, we're doing those
8 in 3.65 days; that is, either approved for
9 examination, or approved for licensure,
10 depending on how they're coming in. And of the
11 paper applications, we're approving those in
12 6.28 days.

13 So, you can see that our online
14 application has really helped us as far as our
15 processing time. Actually, we went from, like,
16 17 days, when we were complete with the
17 application by mail, paper applications, so we
18 were at about 17 days average getting those
19 done, and as you can see, we've dropped down to
20 either three or six days.

21 Some of those are also because we're not
22 getting the money in quick enough, whereas ...
23 if we were to go to Wal-Mart and we swipe our
24 debit card, it comes out of our bank
25 immediately.

1 Well, when you do that with your online
2 application, the way it's set up with the bank,
3 it can take three to ten days for us to
4 actually get that money. So until we actually
5 get the money deposited into MQA's trust fund,
6 we cannot work that application. So MQA is
7 working with the bank on a new contract that
8 that money will be deposited immediately, which
9 will drop our days down even further than what
10 we're seeing now.

11 We've actually processed five applications
12 in one day. That's 'cause the money was there.
13 So I see that happening in the future. If we
14 can get the money in quicker, the days will go
15 down. So, I'm really excited about that.

16 Also, MQA is promoting changes to our
17 database on Thursday, May 31st, to coordinate
18 with the date of the rule-change acceptance, as
19 Janet mentioned, will be June 11th, so we'll be
20 up and running, ready to go far before
21 June 11th. So we -- we're ready. That is it.

22 Anybody have any questions for me?

23 DR. SCHENKMAN: Why does it take so long
24 to do the paper applications?

25 MS. CURRY: Because when a paper

1 application comes in, it doesn't come directly
2 to our office, it actually goes to the
3 mailroom, then goes to another department that
4 actually puts the information in, deposits the
5 money, and then it'll come to us. So that's
6 about a two- to three-day process once it hits
7 the Department of Health in the mail; whereas,
8 the online application is -- you know, there's
9 no paper to go anywhere. It's all already
10 input into the system. We can see it
11 immediately.

12 (Pause.)

13 THE CHAIRPERSON: Any thoughts about going
14 totally online?

15 MS. CURRY: We would love to, and that is
16 in the process. They are looking at that, but
17 funding is an issue, as always. But we would
18 like to, in the future, see going to being able
19 to -- like with our EMT and our paramedics and
20 our rad techs, there's certain information that
21 we still have to get in by fax or e-mail, like
22 the four-hour HIV course completion.

23 So, we're hoping that, in the future,
24 we'll be able to have the applicant actually
25 scan those documents into the online system,

1 where it will be available to us immediately,
2 just like the application is. So, yes, we are
3 looking into that.

4 And we are also -- we're also looking at
5 if you do a reapplication for any reason, if
6 you fail your exam the first time, don't show
7 up, and have to do a new application, that
8 application must be paper at this time, because
9 the way our system is set up, it pings off of
10 your Social Security number. Well, it should
11 ping off your Social Security number, but it
12 doesn't. It actually sets you up a whole new
13 file. So then we have to go in and merge
14 everything back together, and it becomes a real
15 mess if you're not real careful.

16 So, right now, your re-exam applications
17 all have to be paper. So they are working on
18 that, also, which will help speed up that
19 second application process, also.

20 I guess that's it.

21 THE CHAIRPERSON: I know this isn't on the
22 agenda. Maybe you don't even know the answer,
23 but we do have a lot of time this morning, so
24 just as a general question where maybe anyone
25 can answer this.

1 What does the current job outlook look
2 like for your RTs?

3 MS. CURRY: I don't have the answer to
4 that question. When we get that question in,
5 we just always refer them to the Florida
6 Society.

7 MR. FUTCH: Maybe Kathy or Tim could
8 address that. I mean, most of the programs are
9 in there.

10 MS. DROTAR: I can speak to my program.
11 I've got about a -- an 80 percent placement
12 rate over the last five years. And my
13 people -- grads graduated April 28th, and three
14 of them had jobs already when they were -- when
15 they graduated. And I think three more of them
16 are still -- so there are 13 grads. So half of
17 them are employed.

18 So it ... it varies, depending on the
19 time, you know, but we have quite a few down by
20 us. We have quite a few outpatient facilities
21 and doctors' offices, so they tend to pick
22 things up rather quickly, so it hasn't been too
23 bad for that group of students.

24 MS. FORREST: Is your program strictly RTs
25 or basic medical operators?

1 MS. DROTAR: Oh no we're just RTs. Yeah,
2 just radiology.

3 MS. FORREST: I know, six or seven months
4 ago, Mayo, in Jacksonville, had a position
5 open, and they had 89 applicants for one
6 position, and two of them are from Texas, for
7 an RT position.

8 MS. DROTAR: Yeah, they get a lot of
9 applications.

10 MS. FORREST: It's tough.

11 THE CHAIRPERSON: Yeah, I know the nuclear
12 medicine technology job market is not very good
13 right now.

14 DR. SCHENKMAN: It's not good.

15 THE CHAIRPERSON: We let those ... okay.
16 I guess we'll move on to Mr. Futch.

17 MR. FUTCH: Over to me. We have some
18 different things this morning. In May, I was
19 asked to go and speak at the Florida Nuclear
20 Medicine Technology annual meeting about the
21 specialty technologists licensure, which Janet
22 had mentioned this morning. The rule is going
23 to be adopted officially on June 11th. And
24 Gail mentioned that we're ready to take
25 applications --

1 MS. CURRY: We're ready.

2 MR. FUTCH: -- then. But it was the first
3 time I had spoken to that group. I was
4 actually surprised. It's a very large group.
5 I was there on a Thursday afternoon, the second
6 speaker after the opening speaker at
7 two o'clock, and there was 150 people in the
8 audience.

9 Apparently, by the time you get to rolling
10 on Saturday and Sunday --

11 MS. BONNANO: There'll be 200
12 participants.

13 MR. FUTCH: Yeah, it gets even bigger.

14 So, I basically -- I talked about the
15 history of the licensure for the advanced and
16 post-primary that you-all have been helping us
17 with for, what feels like, many many years now.

18 It was very well received. We started out
19 talking about the history of licensure in
20 Florida, and then history of this particular
21 attempt to get advanced and post primary added
22 to the primary categories that we already have.
23 And, as you know, that -- that -- those
24 categories are CT, MR, and Mammography.

25 There were some folks there who were, of

1 course, from nuclear medicine background, being
2 a Nuclear Medicine Technology Society, and they
3 were all very interested in the CT category,
4 and there were many folks in the audience who
5 already had the certification in CT from the
6 AART, and they wanted me to give them an
7 application to sign up right then.

8 MS. CURRY: Oh, yeah, we're getting calls.

9 MR. FUTCH: Which we couldn't do. Gail's
10 folks at MQA actually gave us a whole bunch of
11 slides on their online application process, so
12 we took them through the online application
13 process with the draft of what it's going to
14 look like when it's effective at the end of the
15 month, as well as the paper application. We
16 revised the application that we used for many
17 years for the primary categories, and added
18 specialty categories onto that. And ...
19 surprisingly enough, didn't get too many
20 questions about mammography or MR. But I guess
21 there's other society meetings, perhaps, about
22 that.

23 And if you remember, we picked those three
24 categories because they're the most numerous,
25 according to AART's census, for Florida. There

1 are over 2,000 certificate holders in each of
2 those categories. Now, they may not be
3 mutually exclusive. There could be -- some
4 folks have multiple categories.

5 And ... the only part that, as you know,
6 is not in the current rule update that Janet
7 was talking about was the PET. They were
8 interested in that, too.

9 Mainly, the question is, do they have to
10 have the PET license to actually practice with
11 that, and the answer to that was no. But ...
12 it was -- it was a very enjoyable experience,
13 very good outreach for the Department. And
14 they were all very thankful for you folks and
15 your time and effort in trying to get the law
16 changed.

17 Actually, I have a picture of the two
18 legislators who were sponsors in the House and
19 the Senate for this particular bill up on the
20 screen. So, it was very good. I don't know,
21 you probably were not there at that --

22 MS. BONNANO: My husband was having
23 cataract surgery that day. I had to drive him
24 home.

25 MR. FUTCH: Well, hopefully, that all went

1 well.

2 MS. BONNANO: Yeah. He's so happy it went
3 so well.

4 MR. FUTCH: We were also -- we have
5 also -- just to -- even updates that we've been
6 in this morning -- wanted to mention that the
7 Department's website is undergoing a redesign
8 that's supposed to be effective on July 1st.

9 At some point, if I can actually make a
10 connection from this room, maybe this
11 afternoon, I'll show you what it looks like,
12 but it's ... it's an initiative to retool the
13 website from being kind of bureaucratically
14 organized according to divisions and programs
15 according -- instead of according to subject
16 matter.

17 And so there will be a completely
18 different look and feel to go long with the --
19 completely different look and feel of our new
20 Department's logo. You may have seen this on
21 your cards. It's ... it's kind of borrowing
22 colors and themes and fonts from that, but
23 instead of seeing all of the detailed
24 navigation that you currently see to drill down
25 to the Division, the Bureau, and rest of it

1 will start out with some key subject areas.
2 Licensure and Regulations is one key subject
3 area that's at the top level. Preparedness and
4 Response is another one. Healthy Environment
5 is yet another one, as well as ... Prevention,
6 Safety, and I think it's called "Wellness."
7 That's one group.

8 And Radiation Control will be underneath
9 all of those, and primarily will reside
10 probably under the Prevention, Safety and
11 Wellness link. And, basically, it's in
12 process. We're not exactly sure how it's going
13 to end up. And, actually, in order to make it
14 happen, we're using a completely new
15 content-management system which none of us has
16 ever touched before.

17 So, at the same time, we're building a new
18 website. We're learning to use a new
19 content-management system to build the new
20 website with. So even the more experienced
21 management people are holding weekly meetings
22 in training rooms and saying, how do you do
23 this, how do you do that? How do you get
24 around this? Well, this is what we found.

25 But it's also supposed to be effective

1 July 1st. And ... every one of those main
2 subject areas, you should be able to find
3 Radiation Control.

4 The addresses for the Department, we
5 believe that -- our current address is -- the
6 one that we hand out, the one that we usually
7 use is myFloridaEH.com/radiation, because it's
8 the shortest. That's a domain that we own, we
9 have rights to. So the thinking is that that
10 should still exist after July 1st, and that
11 will just refer people to the new location for
12 the home page of the Bureau of Radiation
13 Control.

14 The actual new website address for the
15 Department of Health is Floridashealth.com. So
16 there will be a multitude of ways to get there,
17 and we'll, of course, use, I'm sure, all of the
18 communications tools at the disposal of the
19 Department to broadcast that to the world at
20 the appropriate time; hopefully before
21 July 1st.

22 (Pause.)

23 MR. FUTCH: So that's it's for the web
24 design.

25 We've also been doing some -- some other

1 work. I just got back -- our continuing --
2 continuing assistance to law enforcement. I
3 just got back from a week in Panama City Beach
4 where the Florida Highway Patrol and the
5 Alabama State Patrol were in town for some
6 training and some maintenance on their
7 radiation-detection equipment that they used
8 for counter-terrorism purposes.

9 They had -- the defense contractor
10 Raytheon was there. Raytheon is the
11 manufacturer of about half of the radiation --
12 the mobile vehicle-based radiation detection
13 equipment in Florida, and 100 percent of the
14 radiation-detection equipment in Alabama,
15 'cause they don't have quite as many as we do,
16 so they got one from Raytheon.

17 In addition, they took delivery of some
18 new hand-held devices that are used for
19 identifying radioactive materials. And they
20 contracted with a company called Loris to come
21 down and do some training on that. And the
22 Bureau of Radiation Control, as we often do in
23 Florida, supplied all of the radioactive
24 sources for several days of training, so they
25 could use those various pieces of equipment out

1 in the field to practice what they are learning
2 in the classroom.

3 So we're there at this ... large
4 multi-towered condominium slash hotel in Panama
5 City Beach, you know, 13, 14 stories, and they
6 are one of these resorts, you know, so they
7 have like Bone Fish and some other restaurants
8 in their commercial strip mall, part of the
9 resort on the backside of the property.

10 And in between is probably -- oh, I don't
11 know, 10 acres or so of empty field that
12 they're using for, you know, future expansion
13 for their site. And in that huge field is
14 where, on one of the days, we got up early and
15 planted about eight or nine sources, all out in
16 the field. And so the two state patrols
17 descended upon the site in rotating teams.
18 They could only fit so many people into one
19 vehicle at a time. Proceeded to go out into
20 the field, and just using radiation-detection
21 equipment, try to find the various sources that
22 I had planted, which range from very small to a
23 little bit larger.

24 And the first thing that the first truck
25 from Florida does is find a 'pot' plant sitting

1 out in the field. It was in this nice little
2 growing container with a little Miracle Grow
3 supply of food.

4 MS. BONNANO: You should just leave it
5 there.

6 MR. FUTCH: Yeah, I know. And,
7 apparently, it just didn't fall out of
8 somebody's trash and grow wild in the woods.
9 It was very nicely hidden up against the tree
10 line.

11 So they called the Panama City Beach
12 police to come take a look at it. The first
13 officer who showed up apparently was not part
14 of the narcotics squad, because he wanted to
15 stake it out and see who came back to harvest
16 the plant. And then the more experienced
17 narcotic officer showed up and looked at him
18 and said, "It's just one plant. You wouldn't
19 do that unless there's a whole bunch more." So
20 they decided not to stake it out. So they
21 pulled it up.

22 MS. BONNANO: Poor little thing.

23 MR. FUTCH: And it's not exactly what I
24 expected them to find, and I didn't even notice
25 it was there. I'm not exactly focused on that

1 kind of stuff. So I had been -- these fields
2 were overgrown, and some of the places I was
3 hiding the sources were just large mounds of
4 weeds. And not that kind of weed, but you
5 know, the regular

6 So I've been driving through these
7 ten acres and, you know, after I planted the
8 first or second one and drove off and turned
9 around and looked behind me, I could see these
10 two tire tracks going straight to the source,
11 you know, the big tall weeds. And so, in order
12 to counteract that, I had been laying some fake
13 trails, as we say, out amongst the -- I never
14 saw the thing, so I don't know. I guess it's
15 all in your training and what you're looking
16 for.

17 But they actually did really well and
18 found -- I think one team found all the
19 sources. And the other ones, especially the
20 one that got diverted off on the potted plant,
21 they were a little defocused. They didn't find
22 quite everything. They were -- but they did
23 really good.

24 THE CHAIRPERSON: It wasn't a radioactive
25 'pot' plant?

1 MR. FUTCH: No, no, it was not. At least
2 it wasn't radioactive enough for them to pick
3 it up with their detectors. And ... so that
4 was the -- that was a ... an interesting
5 experience.

6 And next week, we're actually back in
7 Tallahassee. The Department of Energy is
8 coming to town to do aerial and water based --
9 water-borne detection training with the Fish
10 and Wildlife officers around the State. And
11 the Florida Highway Patrol pilots, who are
12 normally the ones who are out watching us on
13 the Interstate with the little white lines and
14 timing us to see how long it takes to get from
15 one set of white lines to the next, they're
16 going to be at the Tallahassee Airport to --
17 for several days of training.

18 They'll start out with classroom training
19 like this, and use their mobile gamma spect
20 systems that they own, and that the Department
21 of Energy brings down -- shares with the
22 southern region of Florida. And then they'll
23 proceed to using those systems inside cars,
24 because cars are cheaper to operate than
25 airplanes.

1 So they do all -- most of their learning,
2 how to operate the system in that environment.
3 Then they'll move to a day of flying. And the
4 last day, they'll move down to the coast where
5 the FWC's large ocean-going vessel is based.
6 And they'll start a day's worth of water-borne
7 exercises out in the Gulf, I guess, of Mexico.

8 And we'll be there again, supplying the
9 radioactive sources to make all of that
10 possible.

11 And as part of that, I also want to
12 mention that the Department itself, since we
13 last met in October of last year, has purchased
14 its own mobile gamma spectroscopy system that's
15 made by the same folks who made the systems for
16 the Highway Patrol and the Fish and Wildlife
17 and also Department of Energy. And we
18 purchased ours for dual use. It's to be used
19 in conjunction with law enforcement as their
20 own systems are -- FHP doesn't have its own
21 system for -- kind of borrowing one right now
22 from the Federal Government. So this will
23 provide them a way to kind of get up to speed
24 with the same kind of equipment that the rest
25 of the agencies in Florida have, by borrowing

1 ours. But, also, ours was purchased for this
2 same system, this mobile gamma spectroscopy
3 system, can be used to -- in emergency response
4 for radiological disasters, you know, for
5 Fukushima style -- nuclear power-plant
6 accidents or any kind of large spill of
7 materials.

8 You can take that same system, and through
9 the arrangements that we're working on with FHP
10 and FWC, put that system into a helicopter or a
11 fixed-wing Cessna and fly it over an affected
12 area in real time, make a map of exactly what
13 the materials are, where they're concentrated,
14 and it can actually send the data back from the
15 aircraft through some communication methods, to
16 a person on the ground, on their computer.

17 So it was a great addition for us to be
18 able to have that capability. Right now -- or
19 I should say, in the old days, before all of
20 law enforcement folks started getting these
21 systems, if we had that kind of a incident in
22 Florida, we had to wait for -- there wasn't a
23 system like that that could be flown. We had
24 to wait for the Federal Department of Energy
25 team from South Carolina or Washington or Las

1 Vegas to respond with their aerial system,
2 which is, I think the minimum for them to get
3 here is, they claim, six to 12 hours, something
4 in that nature.

5 And so, in our power plant exercises, for
6 decades, we have practiced with field-based
7 personnel, some of Jerry's staff, as Jerry
8 mentioned, with hand-held instruments being
9 directed and communicated over radios to go to
10 this intersection and stand outside and take an
11 air sample and take it back to the mobile lab
12 and have it counted and see what the -- what
13 the iodine concentration was, or read their
14 gross gamma counts at that location and tell us
15 what it was, and with stick spins, basically,
16 we would put it on a map.

17 So this is ... this is, you know, light
18 years ahead of what we used to have.

19 And we'll also be at -- in addition to
20 providing sources, we'll also have some staff
21 learning about the aerial use of these systems
22 at the training next week in Tallahassee, so we
23 can flush out and develop our own SOP for how
24 we're going to use the system in those two
25 different environments.

1 THE CHAIRPERSON: Is it mainly for
2 disaster situations?

3 MR. FUTCH: Well, the gamma spect system
4 is about 50 percent for that, and 50 percent
5 for preventing counter-terrorism issues. It's
6 the same system. It could be used either way.

7 I should mention, the systems that we use
8 in the -- most of the folks in the country who
9 are doing this have kind of settled upon --
10 especially the Department of Energy crew -- its
11 ancestry comes from the minerals exploration
12 industry, oil and gas. And these systems were
13 built to be used from airplanes to map out the
14 naturally occurring formations in the ground,
15 uranium, radium, thorium, potassiums, in order
16 to be used as one -- one data stream to try and
17 predict where they would find oil and gas.

18 So, a lot of the other systems, including
19 some of the ones that were built by defense
20 contractors, are hideously complex. I mean, an
21 entire truckful of somewhere in the
22 neighborhood of, I think, five or six computer
23 systems, all running on different boards, fill
24 up the back of an entire SUV. And if any
25 one part of that goes out, you know, it's --

1 okay, pull over to the side of the road and
2 call the defense contractor, and let's see if
3 we can figure out what part is not working.

4 The system that we purchased, it takes its
5 ancestry from the oil and gas industry. The
6 entire computer system is smaller than the size
7 of one of my computers here, my laptops on this
8 desk. And so it's this little box, a bunch of
9 cables, and then the actual sodium iodine
10 crystals which are four-by-16 inches long.

11 And you can put multiple -- whatever you
12 want your detection capability to be, however
13 much you can afford -- each crystal's about
14 \$30,000. So you can buy as many crystals as
15 you can afford. And it's not rocket science.
16 The more crystals means more targets for the
17 gamma rays to hit.

18 And it's -- it's a much better system.
19 It's recognized, and it can be used for both of
20 those missions. But it's -- since it takes its
21 ancestry from the oil and gas industry, it's
22 really sensitive enough to see the naturally
23 occurring materials. So when you're running it
24 in the back of one of our vehicles, and you're
25 looking at the display, you can actually see

1 all the peaks from the Thorium and the
2 Potassium against the background. And if
3 anything is nefarious, somebody walks by with a
4 little check source, you can actually see it
5 pop up against that background and see -- it's
6 quite remarkable. Maybe, at some point, we'll
7 bring that and show that to you, how that all
8 works.

9 So I think that's it for the PRND update.

10 DR. SCHENKMAN: Did you find any
11 difference between the Raytheon equipment and
12 whatever other equipment the Florida State
13 Troopers had?

14 MR. FUTCH: Yeah. There's -- in terms of
15 sensitivity, they're fairly close. I don't
16 want to get into too much specifics because
17 we're recording this for public use later, but
18 they're not too far off in terms of sensitivity
19 for the illicit sources that you would expect
20 to be used in a -- in a dirty bomb, cesium-137
21 or something like that, which is a pretty good
22 gamma emitter, to begin with.

23 The differences come in -- when it comes
24 down to those naturally occurring elements.
25 So, for example, if the bad guys are really

1 good at shielding their dirty bomb, the system
2 that we've got would probably be in a better
3 position to find that, because it can actually
4 see fairly low levels of really weak emissions,
5 to start with.

6 But in terms of complexity, there's a
7 tremendous amount of difference. The newer
8 systems that you've got, and the ones that FHP
9 and the other agencies have been buying for the
10 past several years, are much more reliable,
11 much less apt to have a -- a little problem
12 that requires a software engineer to go tweak,
13 and much cheaper.

14 I mean, I know \$30,000 sounds like a lot
15 for a crystal, but the original system that FHP
16 got from Raytheon was half a million dollars.
17 Of course, they're a defense contractor, so the
18 more you buy, the cheaper it becomes. It's
19 like F-18s.

20 THE CHAIRPERSON: Is that all?

21 MR. FUTCH: Well --

22 MR. SEDDON: Can I backtrack a little bit?

23 MR. FUTCH: Sure.

24 MR. SEDDON: Going back to what Janet --
25 your update. For actual regulations, the ones

1 with -- specific to fluoroscopy, those have
2 been published, correct? They're already out
3 there?

4 MS. COOKSEY: They're effective.

5 MR. SEDDON: They're effective.

6 Were those -- these ones we reviewed, or
7 is this based upon previous discussion?

8 MS. COOKSEY: It's been probably two
9 years, so I don't know if all the --

10 MR. SEDDON: We went through our
11 discussion like a couple years ago with Don.

12 MS. COOKSEY: Right.

13 MR. FUTCH: The eventual --

14 MR. SEDDON: This is the final result of
15 all that.

16 Jerry, have you had a chance to review
17 this as far as how the inspector is going to --
18 the specific question I have is the way it's
19 worded for measurement of -- for output for
20 c-arm type of units. Sort of gives you three
21 ways to ... review. So how are your inspectors
22 going to be measuring?

23 MR. BAI: So you're familiar with the
24 formal procedures?

25 MR. SEDDON: Correct.

1 MR. BAI: Which are still current. But
2 that -- that was a program, just so we have a
3 new administrator. It's programs drawn to
4 figure out what they want, and then it's going
5 to be my job to figure out how to give it to
6 them. And that may change.

7 MR. SEDDON: The wording is a little -- it
8 leaves you open to measure -- if you have the
9 c-arm above the table, you turn it one
10 way; lateral one way; under the table one way.
11 Basically every c-arm can go all the way
12 around. So there's three ways you can measure
13 max exposure. And we've seen a lot of
14 variations from the inspectors just until now,
15 as far as how they interpret the proper --

16 MR. BAI: Yeah. The original one came
17 from the FDA definition, and the CRCPD, for a
18 mobile -- those are pretty straightforward,
19 30 centimeters from -- that's where you're
20 going to measure the input.

21 And then we had these special procedures
22 where the input phosphor can be moved back and
23 forth, or the table can be moved back and
24 forth. It could change the SID. It could
25 change tube distance. Sometimes they move

1 independently. And then they have different
2 positioning. You know, you've got a single
3 unit that is both bilateral, you know, use in
4 any position that you wish, and then -- and
5 then the former theory was -- everybody here
6 familiar with some of those devastating
7 pictures of radiation burns? You know, for
8 those extremely long procedures where,
9 basically, they move the beam-limitation
10 device, the end of the column there, right up
11 against the elbow, or they didn't even raise
12 the arms, and you literally have radiation
13 burns and radiation bruises.

14 But there is -- really, there is no fix
15 for that, you know. Just two years later,
16 another chunk falls off or, you know

17 Because of that, the former administrator
18 felt that it was very important that something
19 was in place where ... and how do you -- how do
20 you -- there are no ... limitations built by
21 the manufacturer. I mean, you can move a
22 floating table as close as you want, you know,
23 left or right, especially on the laterals.
24 Those are the most dangerous.

25 So, he wanted to see that procedure put in

1 place where the facility is aware not to do
2 that, putting up the end of that tube right up
3 against somebody's skin and then running it for
4 a long length of time, especially on lateral,
5 because it will ramp up the technique.

6 We're going to have to take a look at that
7 again, as a procedure. You know, once the
8 program --

9 MS. FORREST: That's -- as I had spoken
10 earlier, the program's in flux right now.
11 Jerry and I have spoken at great length on
12 several issues, that being one of them, on some
13 things that we need to revisit, some things
14 that, you know, the previous administrator had
15 some good ideas, but some things haven't been
16 visited in a while. And so the program is
17 committed to revisiting some things that need
18 some attention, sooner rather than later, and
19 we're committed to doing that.

20 And Jerry and I, we have a working
21 relationship and get along well. And we're
22 looking forward to addressing a lot of those
23 issues and some other ones to make sure that we
24 have the best outcome for our patients.

25 MR. BAI: Hopefully, we'll clarify.

1 MR. SEDDON: Yeah. Clarification would be
2 good. Or maybe even setting out a recommended
3 radiation-protection program, which is what
4 this refers to, facilities that can use -- that
5 might help correct some of the confusion.
6 Facilities are going to have -- when they start
7 reading this, just to try to figure out how to
8 prepare for an inspection.

9 MR. BAI: Yes.

10 THE CHAIRPERSON: Any more?

11 MR. SEDDON: No.

12 MR. FUTCH: Well, in the vein of -- we'll
13 see how this works, because I forgot the
14 speakers, but I think you'd should able to be
15 hear this.

16 Last fall, the Domestic Nuclear Detection
17 Office, which is the part of Homeland Security
18 that is funding the development of these
19 radiation detectors for law enforcement, is
20 training the officers and actually is
21 certifying people in different states, such as
22 several of our health facilities in Florida, to
23 teach law-enforcement officers.

24 They released a whole bunch of new revised
25 courses to be used, and also a set of training

1 videos to go along with the courses. Some of
2 the training videos were actually shot in
3 Florida, all the waterborne -- not all -- a lot
4 of the waterborne training videos were shot
5 with the Fish and Wildlife crew in Panama City
6 Beach.

7 And I'm going to try and play some of
8 these for you guys, just to kind of give you a
9 feel for what they're using all of this and how
10 they use all of this equipment. And the only
11 problem I think I might have is sound, so bear
12 with me on the sound. Hopefully, we'll hear
13 what is going to come out of this laptop.
14 Unless somebody happened to bring a pair of
15 speakers.

16 THE CHAIRPERSON: Before we do that, take
17 a five-minute break.

18 MR. FUTCH: All right. And then we'll do
19 the videos.

20 (Recess.)

21 THE CHAIRPERSON: Okay. Get to see our
22 videos.

23 MR. FUTCH: In actuality, I guess we're
24 going to do a little change up and see if I can
25 find a better cable to plug in some speakers.

1 Why don't we do that this afternoon.

2 But we have another topic, and that's
3 Radiation Response Volunteer Corps training we
4 have conducted for a number of years. And we
5 did talk about this. Okay.

6 For the past several years, we've gotten a
7 grant from CDC to conduct some trainings of
8 basically volunteers who want to be part of the
9 Medical Reserve Corps, which is the official
10 volunteer mechanism, I guess you'd call it, for
11 the nation and for Florida.

12 And, in this case, for our specific
13 purpose, which is in the event of a major
14 radiological incident involving mass casualties
15 or people who think that they may have been
16 contaminated, like a Fukushima-style accident,
17 is to augment the resources of the Bureau for
18 doing the population monitoring and running the
19 portal monitors.

20 We've been doing this, I guess -- I didn't
21 realize we were doing it that many years, but
22 according to the slides, it's been a number of
23 years.

24 MS. COOKSEY: Well, we had the initial in
25 2008, but it was a couple years before we got

1 additional funding.

2 MR. FUTCH: In 2010 maybe, it picked up.

3 So I want to give you a little sense of
4 some of that and what it looks like out in the
5 field. So, as I mentioned, RRVC was
6 established as part of the Medical Reserve
7 Corps. I should have just advanced this slide,
8 right -- yeah, here it is.

9 The first meeting was in June '08.

10 You-all could read the screen, 96 attendees.
11 And then the regular classes started in 2010.
12 And it seems to me, we usually do somewhere in
13 the neighborhood of eight to 12 classes all
14 over the State of Florida in various cities.
15 We try and -- try to range anywhere from
16 Pensacola to Miami and everywhere in between.
17 And what we do is we go to the local Medical
18 Reserve Corps coordinator, and they advertise
19 it first to their members, and then we also put
20 it on the website, and we do some mail-outs to
21 nuclear med techs, radiographers. And we are
22 looking for people who have, ideally, some sort
23 of familiarity with radiation, to start with,
24 because what we want them to do is, in the
25 event of a disaster, be activated and come help

1 us run the portal monitors and use a
2 contamination-leveling-type screen device and
3 separate the people who truly are contaminated
4 from those who aren't.

5 So, we want someone who is not going to
6 run away, screaming about radiation. Nuclear
7 med techs are ideal because they have the
8 hands-on familiarity with the equipment and the
9 daily experience with materials, as well as all
10 the other knowledge. But there's only about
11 2,000 of those folks in Florida, a little more
12 than that now. And there are 18,000
13 radiographers. So that's the second most
14 popular group. But we also advertise it to the
15 nurses and to the EMTs and the paramedics.

16 And I think, in any given class, probably,
17 oh, I don't know, 20 to 40 percent of the class
18 probably are folks from that category. And the
19 rest are people who are just out in the public
20 and who are, you know, conscious of such things
21 and aware of such things and want to help out
22 in emergency.

23 So the classes end up being a wide range
24 of experience. In 2010-2011, these are the
25 cities where the trainings were conducted. In

1 that year, or those two years, I guess
2 combined, about 400 volunteers were trained.
3 Last year, slightly different mix of cities.
4 Sometimes we get into -- like wound up in
5 Milton instead of Pensacola, for some reason,
6 one year. Or, you know, Winter Park instead of
7 Orlando. The Villages was quite interesting.
8 I had never been to the Villages before.

9 MS. BONNANO: Oh, that's wonderful.

10 MR. FUTCH: Very, very interested group of
11 citizens of the senior variety in the Villages,
12 who were there and, you know, bright and early
13 in the morning and ... wonderful, wonderful
14 class. It was really interesting to teach that
15 group.

16 And it's always nice to find folks who are
17 just brand new to radiation, and just start
18 explaining some of the basics. I'll go into
19 some of the material. We've actually got it
20 here, and I'll show you what we used.

21 Two hundred and forty-five volunteers
22 trained in 2012. And I think we've got a
23 couple of cities left. We got Orlando and West
24 Palm Beach still left to go this year, but
25 these are the cities that we've been to --

1 almost 400, so far. I'm pretty sure we'll put
2 that over 400 by the end of the year.

3 We've actually got some pictures. And ...
4 let me back out of there, go over to the --
5 just give you a framework for what we're doing
6 in the classes.

7 Now, this is actually the whole
8 presentation for the morning. Seven hours
9 of -- seven credit hours. All of the licensed
10 health professionals who go can get CE credit
11 through various mechanisms. And ... it's --
12 basically, the way it breaks down is the
13 morning is indoors, Power Points. This is the
14 actual Power Point here. There's ... oh, 180
15 some odd slides in this. But a good three
16 hours, without breaks, of Power Point. It's
17 not that we do it that way, of course, because
18 we'd kill people, which we don't want to do.
19 And they'd probable walk out.

20 But the morning is explaining the
21 following ... I'll show you. Just go over a
22 couple of these.

23 This is the -- all right. Somebody always
24 put these things together. I hate slides that
25 do this.

1 In the introduction, we explained a little
2 bit about the Bureau, why you're here, and how
3 many people do we have for monitoring, and why
4 you need to help us out.

5 We spent about 45 minutes to an hour on
6 radiation fundamentals. That's an experience.
7 That's an interesting thing. A lot of folks
8 just have only the idea about radiation from,
9 you know, science-fiction movies and popular
10 press, so it's a great eye-opener for a lot of
11 people.

12 Then we talk about the possible reasons
13 for nuclear power plant accidents, weapons of
14 mass destruction, and -- destruction where
15 there might be a mass casualty.

16 Let me break out what we call a strike
17 team kit, show you some pictures of that. Put
18 the actual instruments -- put them on the
19 table, and dosimetry, how we measure a dose,
20 and we go through that with them in the
21 morning. Show them how to operate each
22 individual instrument. Then show them the
23 overall kind of state response to an accident,
24 the county, what the county's responsibilities
25 are, and then we talk about what their

1 responsibility would be in the community
2 reception center for population monitoring.

3 And then the afternoon is basically what
4 everybody always likes, which is ... to get the
5 equipment out and set up the portal monitor.
6 And we have a variety of exercises, and that's
7 what most of the pictures are from, and we'll
8 show you those in just a second.

9 So that's the rough thumbnail sketch.
10 When we're talking about ... the Bureau, we've
11 got this ... commands -- the organization, and
12 here's the Bureau, and then we start talking
13 about, you know, what we do.

14 And this is a -- more pictures. It's
15 always good to have pictures. And we talk
16 about our surveillance programs, monitors, the
17 power plants. Everybody always loves it when
18 state employees are paid to go fish. We don't
19 get to eat the fish. We grind it up in a
20 blender and put it on a radiation detector, but
21 it's still interesting.

22 We monitor some of the phosphate lands.
23 We have repair and calibration services. We
24 respond to accidents and incidents, including
25 the FedEx plane crash in Tallahassee. That's

1 on the upper left. And the steel recycler over
2 in Jacksonville, the Ameristeel, where they
3 shredded a source contained there, the whole
4 facility had shut down for a while. Cost
5 millions of dollars.

6 We talked about our training that we do
7 for a variety of purposes. Firemen, policemen,
8 emergency responders of all types.

9 Inspection of low-level waste coming from
10 the power plants. Our RAM storage facility in
11 Orlando. Somebody usual picks out the
12 invigorators there in the middle slide where
13 you get the radium-infused water. Not too many
14 people want those anymore.

15 We actually have a class with people who
16 know what all this stuff is. I bought one of
17 those. You know, can I have one of those?
18 Yes, because we won't have to dispose of it and
19 pay money to do it.

20 And radiation medicine -- this is all in
21 the part where we talk about what the Bureau
22 does, monitoring the Plutonium launches from
23 Cape Canaveral when the various devices go up.

24 And then the PRND side of things and --
25 where we're at. So that's ... a little bit

1 about the Bureau. And then the fun starts.

2 And this is the radiation fundamentals.

3 And we start at a very basic level with atoms
4 and protons and neutrons, and move on up from
5 there. I won't go through all this because we
6 don't have much time, but I wanted to show you
7 a few of the high points that usually cause
8 some discussion.

9 We talk about different types of radiation
10 that you might be worried about in an accident.
11 And then we break it down and start talking
12 about each one individually, and their
13 properties and, you know, shielding materials
14 and the rest of that.

15 And we get to this one on the alpha
16 particle. We use Mr. Litvinenko as an example
17 of -- the former Russian spy who was allegedly
18 eliminated by the Russian government because
19 they didn't like what he was saying in Britain.

20 Polonium-210, which is an alpha particle
21 emitter, that one always causes -- they like
22 that one. Kind of brings home the point of
23 alpha radiation, and it's dangerous. What a
24 beautiful poison it would be, too, if you had
25 enough of it and could afford the state-level

1 amounts of it.

2 (Pause.)

3 MR. FUTCH: And we usually talk about ...
4 some of the basic concepts, and this is taking
5 a while to come to this point, but we try and
6 get a sense of how much material there is. And
7 people always want to talk about pounds and
8 reintroduce the concept of activity. In this
9 way, we can give them some relative activities
10 for the same weight of different materials. So
11 you could see the tremendously different
12 amounts of radioactivity.

13 And everybody always thinks uranium is the
14 most radioactive thing in the world, and it's
15 like three microcuries per gram. And
16 Iridium-192 it's traveling down the street in
17 the industrial radiography camera, almost like
18 10,000 curies in a tiny little paper-clip-sized
19 amount that's in the camera. So we start to
20 give them a sense of what's important with
21 things of that nature.

22 And then we talk about half-life, and give
23 them some examples of -- ranging from medical
24 isotopes to the naturally occurring stuff, and
25 talk about the differences in the half-lives.

1 And, usually, we ask them if they want to use
2 Uranium 238 for a medical isotope, and
3 everybody says, no. And they -- you know, you
4 can figure out why.

5 And, you know, we got the little graphics
6 of showing, you know, ten half lives and the
7 rest of it.

8 Sorry for popping around here, but I don't
9 want to be here for six hours. What else do we
10 have in here?

11 Oh, we talk about which parts of the body
12 is most susceptible to radiation. And then we
13 talk about how we know certain things. And we
14 have this picture of -- I don't know who this
15 is. Anybody know who this is? I don't know
16 this particular person, but it shows a lady
17 looking through a intensifying screen at the
18 bones in her hand. This is usually when we
19 start talking about causes to the human body in
20 high doses and the rest of it, and then show
21 the x-ray tube and the things that happened to
22 the early radiologists with the doses to hands
23 and hand -- burn and then infected and then
24 lost, and also eye exposure and the rest of it.

25 (Pause.)

1 MR. FUTCH: Let's see. Typical doses to
2 kind of bring home -- since we're talking about
3 meters and numbers and the rest of it, how do
4 we bring that home to the people?

5 Somewhere in here, I think around here, we
6 talk about typical doses for various and sundry
7 things. We still use ten millirem, even though
8 it's probably an overestimation I guess these
9 days, for chest x-rays.

10 Living next to a coal plant, living next
11 to a nuclear power plant, everybody always
12 thinks it's worse to live next to a nuclear
13 power plant. They forget about the naturally
14 occurring material that's in the dust from the
15 coal plant. Coast to coast, being both several
16 miles, the atmosphere being more exposed to the
17 cosmic radiation.

18 Smoking, if you didn't have a reason to
19 quit, there's more. From the -- the Polonium,
20 I guess, that's in the cigarette smoke.

21 And then we get into ... typical doses to
22 different folks, different populations.

23 Somewhere in here -- oh, we start talking
24 about what sources are out there. We've got a
25 little graphic here of all the different things

1 that you can think of.

2 We actually bring a lot of these consumer
3 products and use them in the afternoon to -- as
4 sources for people to measure and gain
5 experience with the dose-rate meters and the
6 contamination meters in the afternoon classroom
7 experiences, so we've got Fiestaware where
8 we've got radium dial clocks, we've got the
9 whole ... we've got some ... where is the
10 one

11 Some maps of the naturally occurring
12 distribution and dose rates in the United
13 States.

14 And then we've got ... food chain and, you
15 know, if there's naturally occurring material
16 in the ground, and it's absorbed by the plants
17 and the chicken, you eat the chicken -- sorry
18 if there are any vegetarians.

19 The next thing we talked about is natural
20 radioactivity in your body. Of course, pico
21 means really, really small.

22 And let's see what else we got.

23 Some more fundamentals. We get a little
24 bit of explaining the time, distance, and
25 shielding, of course, and the rest of it.

1 And then down here we start talking about
2 the sources of things that might result in
3 potentially contaminated mass numbers of
4 people.

5 We talk about the national response
6 framework which has a ten kiloton nuclear
7 explosion, which is typically what most folks
8 think the terrorists might be able to come up
9 with. Uranium 235, and the consequences from
10 that to the population.

11 And then we talk about weapons of mass
12 destruction and the different ways that those
13 might be distributed in the -- in the method
14 that everybody thinks about, which is, you
15 know, connect a pipe bomb or something to a
16 lethal source of material and just blow it up
17 and disperse it.

18 And we talk about the other ways that you
19 could disperse material that nobody is going to
20 think about because, you know, it's in a crop
21 duster, or it's in a firework at a big football
22 game, NASCAR event.

23 And then, eventually, it gets to where
24 we're talking about threats to nuclear power
25 plants. And they specifically talk about

1 cutting off power, airliners hitting the plants
2 and assault, and they give a comparison size,
3 talk about how big the containment building is,
4 how hard it would be to hit with an airplane
5 compared to the World Trade Center or the
6 Pentagon.

7 They go through a lot of ... lot of
8 details about power plants, and there's even a
9 video that shows a F-4 Phantom on rocket sled
10 being propelled into the side of a concrete
11 wall built to the same specifications you would
12 build for a nuclear power plant. And maybe
13 I'll show that this afternoon if I can get the
14 sound working.

15 But, basically, the plane was vaporized
16 and the wall was unaffected. It's still going
17 like four or five hundred miles an hour into
18 the barrier.

19 And then, eventually, into ... actual
20 explosives. But -- so you -- through all
21 this ... there's even a section -- anybody know
22 what Rad Resilient City is? Have you heard of
23 that?

24 There's a -- it's a great website. We
25 talk so much in this class about terrorists

1 building Hiroshima-sized nuclear explosives and
2 what the devastation would be.

3 We wanted to put in something positive, so
4 the University of Pennsylvania Medical Center
5 has on the web this Rad resilient City -- it's
6 called radresilientcity.org, if you want to go
7 there and take a look at it.
8 Radresilientcity.org.

9 And there's a whole bunch of materials
10 that they developed in concert with some health
11 physics experts, people from the CDC, the
12 Department of Energy, and the Weapons Labs, and
13 the whole idea behind this project is trying to
14 change or trying to begin to change the
15 public's thinking about ... the survivability
16 of a nuclear bomb in the United States. And
17 what we usually say is that -- you know, we've
18 all grown up and are conditioned to thinking in
19 kind of cold-war terms with two super powers,
20 with thousands and thousands of nuclear --
21 multi-megaton nuclear warheads, you know,
22 coming down on either side, and survivability
23 of that, which is, you know, pretty much none.
24 Or ... at least you probably would'nt want to
25 try and survive. It wouldn't be a fun thing.

1 Which is very, very different from a terrorist
2 organization, even a state-sponsored terrorist
3 getting ahold of enough material for a
4 ten-kiloton type bomb, which is the
5 Hiroshima -- ten to 15 kiloton Hiroshima-size
6 bomb, which is very survivable for at least the
7 people who are not in the immediate vicinity
8 for the blast itself.

9 So this whole Rad Resilient City project
10 is the health physics folks and medical physics
11 folks and everybody else coming together,
12 including one of our own folks from Florida,
13 Dr. Lanza from the Pensacola County Health
14 Department, putting some basic rules of thumb
15 and communication messages together for people
16 to understand what you can do if, God forbid,
17 something like this were to happen.

18 And what they've put together is --
19 there's some tenets -- they call them tenet of
20 preparedness. We're only talking about this
21 particular size, and it's a ground-based
22 detonation. It's not, you know, delivered from
23 the air or something like that.

24 And the first tenet I've already described
25 to you, which is that, you know, in contrast to

1 the cold-war image, this is a much more
2 contained survivable type of event. And they
3 describe damage zones. And, basically, you've
4 got the center of the blast there, and that
5 first purple color is -- is the non-survivable
6 zone. This is the one where, you know, pretty
7 much buildings are reduced to rubble, and
8 there's the huge blast effect which does a
9 number on the human body, and the thermal
10 radiation.

11 But then, beyond that, from about roughly
12 a half a mile out, you see these other zones,
13 and they're progressively more survivable,
14 depending upon what kind of structure that you
15 are in.

16 And then the biggest thing, and the reason
17 most of this project exists is trying to show
18 folks the fallout is what you're really trying
19 to avoid. That's where the ... the blast
20 itself, the neutrons from the blast take the
21 material from the ground that's not
22 radioactive, and the prompt neutrons make that
23 material radioactive, and then it's, you know,
24 thrown into the air with the force of the
25 blast. And the whole thing is trying to avoid

1 what you can, to take shelter to avoid that
2 fallout, and how long you have to do it.

3 And they actually rate different
4 structures, and they go into this. And this
5 again is talking about trying to survive from
6 the fallout, which is where most of the
7 casualties would occur. And it gives different
8 zones and different time scales, and it's way
9 too busy to go over in this meeting, but
10 basically, it starts out at time zero above,
11 and then it starts giving different
12 chronological updates as you move down this
13 chart. The last two, I think, were 12 hours
14 and 48 hours. And the first couple, I think,
15 are like an hour and two hours and such like
16 that.

17 And then the whole point of this is, if
18 you're close enough to survive and then still
19 see and hear the blast, what you want to do is
20 take shelter as quickly as possible, hopefully
21 within the first ten minutes.

22 Now, if you're 10 miles away, right, and
23 this thing goes off, and the wind is moving at
24 ten miles an hour, the first fallout is not
25 going to reach you in ten minutes. It's going

1 to take a little longer than that. But, again,
2 this is a great big -- kind of rules of thumb
3 for everybody to go by. So what they want is
4 for folks to get into shelters as quickly as
5 possible.

6 So then they actually show them different
7 ratings for shelter. And that is -- this is
8 what's on the screen right now. And they put
9 everything into basically fallout protection
10 factors. It's kind of like the SPF for your
11 sunscreen. It's a relative scale. And they
12 show a one-story, wood-framed building on the
13 left, and I think -- I can't read the numbers
14 from here, but I think it says, two to three
15 protection factor over being out in the open.

16 And -- and they also show, if you're lucky
17 enough to have, you know, underground parking
18 garages or maybe even a basement in a house,
19 which is not that common in Florida, of course,
20 but they usually go to the right. They start
21 to show the brick structures and then concrete
22 structures and then multi-story buildings. And
23 you can see that the -- of course, the greater
24 the number, the better the protection factor.
25 So the best place to be is like in an

1 underground parking garage underneath a big
2 downtown office building. You got a protection
3 factor of 200 there.

4 But then we also show them some -- you
5 know, some different things. If you happen to
6 be in an office building, where do you want to
7 be and where do you not want to be?

8 Well, if you are one those people who paid
9 for the real expensive penthouse apartment,
10 it's not going to help you out in this
11 situation, because you're very close to the
12 roof where all the deposition is going to
13 occur. So you have about the same protection
14 factor as some of these other one- or two-story
15 structures down here on the left.

16 The same is true of ground level in tall
17 buildings. You can see the ground level -- the
18 big tall building on the right has a protection
19 factor of ten. Well, it's on the ground, and
20 the fallout's also going to fall on the sides
21 of the building, but also on the ground around
22 the building.

23 So, one of the best places to be in the
24 office building, if you can't be underground,
25 is to be right smack in the middle where you

1 see a little blue 100. You are kind of
2 equidistant from the roof and from any roof
3 that might be in deposition, and also from the
4 ground.

5 So this is -- again, it's all relative.
6 You know, if you have to run to some building,
7 which building is better? Well, any building
8 is better than none at all.

9 And then some of the other things -- okay,
10 so get to the shelter in the first minute, and
11 then the other thing about a ground-level burst
12 from a nuclear blast is that an awful lot of
13 the radioactivity in the fallout dies off very
14 quickly, in the first couple of hours. So
15 whatever shelter you got into in that first
16 minute or couple of minutes, after the first
17 hour, if you can get to better shelter, at that
18 point, enough of the radioactivity has died
19 off, and like right across the street is one of
20 those multi-story, big underground parking
21 garages. It's better if you actually leave
22 your little one-story, wood-frame house and get
23 over into that structure, but don't do it
24 before the first hour, because you want to wait
25 that long for enough of that intense

1 radioactivity to die off.

2 And then -- and if you can't upgrade,
3 don't. Stay where you're at. It's better than
4 nothing at all. Then start listening to the
5 radio and try and find if there are evacuation
6 pickup points, folks are going to be coming in
7 to take people out. Try and do that at -- you
8 know, by the end of the first day or at the end
9 of the first day.

10 So that's what's the whole Rad Resilient
11 project is about.

12 All right. So -- and then the rest of
13 this, we actually get into the equipment. And
14 here's the Strike Team Kit and two instruments
15 that we use. This is the Canberra UltraRadiac.
16 This is the dose rate meter, and the one on the
17 right is a Ludlum 2401-P, and this is what we
18 use for monitoring contamination, and it has
19 the pancake type of probe which will pick up
20 some alpha and all beta gamma built into the
21 device itself so there's no separate probe.
22 It's all one combined instrument.

23 And they show how to operate this in
24 nitty-gritty detail. Then they go through the
25 level. They show them some dosimeters. They

1 still show them the old pen, you know, look
2 through the dosimeter at the light,
3 direct-reading dosimeters because that's what a
4 lot of the counties have in quantity. Still
5 those old civil-defense quantities of
6 instruments are out there.

7 And, of course, we show them how to
8 operate the portal monitor, how take out the
9 kit, how to assemble it, and how to operate it.

10 But let me drop back to other presentation
11 and show you some of the pictures.

12 This first set of pictures is actually the
13 oldest. It's from 2012, and I think this is
14 Gainesville or Jacksonville. This is some of
15 the folks with the meter case or the Strike
16 Team Kit open, and you can see the lady
17 holding -- it looks like the UltraRadiac over
18 there on the far corner.

19 Kill some of these -- kill some of these
20 lights. You got the light control over there?

21 MS. ANDREWS: Sure.

22 MR. FUTCH: Now, this is the classroom.
23 This is going over the instrument portion of
24 the -- of the morning lecture there, with all
25 the Strike Team Kits in front of them.

1 This is Charley Adams who was with us for
2 many years, former Air Force pilot. He's now
3 retired.

4 This is some of the presentation Charlie
5 is going over.

6 That's beautiful. Thank you. Even
7 better.

8 Yeah, why not. We can all go to sleep
9 now.

10 MS. ANDREWS: All or nothing.

11 MR. FUTCH: Let me just go through here
12 and give you some more interesting things.

13 Okay. And that's the portal monitors in
14 their cases, those black cases. They'll fit in
15 the back of an SUV.

16 MS. ANDREWS: Sorry.

17 MR. FUTCH: That's okay. Just leave it
18 off. That's fine.

19 And what we usually do is leave one
20 assembled -- I apologize, some of these are a
21 little fuzzy -- usually assemble one, kind of
22 change the routine around. Now we usually
23 assemble one, and have that as an example to
24 show them, and then have it talking through
25 assembling the other one. Which you can see

1 they're pulling it out of the case. The
2 instructions.

3 And now it looks like we're back to using
4 the instruments. I think we're going to go to
5 some of the hands-on stuff.

6 Okay. So she's actually using the Ludlum
7 right now with one of the sources on the table.
8 There are various sources. And we're just
9 trying to get them used to reading the meter.
10 One's electronic, auto-ranging meter. The
11 other one is the old-style manual with the
12 needles. You have to change the dial to go to
13 a different range.

14 They're filling out their proficiency
15 station sheets. This is actually where they're
16 just reading the dosimeters. You can see she's
17 holding -- the lady on the right is holding an
18 electronic dosimeter. Very easy. All you do
19 is pick it up and read the display.

20 The UltraRadiac used in dose mode is the
21 same way. It's maybe one or two buttons to
22 pull up the dose rate reading. The pen-based
23 dosimeter to the yellow thing on the device
24 right there is the most difficult. You haven't
25 lived until you've tried to show an elderly

1 person in The Villages how to read a direct
2 reading dosimeter. It's like using a
3 telescope. You know, you got to look through
4 here, and you got to find these little fine
5 lines inside of it. I hope to goodness we
6 don't have to actually use those in a real
7 event.

8 Now, we have couple of dummies that we
9 bring, besides our staff, these guys that we
10 employ here. No, I'm kidding. And we plant
11 little sources all over the -- all over the
12 dummy. It's actually -- usually we use little
13 Coleman lantern mantles with Thorium in them.
14 And we usually put one inside the mask, and we
15 put one down by the foot, one in the chest
16 somewhere. And they're supposed to go over the
17 whole body and try and find all the locations
18 and take a reading.

19 You can see she's not using the best
20 technique. She's a little far away. But
21 that's normal. That's usually the way people
22 start out.

23 And then we're back to the table, showing
24 the lady in this case taking readings off the
25 different objects. You can see the fiesta wear

1 in the orange bowl behind her. There's a
2 bottle of no-salt that the meter will actually
3 pick up the beta and the gamma coming off the
4 Potassium 40 inside of it.

5 And the lady in the back is actually
6 trying to use the directory and dosimeter and
7 trying to read -- that's another station, the
8 one we showed you before, close up. Yeah.

9 (Pause.)

10 And people get so into this. You know,
11 all we're doing at this particular station is
12 just reading a meter. They've got their little
13 sheets down there. Half of them think that
14 there's going to be a test at the end, so
15 they're very, very intense on getting the
16 number right. And all we're trying to do is
17 get them to read both the number and the units,
18 and put it down on a piece of paper. But they
19 are taking this very, very seriously.

20 MR. JOHNSON: How do you advertise these
21 classes?

22 MR. FUTCH: A couple of ways. The first
23 thing we do is make contact with the local MRC
24 coordinator in the region that we're talking
25 about, and then they use the local county

1 resources and their contacts in e-mail, in
2 websites, to put that out.

3 And then at a department level up in
4 Tallahassee, we'll put it up on our website.
5 In fact, if you were to go to our website right
6 now, you could find the two classes that are
7 there. And that's where the general public can
8 find out about it.

9 And then, also, we use the resources of
10 MQA. MQA has all the contact information for
11 all the nurses, the x-ray techs, the nuclear
12 med techs, the EMTs and the paramedics in the
13 state of Florida. So as soon as the MRC
14 person -- for example, right now, there's one
15 in West Palm Beach.

16 The West Palm Beach MRC person talked to
17 the office and decided they were going to do a
18 class. They started their advertising. Janet
19 obtained lists of nuclear med techs and those
20 folks in those counties around West Palm Beach,
21 and started doing some direct e-mailing to
22 them.

23 And there's actually -- MQA is great
24 because they've got one part of their
25 application where they actually ask people if

1 they want to assist in the event of an
2 emergency. So we just pick those people who
3 basically pre-identified themselves, that want
4 to assist in the event of an emergency, and --
5 and use those for the -- for the direct e-mail.

6 And we found that's better than what we
7 used to do, which pretty much got us
8 blackmailed -- blackballed, and spammers
9 through many, many different systems like gmail
10 and Yahoo.

11 But I think we've had pretty good response
12 since we've started this. Very, very
13 interested people, even more so than before
14 showing up for these -- for these classes.

15 MR. JOHNSON: How do you choose the
16 locations?

17 MR. FUTCH: It's pretty much which MRC
18 local coordinator wants to do the class. The
19 MRC folks have to do a certain amount of -- the
20 volunteers have to do a certain amount of
21 training every year, so it's always a struggle
22 for them, so they'll come to us. The lady in
23 Pensacola, oh, my Lord, she's a wonderful
24 person, and she -- she contacted John, and we
25 got the class set up. And while we were there,

1 the night before the class that we'd already
2 set up, and you have all these volunteers
3 coming in, she took us out to dinner at the
4 local watering hole and basically twisted our
5 arms for more training, because, you know,
6 they're in Pensacola.

7 So, unlike Orlando, lots of things -- you
8 can't just like, you know, drive by. And
9 they're in the very western part of the state,
10 and it's hard to get people to come, I guess,
11 to Pensacola to train. And so they're
12 suffering from wanting more training to give to
13 their MRC people out there.

14 So that's -- that's kind of how it starts.
15 We have to have that local -- that local
16 interested person who wants to do it.

17 THE CHAIRPERSON: Do they have any
18 physicians taking these courses?

19 MR. FUTCH: We do -- most of them are
20 retired. There's a lot of -- I shouldn't
21 actually say, "a lot" -- there are a few --
22 probably in a class of 50 people, there'll be,
23 you know, 20 nuclear med techs, radiographers,
24 maybe another ten if you include the nurses,
25 and there'll be two or three retired physicians

1 or occasionally physician assistants who are --
2 who are able to come. I mean, it's a lot of --
3 you know, it's a devotion of an entire day.

4 Now, we do the classes according to the
5 wishes of the MRC, so most of the classes are
6 on Saturdays. And these days, the department
7 staff who are doing these are probably donating
8 the time to go do the class on a Saturday.

9 Occasionally, we'll have some MRCs that
10 want to do it on a week day. Those are usually
11 the ones that are more plugged into, like, a
12 hospital. Or they know they just have a lot of
13 people in -- for whatever reason, their
14 preference is for their people to come during
15 the work week and do it on a work day.

16 But it really doesn't matter to us.
17 Whichever the local folks want, that's what
18 we're going to do.

19 DR. SCHENKMAN: Everybody has to have some
20 kind of pre-training, like -- or do you just
21 get people off the street?

22 MR. FUTCH: Before this class? Yeah, we
23 get people off the class [sic]. The way it
24 works, one of the appeals for the MRC itself
25 is, you know, in Florida, if a disaster

1 happens, you can't just walk up and volunteer.
2 They won't accept that. So the way that you --
3 if you're going to volunteer for anything, you
4 have to be in one of these groups of people
5 identified ahead of time. They're actually --
6 they're actually doing background checks and
7 fingerprinting on these people now, which they
8 didn't do -- they didn't do it years and years
9 ago.

10 So there is a -- you got to be -- you got
11 to want to do this, to be able to go and, you
12 know, be fingerprinted and all the rest of that
13 stuff.

14 But the ... so people who -- who go, they
15 have some advantages. If there are any
16 counter-measures that can be administered --
17 like, usually, we are talking radiation, you
18 know, any kind of accident that might have
19 Iodine of any kind. Usually Iodine 131. You
20 know, there is Potassium Iodide, which is
21 available in stockpiles in different health
22 departments in the state of Florida for use in
23 power plant emergencies.

24 If you're a member of the MRC, you're
25 considered to be an emergency responder, and

1 you're going to be one of the people who's
2 first in line, just like department staff or
3 anyone else, who's going -- 'cause you're going
4 into the accident. Right? And the department
5 has responsibility to protect you. So you're
6 going to be one of the people who has that
7 available to them.

8 And, also, because we don't want you
9 worrying about your family, your immediate
10 family members would also have that available.

11 If you're part of the MRC, and you're
12 volunteering on behalf of the state, the
13 state's liability also protects you, so you
14 don't have to worry about ... someone trying to
15 come afterwards and saying you harmed them in
16 some way, and suing you personally for some
17 kind of damages.

18 So there are certain advantages to being
19 part of the Medical Reserve Corps and
20 volunteering in that fashion. But, yes, there
21 are a great many people who just are retired,
22 they're interested in community service or one
23 or the other or both, and they hear about these
24 things through the local folks or through the
25 state folks, and they just want to come and be

1 a part of it.

2 And there are the occasional people who
3 come and ask lots of odd questions of us. I
4 had one lady -- I won't tell you where or when,
5 but she's a very nice lady, very ... into the
6 class, and she came up to me at a break, and
7 she handed me this whole packet of ... whole
8 manila envelope full of papers, dog-eared
9 papers, pages going this, that, and the other
10 way, and she was like, you know, very, very
11 concerned about the, you know, Department of
12 Energy and -- and contaminating people with
13 their, you know, waste processes and their
14 nuclear power or nuclear weapons production
15 facilities, and would you -- would you please
16 just give this to your -- to your, you know,
17 health physicists here in the state of Florida.

18 And I'm like ... well, sure, ma'am, you
19 know, thank you very much. And we got back and
20 we opened it up, and the lady had been
21 corresponding with the federal government for
22 years. She had letters and e-mails that she
23 corresponded with, like, Janet Reno, when she
24 was the ... the attorney general. You know,
25 and she was just really, really, really

1 concerned. And, you know, it didn't all hang
2 together, if you read it. It was, you know, a
3 little bit of this -- somebody who wasn't into
4 this, didn't really have a background or
5 anything, and pulling together different stuff.
6 She was very -- so, occasionally, I get folks
7 like that. Just makes life really interesting
8 in the classroom, to answer the questions.
9 Keeps us on our toes, I'll tell you that. We
10 never know quite exactly what we're going to
11 hear.

12 Let's see here. I'm not going to show you
13 all of these because there are far too many,
14 but we'll get ahead to some of the ... ones
15 that focus on the more recent times.

16 (Pause.)

17 MR. FUTCH: Yeah, I can see some of the
18 pictures here. We got the portal monitor set
19 up in this one. And we'll put a little check
20 first on somebody and run them through.
21 They'll be the victim, and they'll get practice
22 using the hand-helds on real people as well as
23 the dummies.

24 (Pause.)

25 MR. FUTCH: This is one from Pensacola.

1 Now this is Bill Roberts. He's our inspector
2 in the Pensacola region, one of Jerry's
3 inspectors. And ... the folks right there that
4 are sitting there, a couple of nurses, I think,
5 they've got that Strike Team Kit, and he's
6 showing them how to use the ultra radiac to
7 take readings.

8 And these two folks -- this gentleman here
9 is -- I forget his last name, but David is his
10 first name. That's his daughter. He actually
11 signed up for the class with both of his kids.
12 He's an MRC member out in the Pensacola region,
13 was actually kind of, I guess, like one of the
14 right-hand people for the local MRC coordinator
15 out there. And that whole family was
16 incredibly ... just ... you know, with it,
17 ready to use this stuff. This young lady here
18 just jumped right in and ... used everything
19 properly. And they're actually taking some of
20 the pictures.

21 The camera you see at the bottom of the
22 screen -- not this particular one, but some of
23 the other ones from this class, they actually
24 took and shared their photos with us. And I
25 think his son had to pull out at the last

1 minute, and just the daughter came.

2 There's the morning pictures from
3 Pensacola, showing some of the folks with the
4 kits open. And

5 (Pause.)

6 MR. FUTCH: Anyway ... I think that's it's
7 for the volunteer part. Any questions? You
8 can grab the lights.

9 DR. SCHENKMAN: You ever get people asking
10 questions that are more of a suspicious nature?

11 MR. FUTCH: Oh, goodness, yes, yes
12 exactly.

13 DR. SCHENKMAN: Is that why they're
14 fingerprinting them?

15 MR. FUTCH: I don't know about that,
16 because the thing you got to remember is this
17 class is on the front end, so only a portion of
18 these folks have actually been the through
19 formal MRC process.

20 They actually recruit folks from this
21 class. The MRC people love it because -- for
22 example, Miami, we had 88 people registered for
23 the class in Miami. There were so many people
24 who had to move it, we got there the day before
25 and went to the room where we were going to

1 have the class. It was actually in the health
2 department. And the room held, like, 40 people
3 comfortably. And, normally, that's not a
4 problem for us because, you know, we normally
5 can ... use some of the hallways and -- and we
6 got to find a spot for the practical exercises.
7 Well, we ended up on the second floor of that
8 building, so we couldn't very easily just, you
9 know, go outside and do what we normally do.
10 We physically had to move it the night before
11 to the Miami-Dade County Emergency Operations
12 Center which, you know, is a huge facility.

13 And, Janet was so happy to get that call
14 that night, because that meant that she and her
15 staff had to go contact all those 88 people and
16 tell them, "We're moving you to a different
17 spot." And then the local Miami-Dade folks put
18 some people out front and got everybody all
19 referred to the other facility. And I think
20 50 -- you remember how many people showed up?
21 It was 50 --

22 MS. COOKSEY: -- five.

23 MR. FUTCH: Fifty-five or so showed up at
24 that facility. That's a pretty good class.
25 You've seen the material. You've seen the kits

1 and the stuff you are going to get through.
2 Out of that 55, in Miami, I think only about 15
3 of them were MRC members, maybe a few more.
4 And everybody else in that class was brand new
5 to the MRC. And that lady was -- she was in
6 heaven. Michelle from -- from Miami-Dade
7 County. She loved it because it was -- you
8 know, she was recruiting. She was putting --
9 handing pamphlets out to everybody.

10 And so it's -- you know, it's also a big
11 recruiting tool for people who haven't seen
12 this, but are interested in some kind of
13 volunteering.

14 Well, I don't have any more.

15 THE CHAIRPERSON: Time to break for lunch.

16 MR. FUTCH: Okay.

17 MS. ANDREWS: We've made reservations at
18 the Macaroni Grill. It's not very far. There
19 are very few restaurants around here that could
20 accommodate our size group, so we made a
21 non-democratic decision to where you-all could
22 have lunch today. It is very good, though.
23 So, hopefully, everyone will enjoy that.

24 THE CHAIRPERSON: What time do you need to
25 be back?

1 MS. ANDREWS: We're scheduled to be back
2 here at 1:30.

3 MR. FUTCH: It's 12:15. I think we're
4 probably not going to make that but...

5 THE CHAIRPERSON: Okay. So why don't we
6 adjourn at 12:15. We'll meet at the Macaroni
7 Grill. (Recess.)

8 AFTERNOON SESSION

9 THE CHAIRPERSON: It looks like most of us
10 are back, so why don't we get started.

11 (Pause.)

12 THE CHAIRPERSON: Okay, everyone. The
13 next item on the agenda is a request from
14 Dr. Williams.

15 DR. WILLIAMS: I can talk about it first,
16 yeah. I mean, everybody will remember, a few
17 years ago, when electronic brachytherapy
18 therapy was emerging as a new technology. We
19 had been concerned. We put some regulatory
20 language in place that essentially coupled
21 electronic brachytherapy to isotope-based
22 therapy, isotope HDR, and that allowed us to
23 maintain a level playing field -- and that's
24 been fine. KV brachytherapy has not really
25 emerged as a commonly used technology, it's

1 still sort of out there, but never really
2 materialized as a -- as a, you know, commonly
3 seen procedure.

4 Well, over the last few months, I had
5 gotten two calls about the same thing, one from
6 the Cary medical director or medic up in
7 Jacksonville, Jim Cocoran. He's a good friend
8 of mine. And he had brought to my attention
9 some concern that he had about an orthovoltage
10 user in South Florida who had been using the --
11 a -- a low-energy machine, not -- I don't know
12 if it was KV brachytherapy. That was one of
13 the questions I had -- to treat patients.
14 There was some concern about -- about the
15 necessity and, you know, quality and things
16 like that.

17 And then I got -- within a short period of
18 time, I got another call from a local
19 dermatologist, a John Strasswimmer, and he's
20 a -- a widely recognized sports and Mohs
21 surgeon. He was concerned about another
22 dermatologist who was using low-energy
23 orthovoltage therapy from a company called
24 Sensus. That's S-E-N-S-U-S, Sensus Healthcare.
25 And he was concerned about medical necessity,

1 you know, quality control, things like that.

2 And so the question that I had -- and I
3 want to put on the agenda to at least initiate
4 a discussion is where do these Orthovoltage
5 machines fit into the regulatory environment?

6 I assume they're not KV brachytherapy;
7 therefore, not really linked like electronic
8 brachytherapy is to HDR-based, ISO-based
9 therapy. And do we have any reason to take a
10 closer look at it as far as who's doing it in
11 the field, whether they're being checked by
12 physicists, how they're calibrated, who
13 supervises them, you know, the overall concern
14 for public good, basically.

15 (Pause.)

16 THE CHAIRPERSON: What are they using it
17 to treat?

18 DR. WILLIAMS: Skin cancers, a lot of
19 them.

20 MR. FUTCH: Well, Mark, Jerry, do you
21 guys --

22 DR. WILLIAMS: I can tell -- if I just did
23 a -- quickly add up, just not an ambush or
24 anything.

25 MR. BAI: We have a section inside of our

1 regulations that specifically deal with therapy
2 type for superficial -- there's the Grenzs,
3 there's the Orthovoltage energies which are
4 separate from external therapy units like
5 electronic therapy through accelerators,
6 LINACs. But there's a very specific section.

7 As far as the regulation of it, I've only
8 seen it -- they used to be prevalent in
9 oncology centers, but I don't recall having
10 seen an oncology center actually use one of
11 these devices. It's almost exclusive nowadays
12 for dermatology oncology treatment.

13 DR. WILLIAMS: I would agree. We used to
14 have an Orthovoltage machine in our office, but
15 it got to where we couldn't get parts for it,
16 and nobody wanted to service it.

17 MR. BAI: They usually outlive the owners.

18 DR. WILLIAMS: In Bethesda Hospital just
19 up the road from me, had the same fate.

20 These other devices are sort of
21 standalone, portable, low-energy units. I
22 guess they vary from --

23 MR. BAI: Are you talking about electric
24 E.B.?

25 DR. WILLIAMS: No, orthovoltage.

1 MR. BAI: Oh.

2 DR. WILLIAMS: And I guess they resemble
3 old orthovoltage machines, except that they're,
4 I guess, newer and more affordable.

5 MR. SEDDON: I think the regulations, they
6 go down a certain KV.

7 MS. FORREST: Yes, sir. Similar to the
8 SRT-100. And right now they're considered
9 therapeutic x-ray systems, and the rules are,
10 if it's less than 1 MeV -- and that's where
11 this is falling under. And, basically -- and
12 forgive me if I speak out of turn, and jump in,
13 and correct me -- that you had asked earlier,
14 you know, where does it fall for regulations
15 and calibrations.

16 Anything that emits less than 150, it
17 falls under this therapeutic, and it's going to
18 fall under our general guidelines. So it's
19 going to be treated just like running this
20 administration and any regular registration.

21 So, there's not going to be anything
22 special that we're to ask them to do for
23 calibrations. It's going to be for just
24 regular inspections. We're not going to ask
25 them to do anything special, because it's

1 emitting a low -- did I answer that correctly
2 or incorrectly, or is that clear as mud?

3 MR. SEDDON: I think what you're saying is
4 that there is -- below 150 KV is diagnostic,
5 considered and --

6 MS. FORREST: Yes, sir. For therapeutic
7 value.

8 MR. SEDDON: But then above that, we have
9 Orthovoltage range, which requires calibration
10 of a physicist. So those are -- we actually
11 have Orthovoltage machines, an old one, like 50
12 years old that's -- not that old, but used
13 really particularly in our oncology center, one
14 of our oncology centers. So, yeah, they just
15 do the annual check on it.

16 I'm not sure of the regulations as far as
17 medical use of it, 'cause you don't really have
18 a lot of regulations regarding brachytherapy,
19 electronic brachytherapy where you have, you
20 know, these requirements for position and
21 training, things like that. They don't really
22 have them on the machine side, so it's not
23 quite the same.

24 Now, you're saying it goes down as low as
25 30?

1 DR. WILLIAMS: My understanding of the
2 device, something that I've been able to find,
3 is that these devices range from 50, 100 KV. I
4 have not seen anything that's as low as 30 KV,
5 but my understanding was that if it's under 30
6 KV, we have no statutory -- regulatory
7 authority whatsoever, unless there's

8 THE CHAIRPERSON: What's the dosages
9 they're giving?

10 DR. WILLIAMS: As near as I can tell, they
11 give a variety of -- generally in long
12 fractionation schedules that evolve out over
13 five and six weeks, or smaller or skin
14 donations.

15 THE CHAIRPERSON: So it's like using a
16 fluoro machine for therapy?

17 DR. WILLIAMS: It's close. These are very
18 low doses per day, and they're -- I mean, there
19 are medical-necessity questions about it. I'm
20 not sure if that's the purpose of this
21 committee. My concern here is who's
22 calibrating them, you know, who's got the T&E,
23 and are we sort of looking at a hole between
24 isotope-based brachytherapy,
25 electronic-based brachytherapy, and

1 higher energy megavoltage therapy from the
2 standpoint of T&E and --

3 MR. BAI: The units are required to be
4 calibrated once annually by a medical physicist
5 who is licensed. The actual therapy -- I mean,
6 the actual annual calibration for these units
7 will involve -- usually, it's a fixed KV unit
8 on most of these. The only variable is time on
9 these units. Besides that, they have different
10 filters that you place in, so it needs to be
11 calibrated with all -- each filter. And,
12 basically, what they do is, they put, with
13 calibrated ... dosimetry or electrometer in the
14 final chamber.

15 But it's -- they -- usually, what they do
16 is simply put an output at the treatment
17 distance. Normally treatment distance is fixed
18 on these units, and an amount of dose-per-unit
19 time for each filter that is inside there.
20 And, basically, it just comes out through a
21 little chart. And then when the doctor plans
22 out the fractionation schedule, he just simply
23 correlates the amount of time it takes for that
24 fraction and that distance with that filter.

25 MS. BONNANO: You have to have a license

1 to own this machine and to license
2 technologists to use it?

3 MR. BAI: No. Most of the treatments that
4 I have seen, the physicist comes in there once
5 a year to do the calibration, but they don't
6 necessarily have a physicist on hand. It's a
7 consulting physicist that does it.

8 The treatment itself is usually done by
9 the dermatologists themselves. In one case I
10 think we had some PA's doing it down south.

11 MR. FUTCH: Yeah.

12 MS. BONNANO: Do you know where all these
13 are?

14 MR. BAI: Yes.

15 MS. FORREST: They're registered.

16 MS. BONNANO: They are registered.

17 MR. FUTCH: What's the -- are we talking
18 about a particular manufacturer or a couple of
19 manufacturers, and does anybody know the name?

20 DR. WILLIAMS: The name of the
21 manufacturer that I was given was Sensus.
22 S-E-N-S-US, but I think they made one of the
23 more widely known, but they're certainly not
24 the exclusive provider.

25 MR. FUTCH: Is this the SRT-100?

1 DR. WILLIAMS: That is. But I'm sure
2 there are others. The issue is not really
3 Sensus. The issue is what, if anything, should
4 we be considering differently from what we're
5 considering now, if anything.

6 MR. SEDDON: Jerry, when you guys do your
7 inspections of these type of machines, do you
8 do anything above and beyond verification of
9 the annual calibrations, or do you do more like
10 a

11 MR. BAI: No, just go inside there. We
12 ask questions. Who actually operates the unit.
13 In this case, most likely the physician
14 himself.

15 MR. SEDDON: Right.

16 MR. BAI: And then if it is not the
17 physician, of course it has to be a therapy
18 technologist that is operating it. And then we
19 ask questions about all the variables such as,
20 do you use the filters, and what distance do
21 you treat at, if not just one fixed distance,
22 and how do you collimate to the area of
23 interest and all that kind of stuff. And we
24 just make sure that the safety aspects are met,
25 and they are inspected annually.

1 THE CHAIRPERSON: How does this differ
2 from the regulations for the Orthovoltage
3 machine?

4 MR. BAI: Same thing, Ortho, Superficial,
5 Grenzs.

6 MR. FUTCH: Now, correct me if I'm wrong,
7 but on the side of the qualifications of the
8 user, we're not putting any of the electronic
9 brachytherapy or materials-based therapy
10 authorized user requirement on these folks?

11 MR. BAI: No. Electronic brachytherapy is
12 a completely different track from the 64E-5.

13 MR. FUTCH: So, all the extra
14 therapy-based things that are for those other
15 devices don't apply to this particular --

16 DR. WILLIAMS: Right.

17 (Pause.)

18 MR. SEDDON: Do you see a need for that,
19 Dr. Williams?

20 DR. WILLIAMS: Most of these -- most
21 dermatologists aren't that interested in
22 radiation therapy. And the ones that are, you
23 know, generally have collateral motivation
24 besides just primary good patient care.

25 MS. BONNANO: Do you think?

1 DR. WILLIAMS: And so if I could have
2 anything that I wanted, I would have the same
3 regulatory authority across the board for the
4 use of radiological devices in a therapeutic
5 setting. This has been the settled law of the
6 land forever. This is not new. When KV
7 brachytherapy came along, we had new technology
8 to digest, and we had an opportunity to create
9 a regulatory framework, and it's very
10 compatible with high-quality patient care and
11 quality assurance. To go back and die on the
12 orthovoltage shield hill would be next to
13 impossible. That would be probably a very,
14 very difficult challenge.

15 I wouldn't say that I believe patients are
16 being injured every day, you know, out there
17 with it, but I think that the standard that the
18 dermatologist uses for therapeutic use of these
19 machines is different from a radiation
20 oncologist, and substantially so.

21 (Pause.)

22 MR. FUTCH: How many devices do you think
23 we have like this?

24 MS. FORREST: I don't know. Philip is
25 pulling the record and that, and I haven't

1 received anything from him on that, and that
2 wasn't his fault. That wasn't a request that
3 he got relatively quickly. He's going through
4 the J.R. numbers to see. It's not a very large
5 number of them within the state.

6 DR. WILLIAMS: Probably a few dozen. I
7 think, the Sensus website, just picturing in my
8 mind the number of dots they had across the
9 state, I'd say, maybe two dozen.

10 MS. FORREST: In his original assessment,
11 Philip said he was thinking rough, off the top
12 of his head -- he's usually pretty spot on with
13 this stuff, if you knew Philip -- was less than
14 30. So that would tell you what you were
15 thinking.

16 MR. FUTCH: When we had the issue with the
17 PAs, we were talking about before, it was a
18 really tiny number of systems that were
19 involved. At least back then, I kind of got
20 the impression it was -- the dermatologists had
21 been doing this for a really long time, who
22 were still doing this, and that there weren't
23 too many other new ones coming in to kind of
24 continue the tradition. Are you saying that's
25 different now?

1 DR. WILLIAMS: What Dr. Strasswimmer was
2 explaining to me is that in the state oncology
3 meeting, these companies have assumed a much
4 higher profile now and much more aggressive
5 moving of their products in the dermatological
6 field.

7 MR. BAI: So it's flipping around where it
8 moved away from these units because accelerator
9 electronic therapy was replacing these units,
10 now it's going the other way.

11 DR. WILLIAMS: The pendulum swings in the
12 long measure of time. In lots of different
13 aspects of medicine, you know, the pendulum
14 will swing back and forth.

15 You know, the healthcare system --
16 obviously, if you're pushing on one side,
17 another side pushes out. And, again, most
18 surgeries have been decreasing over time, will
19 continue to decrease, and you get increasing
20 restrictions on what can be covered. As you
21 push on that side of the healthcare system, you
22 can expect this other side of the system
23 to

24 MR. BAI: You'll find that there's going
25 to be hundreds of these units that are put on

1 storage status around the State. They're
2 sitting inside these oncology centers, just
3 sitting because they could not find a buyer for
4 them. And if it is swinging the other way,
5 why, buy a new one. You got the facility right
6 down the street has a perfectly good, working
7 unit that would be available, so --

8 DR. WILLIAMS: The economics of it are
9 pretty strong just to buy a new device, and
10 these -- many of these companies will offer
11 turnkey operations. Take a few signatures, and
12 you're in business, basically.

13 MR. BAI: How are the reimbursements?
14 Usually, everything's tied into how the
15 reimbursements go.

16 DR. WILLIAMS: It's quite high by
17 traditional dermatological standards. A
18 dermatologist will go on like a liquid nitrogen
19 can and freeze seven lesions in about 45
20 seconds. They'll make a few hundred bucks.
21 They traditionally have a strong, you know,
22 reimbursement stream.

23 This is obviously not quite that potent,
24 but it still does have a good code set behind
25 it. Its code legacy goes back to radiation

1 oncology, not dermatology. And it's -- the
2 reimbursement process of care resides in the
3 radiation oncology, 77xxx series. And like any
4 other fraction it's cost of radiation albeit at
5 a low-energy level. It's not like IMRT, which
6 is our big code fraction. But, at this
7 level, over long courses of therapy, it
8 reimburses quite strong.

9 The interesting aspect of it is that you
10 don't need the long course of therapy,
11 discretion in medicine being what it is. You
12 can get -- we give six treatments for our
13 skin-cancer patients. We have a very active
14 skin-cancer program in Boca Raton, and many of
15 these other places are giving six weeks of
16 therapy, reimbursed by the day.

17 MS. BONNANO: There's ethics problem here.

18 MR. FUTCH: Yeah. How do you decide, the
19 Radiological Society or the Florida
20 Dermatological Society, from the standpoint of
21 medicine, which is not the purview of this
22 committee at all, but is there one -- is there
23 a better way? Is there -- for the patient?

24 DR. WILLIAMS: There's no embedded process
25 in the healthcare system to police these types

1 of discretionary decisions. We had worked with
2 Jim Cocoran in Jacksonville on the LCD for T1
3 skin cancer, which is pretty good. There are
4 some restrictions in it, but in certain
5 circumstances, you do need to fractionate out
6 to the long course.

7 If it's on the eyelid, for example, or on
8 the lip, you don't want to burn it too fast or
9 you'll get a lot of long-term -- short-term and
10 long-term reactions. You need to get radiation
11 slower. But on free scan, you give it in six
12 doses, and you're done.

13 Now, a dermatologist who has no skill set
14 in radiation biology, fibrosis, you know,
15 long-term physics, you know, the consequences,
16 the whole universe of radiation oncology, you
17 know, scope of practice is going to make a
18 decision maybe based on other factors besides
19 just, you know, anatomical location and
20 radiation biology.

21 THE CHAIRPERSON: It sounds to me that
22 there's a valid issue here that needs to be
23 addressed. And I don't know that we're the
24 right group to do it right now, but maybe if
25 the radiation oncologists come up with some

1 sort of position paper, recommendations, we
2 could then consider the next way to go.

3 MR. FUTCH: Yeah. It sounds like a little
4 more education needs to be done, maybe with
5 some of the ways to explain exactly what the
6 system is and what it does, and then
7 probably ... have someone from the
8 dermatological society --

9 DR. WILLIAMS: It would be interesting. I
10 can talk to ASTRO, you know, and see if they
11 have any facility to bring something forward on
12 the national scene. But maybe -- and it would
13 be interesting to have the dermatologist give
14 a -- you know, some type of a ... response to
15 what they feel is the appropriate T&E for these
16 types of devices.

17 MR. FUTCH: If they were to presumably
18 come up with their own standard that they feel
19 should be maintained by dermatologists, it
20 would be a lot easier to try and see if you can
21 move forward with adopting some of that on
22 regulations; not saying it's even possible in
23 our current climate to adopt much in the way of
24 regulations, but that would certainly be the
25 most likely thing.

1 THE CHAIRPERSON: Alternatively, the
2 payers could decide to bundle the single
3 payment, whether it's got six doses or 30
4 doses?

5 DR. WILLIAMS: I'm not an authority on the
6 commercial insurance side of skin cancer
7 reimbursement, but on the Medicare side,
8 everything is still in a -- in a component-
9 coding methodology, RBRVS-type stuff, and
10 probably will be for some time to come. But
11 that's speculation.

12 Generally speaking, I don't like insurance
13 companies', you know, leverage to control, you
14 know, medical decision making. It's usually
15 not the avenue I prefer.

16 I think it is an issue. I mean, there is
17 a question as to what they're doing out there
18 and what their training level is, and -- if
19 any -- and whether they should have any type of
20 expertise that was --

21 MS. DROTAR: Are they required to have a
22 radiation-control program?

23 MR. BAI: Yes. Anybody with therapy units
24 is supposed to have at least a rudimentary --

25 MS. DROTAR: How do they comply with that?

1 I mean, they're building their own --

2 MR. BAI: Well, I know that almost any
3 oncology center --

4 MS. FORREST: I'm sorry, when you had your
5 head turned, I couldn't hear what you said.

6 MS. DROTAR: No, I was just wondering how
7 they comply with the radiation safety program
8 since everybody has to have one, is everybody
9 badged? I know it's a low dose, but is there
10 any shielding or any other --

11 MR. BAI: They are not required to be
12 badged on these units because they're never
13 within the treatment -- well, you know
14 what --

15 MS. FORREST: Well --

16 (Inaudible.)

17 MS. DROTAR: Are there other people that
18 are around that are assisting the office, if
19 that's within close proximity?

20 MS. FORREST: Well, the office itself,
21 because it's such a low dose, if that door is
22 shut and you're an office worker out there,
23 you're not in --

24 MS. DROTAR: I doubt that --

25 MS. FORREST: They are supposed to have a

1 plan. How that's enforced, when the inspector
2 comes, they review it.

3 MS. DROTAR: Yeah, but I just -- you know,
4 when Dr. Williams pointed to that --

5 MS. FORREST: Exactly.

6 MS. DROTAR: This is something 'cause then
7 that's something that's more enforceable on
8 that side if it's already in place.

9 MR. BAI: These units are an order of
10 magnitude, less sophisticated than --

11 MS. FORREST: I've worked on -- I've used
12 superficial units, and when I did, it was
13 inside another room, too, even though that's,
14 you know, a low dose. But safety-wise, we were
15 just, you know, using a room to monitor the
16 patient. 'Cause it is, you know, couple of
17 minutes sometimes.

18 MS. BONNANO: I think the problem is going
19 from the radiation therapy situation to a
20 dermatology situation. I wonder, did the
21 vendor give them six hours of training, and
22 that satisfies the state requirements? What
23 training --

24 MR. BAI: In the state of Florida, a
25 physician can use that unit.

1 MR. FUTCH: That's what I was saying
2 before, there's no authorized user-type
3 requirements for the position for these kinds
4 of systems.

5 THE CHAIRPERSON: What about from the PA,
6 if you decide --

7 MR. FUTCH: The Board of Medicine has
8 informed us, many years ago, that the PA is
9 able to do what the physician can do, if the
10 physician says that's what they can do.

11 MS. BONNANO: Oh, so they can.

12 MR. FUTCH: Oh, yeah. I'm not saying
13 there's lots of PAs doing it, but from the
14 standpoint of our statute regulation, there's
15 no way to stop that. That's a Board of
16 Medicine thing.

17 DR. WILLIAMS: Well, from a ... definition
18 standpoint, what is the difference between KV
19 brachytherapy and Orthos brachytherapy?
20 Because, from an engineering standpoint, the
21 difference is that the probe itself has the
22 electronical device, the analytic cathode in
23 it.

24 MR. BAI: Well, one of them is a Tall
25 brachytherapy, whereas the other one would be a

1 brachytherapy from within the REMS and Orthos.
2 They're all external beam REMS, whereas the
3 electronic brachytherapy actually catheters
4 from the inside out.

5 DR. WILLIAMS: Not for superficial
6 therapy. Electronic e-brachy is definitely
7 superficial since it has a surface applicator.

8 MR. BAI: Correct. But it's all
9 considered the same thing, external beam
10 therapy.

11 MR. FUTCH: I think these are good reasons
12 to seek more education, starting with
13 rudimentaries. Maybe get them to come to
14 future meetings and get them to explain what's
15 going on. And if they could find somebody from
16 a dermatological society or someone who is a
17 shining example of how things should be done,
18 come and talk about it.

19 DR. WILLIAMS: Dr. Strasswimmer would
20 come.

21 (Pause.)

22 THE CHAIRPERSON: So you'll try to follow
23 up on this next meeting?

24 MR. FUTCH: I think so.

25 THE CHAIRPERSON: Are you okay?

1 MS. FORREST: Yes, sounds great.

2 THE CHAIRPERSON: Any other comments?

3 MR. FUTCH: Any national standards, other
4 states that have adopted something along these
5 lines that we know of? Anyone?

6 MR. BAI: There are AAPM standards for
7 this.

8 MR. FUTCH: In the --

9 MR. BAI: In your protocols.

10 THE CHAIRPERSON: Are there any
11 appropriate use

12 MS. BONNANO: Is that state by state,
13 or

14 DR. WILLIAMS: I don't know, to be honest
15 with you. As to -- as to a user's guide, but
16 I'm not sure it qualifies. It's more like an
17 ACR, appropriateness criteria. Yeah, I think
18 the right resources are AAPM and ACR.

19 THE CHAIRPERSON: Okay. The next item
20 number is the approval of the bylaws.

21 MS. ANDREWS: You-all were sent a copy of
22 the bylaws that were in revision format. And I
23 incorporated any changes that you made into it.
24 There was the -- a version -- the latest
25 version that we had that I have updated. I

1 have copy of it in the packet. This would
2 constitute the changes that we had, you sent to
3 me. So if everybody is in agreement with
4 these, I think the intent is to vote on these
5 as the official bylaws. Or if anybody has any
6 questions.

7 MR. FUTCH: What are -- correct me if I'm
8 wrong -- what is it that has changed since we
9 looked at this last one?

10 MS. ANDREWS: Basically, the Department of
11 HRS, it was still 'Rehabilitative Services'.

12 MR. FUTCH: They had a 'Secretary' of State
13 Surgeon General?

14 MS. ANDREWS: Exactly. We updated the
15 Bureau of Radiation Control. I think it said
16 "Office" before; changed from the Bureau, Chief
17 of the Bureau of Radiation Control, was updated
18 there.

19 Let's see what else might have been
20 changed.

21 (Pause.)

22 MS. ANDREWS: And we decided to -- where
23 there is a Department of Health, we would refer
24 to it as The Department throughout.

25 (Pause.)

1 MS. ANDREWS: And so it was more
2 so updating the departmental information, the
3 Articles. The Composition and Memberships
4 pretty much stayed the same. The Purpose
5 stayed the same.

6 MR. FUTCH: Well, I think you've done a
7 remarkable job of keeping it concise and brief.

8 MS. ANDREWS: And, yes, it is brief. It
9 is concise. Unless you-all want any other
10 changes made to it. As I said, this was
11 what ... this incorporated the changes that
12 were sent back to me from everybody.

13 THE CHAIRPERSON: Move discussion?

14 (No response.)

15 THE CHAIRPERSON: Do we have a motion to
16 approve?

17 DR. SCHENKMAN: I make a motion to approve
18 the bylaws as is written here.

19 MS. BONNANO: Second.

20 THE CHAIRPERSON: All in favor?

21 EVERYONE: Aye.

22 THE CHAIRPERSON: Any opposed?

23 (No response.)

24 THE CHAIRPERSON: We have new bylaws.

25 MS. ANDREWS: New bylaws.

1 THE CHAIRPERSON: Okay. The next item of
2 business is the nomination of a chair and vice
3 chair.

4 I'd just like to comment, I've been chair
5 of this committee probably for about ten years
6 right now. So I would certainly welcome a
7 nomination from someone else who would like to
8 assume these duties.

9 I guess the vice-chair is Randy?

10 DR. SCHENKMAN: That's me.

11 THE CHAIRPERSON: So both of these offices
12 are open for nominations. And I encourage
13 people to ... consider doing this.

14 DR. WILLIAMS: Can the vice-chair rotate
15 up to the chair? Is that -- will the
16 vice-chair rotate up to the chair?

17 DR. SCHENKMAN: If that's what you'd like.

18 DR. WILLIAMS: I think that would be
19 fabulous, from my standpoint.

20 DR. SCHENKMAN: Well, we need another
21 vice-chair.

22 DR. WILLIAMS: I would like to nominate
23 Mark Seddon for vice-chair.

24 MR. SEDDON: Okay.

25 DR. SCHENKMAN: I'll second that.

1 THE CHAIRPERSON: Any other nominations?

2 (No response.)

3 THE CHAIRPERSON: So the motion is for
4 Dr. Schenkman to be chairman, and Mark Seddon
5 to be vice-chairman. Do you have to vote
6 separately, or is --

7 MR. FUTCH: I don't care. I don't think
8 it matters.

9 THE CHAIRPERSON: All in favor?

10 EVERYONE: Aye.

11 THE CHAIRPERSON: Any opposed?

12 (No response.)

13 THE CHAIRPERSON: Congratulations.

14 DR. SCHENKMAN: Thank you.

15 Congratulations. Thank you-all.

16 THE CHAIRPERSON: Okay. Is there any
17 other old business that we need to discuss?

18 (No response.)

19 THE CHAIRPERSON: Anyone have any new
20 business that they would like to discuss?

21 We just have 2:30 --

22 MR. FUTCH: When does the first plane
23 leave that someone has to catch? I think 4:30.
24 Is that good?

25 DR. SCHENKMAN: We're 4:50.

1 MS. ANDREWS: I want to bring your
2 attention to our travel packets, though, before
3 we close out.

4 I put travel packets before each of you.
5 There are those of you who drove, and if you
6 know your mileage, and you don't have any
7 receipts to turn in to me, you can fill those
8 out now, if you would like to, and turn them in
9 to me.

10 Anyone who has receipts, of course, has to
11 turn those back in later. I've given you a
12 self-addressed return envelope for me. The
13 instructions on top of the green papers should
14 be self explanatory. If you have any questions
15 though, let me know.

16 You have a worksheet included in your
17 packet to fill in the pencil -- pencil in all
18 your information, and there is one sheet in
19 there that's for a signature only. And if
20 you'll be kind enough not to fold it, just put
21 it back in the brown envelope and send it back
22 to me, I use this to put your travel voucher --
23 run your travel voucher on that signed sheet.
24 So there's an original signature.

25 So, as soon as you get all of your

1 information and your receipts back together and
2 send that back to me, I can complete your
3 reimbursements.

4 I also have ... for those of you who
5 either self parked or used valet parking, if
6 you would let me know, I have discount vouchers
7 for parking. And it's four dollars for self
8 parking, and seven for valet. And I'll pass
9 these down this way.

10 Anybody here?

11 MR. FUTCH: While we're on the subject of
12 what was -- do we have some members who have --

13 MS. ANDREWS: That appointment packet has
14 not come back, but it will be before Mark
15 Seddon is going to be reappointed and Patricia
16 Dycus, are the two people who were ... did I
17 get that wrong?

18 MS. DYCUS: No, I just heard my name.
19 What did I say?

20 MS. ANDREWS: Are the two up for
21 reappointment beginning July 1st. And I'm just
22 waiting for the packet to come back from the
23 Surgeon General's Office, and I will send out
24 letters after that.

25 MR. FUTCH: I was going to say that I have

1 got some of these videos that I can show, but I
2 thought maybe you want to pick a date for the
3 next meeting, and then ... if anybody has to
4 slip out, it's no --

5 MS. ANDREWS: There's calendars in the
6 very last tab -- or calendars -- for us to go
7 through. And ... I didn't write in on yours
8 the holidays. Pretty standard ones. The
9 November 12 Veterans' Day. Thanksgiving is on
10 the 28th this year, of November. Labor Day is
11 on the 2nd of September.

12 Does anybody have any opposition to
13 looking into November for this fall?

14 (No response.)

15 MR. ATHERTON: As long as it's early
16 November.

17 MS. ANDREWS: Early November?

18 DR. SCHENKMAN: When you're saying early
19 November --

20 MR. ATHERTON: You know, the closer you
21 get toward the end, Thanksgiving and the
22 holidays start to get busier.

23 MR. FUTCH: And we have the perpetual
24 request from Jerome, who always has problems
25 with May and October. But he wants to go

1 earlier, usually, right? Close toward summer
2 and not later?

3 MS. ANDREWS: November is better for him.

4 MR. FUTCH: November is better.

5 MS. ANDREWS: And so the first Tuesday of
6 November is the 5th, so -- and then right after
7 that, I got Veterans' Day.

8 MR. FUTCH: So what about the 5th? Would
9 that be --

10 DR. SCHENKMAN: That would not be good for
11 me. My son is getting married on the 2nd. So
12 I don't think I'm going to be back to Florida
13 yet. Does it have to be a Tuesday?

14 MR. FUTCH: Not for my purposes. That's
15 something that this group decided on a long
16 time ago, and just kept going with it.

17 DR. SCHENKMAN: What about the 12th?

18 MS. ANDREWS: The 12th is Veterans' Day.

19 DR. SCHENKMAN: Oh.

20 MS. BONNANO: We don't want you to have to
21 travel on a holiday.

22 MS. ANDREWS: Not again.

23 MR. FUTCH: Curses to Microsoft for not
24 putting the holidays in Outlook.

25 THE CHAIRPERSON: Is the 19th too late?

1 MR. LAGOUTARIS: That Thursday, no. When
2 will thanksgiving be, the 28th?

3 MS. BONNANO: The 19th is good for me.

4 MS. ANDREWS: Does the 19th sound -- is
5 that good for you? Is that too late?

6 MR. ATHERTON: That's fine. That's fine.

7 MR. FUTCH: Try it.

8 DR. SCHENKMAN: The 19th works for me.

9 MR. FUTCH: We were talking about other
10 times in the week.

11 DR. SCHENKMAN: Unless anybody wants to
12 make it ... a day different, you know, a
13 different day than a Tuesday.

14 MR. FUTCH: Like the 7th of November?

15 DR. SCHENKMAN: The 7th would be okay for
16 me.

17 MS. ANDREWS: Is that better?

18 DR. SCHENKMAN: Is that okay for
19 everybody, a Thursday?

20 MS. BONNANO: Sure.

21 MR. FUTCH: We're just breaking the mold,
22 aren't we. Thursday. What kind of --

23 MR. LAGOUTARIS: Chairwoman for five
24 minutes, and she's already shaking it up.
25 Shake it up.

1 MS. ANDREWS: Okay. So we're looking at
2 November 7th.

3 DR. SCHENKMAN: Right.

4 MS. ANDREWS: That's a Thursday.

5 DR. SCHENKMAN: So if that seems to work
6 for everybody, let's do that.

7 MS. ANDREWS: So that means travel on the
8 6th for some people, so that's still okay.

9 MS. BONNANO: Yeah.

10 MS. CURRY: Us.

11 MS. ANDREWS: Us. Right. Some people,
12 meaning us.

13 DR. SCHENKMAN: Let's start our new year
14 with something new.

15 MS. BONNANO: Are we meeting in Orlando or
16 Tampa?

17 MR. FUTCH: Oh, my goodness, another
18 decision. Orlando or Tampa?

19 DR. SCHENKMAN: Oh, I like Orlando. What
20 does everybody else like?

21 MS. CURRY: Orlando.

22 MR. ATHERTON: Orlando.

23 MR. FUTCH: We certainly have been in
24 Tampa far more often, so I think Orlando -- we
25 should try that for a while.

1 DR. SCHENKMAN: This was easy.

2 MR. FUTCH: Isn't Orlando a great place to
3 fly in and out of?

4 THE CHAIRPERSON: About the same as Tampa.

5 MR. FUTCH: All right.

6 DR. SCHENKMAN: Okay. Anybody have
7 anything else before --

8 MR. FUTCH: We start the film strips?

9 All right. Well, there's several videos
10 here from the federal government's Domestic
11 Nuclear Detection Office (DNDO), and we'll just
12 start with the first one. And we couldn't --
13 we couldn't make the external speakers work,
14 but we tried this in the room before, and we
15 thought we could be heard, so we'll just try it
16 with the laptop speakers and see how this goes.
17 If I could turn this over when it's connected.

18 (Video clips played.)

19 MR. FUTCH: I'm very impressed, there was
20 some bass to it. But, basically, that was a
21 little snippet from all the individual training
22 videos. We've got -- you saw the Suffolk
23 County folks. The New York guys have been
24 doing this for a long time. So DNDO went to
25 them for part of the pre-event screening at ...

1 it was a baseball game. The Philadelphia guys
2 were involved. The Los Angeles county people
3 were the ones that had the Rose Bowl. And I
4 didn't see the -- the Gulf Sentry crew in this
5 one, but they have their own separate little --
6 separate little video.

7 Let me see if I can find that. Some
8 other ... fisheries patrol. That sounds --
9 that kind of sounds like them.

10 (Video clip played.)

11 MR. FUTCH: So this is the boat from
12 Carrabelle.

13 (Video clip continued playing.)

14 MR. FUTCH: So they use them, the Thermo
15 RadEye, PRD RadEye.

16 (Video clip continued playing.)

17 MR. FUTCH: I don't know if anybody is
18 from Panama City, but I think they actually
19 shot this off the coast from there.

20 (Video clip playing.)

21 MR. FUTCH: Now, we actually couldn't, the
22 day they were doing it, provide the real
23 sources, so they faked all of the sources on
24 this, so ... it's a little unrealistic to think
25 it would pick up something from that far away,

1 and that those guys would still be there
2 without experiencing some problems. But you
3 know, it's Halloween.

4 So -- and that's the RSI detector that
5 they've got. That's the screen. And they
6 probably didn't know what to take a shot of to
7 show you. So there's -- no idea what that is.
8 Well, look, it's actually alive.

9 That peak looks about what a Cesium-137
10 would be.

11 So he's going to send some stuff to the
12 national lab scientists, take a look at it.

13 The detector is right behind the
14 wheelhouse on the back deck. It's that -- that
15 large black thing over there.

16 MR. JOHNSON: Is that always on that boat?

17 MR. FUTCH: No. FWC rotates their
18 detector between their helicopters and the
19 large-vessel boats. Different parts of the
20 state.

21 THE CHAIRPERSON: This is okay with sea
22 water?

23 MR. FUTCH: So far. We have seen some
24 systems from other manufacturers that were not
25 self contained in the carbon fiber NATO pod. I

1 call it Mr. Spock's coffin, because it kind of
2 looks like the coffin from Star Trek II, "The
3 Wrath of Khan," but all of the important
4 components are all internal. It's built to go
5 on an aircraft. They put it on their cue, and
6 then they moved it outside on one of the skids.

7 So, all of the connections that you're
8 making are all inside. They're actually --
9 they actually use WiFi to deliver the data
10 inside the pod, into the cabin. So there's no
11 external connection to fail, unlike some other
12 manufacturers which have some external
13 connections.

14 We saw one of them that mounted it on the
15 railing on another boat in a different part of
16 Florida, and they had all this cabling, and
17 they put the detector so that the -- the
18 connector to the detector, which was
19 encompassed by the wire, was facing to the bow,
20 so that when the boat was moving, the spray was
21 actually hitting the front of the detector.
22 And they had the wires ... mounted to the rail,
23 and the wires kind of looped down into the
24 detector like this. So as the wires caught the
25 spray, the water would drip down, go right into

1 the connector in front -- that's not going to
2 last too long. We told them about it. I don't
3 know if they ever changed it.

4 Let me see what else I have.

5 Recreational boating. I'm not sure what's
6 the different about this one. Well, the guy
7 doing the talking with the white hair is
8 Captain Brad Williams. He's retired now. But
9 he's still a reserve officer with FWC. He was
10 their statewide PRND.

11 (Video clip playing.)

12 MR. FUTCH: So the previous scenario was a
13 fishing --. The FWC has lots of reasons to
14 stop folks. They could stop anybody for just
15 the safety check. They don't need probable
16 cause.

17 Yeah. See, this is really a hard thing to
18 do on a boat. You can't really make them go
19 jump in the water while you're searching the
20 vehicle.

21 (Video clip playing.)

22 MR. FUTCH: So he's just wearing that same
23 PRD that he had in vibrating mode that was
24 going off as he was talking about -- he was
25 getting a reading on it.

1 (Pause.)

2 MR. FUTCH: So one counts per second, back
3 107 counts per second, and out on the water,
4 because you've got the shielding and actually
5 the material, it's almost zero in water,
6 normally, unlike standing on land.

7 (Video clip playing.)

8 THE COUNCIL: Who had the cardiacs?

9 MR. FUTCH: We'll find out in a second.

10 (Video playing again.)

11 MS. BONNANO: What did you do yesterday?

12 (Video continued playing.)

13 MR. FUTCH: Sure, being told the source of
14 radiation didn't help you today. His partners
15 are going to throw him out of the boat.

16 (Video clip playing.)

17 MR. FUTCH: It's always at the house.
18 It's always on the dresser.

19 (Video clip playing.)

20 DR. SCHENKMAN: How many of the officers
21 are that nice?

22 MR. FUTCH: FWC is pretty good, at least
23 the ones I've worked with.

24 MR. BURRESS: I got stopped twice in the
25 same day at a Carrabelle office. Now I know

1 why. Don't take my sources fishing.

2 MR. FUTCH: Now, he didn't have the
3 advantage of having the boat with the whole
4 gamma spect system sitting on it. But they've
5 got quite a few of the hand-held devices spread
6 around the state of Florida. They didn't
7 incorporate it into this training video.

8 But if he had had some reason to suspect
9 there was something else going on, like there
10 was something in the boat, and it wasn't
11 obviously following a person who appeared not
12 to have anything on them or anything else, he
13 could have called for one of the RIID devices
14 to come out there and help them until the guy
15 got there with the RIID, and then saw that it
16 was probably Tech 99 or something like that,
17 with the scan. It only takes a minute or two
18 to make the scan.

19 But we trained them that, you know, if
20 there's not a reason to suspect that the person
21 might be holding a device or a piece of a
22 device, there's always the possibility that he
23 could have been working on something, and it
24 could be Cesium 137, causing the scan and maybe
25 just not very good at working and keeping

1 himself from being contaminated.

2 But, you know, you look at the situation.
3 The guys, they still have to use all their
4 normal cop skills and abilities to make a
5 determination not to hold a guy for, you know,
6 half an hour or 45 minutes while somebody
7 brought in a RIID.

8 But ... so that's -- that was the boat
9 stuff. I think there's at least one more of
10 these, choke-point things.

11 THE CHAIRPERSON: Anyone that has to
12 leave, feel free.

13 MR. FUTCH: These might be the
14 Philadelphia or the New York guys. I can't
15 remember.

16 (Video playing.)

17 MR. FUTCH: Oh, it's Brad again. Okay.

18 (Video playing.)

19 MR. FUTCH: So this was an intelligence-
20 driven operation, so they're going to set up a
21 choke point with a couple of boats someplace,
22 probably like underneath that bridge where
23 there's a natural restriction, where they can
24 put up some backpacks, radiation detectors, and
25 have a pretty good chance of picking up a

1 source going through.

2 MR. ATHERTON: Is it as common to find
3 boat sources as land -- as trucks?

4 MR. FUTCH: Not really. Although it's
5 much easier to pick them up if you're close.
6 But the only time they ever get close enough is
7 if they're doing one of those boating safety
8 checks, or they're having a choke-point-type
9 situation ahead of time.

10 So they're taking the backpack systems
11 which have Helium-3 neutron detectors, as well
12 as sodium iodine crystals in them for gamma
13 detection, and putting them all over the
14 superstructure of the boat to get a good view.

15 (Video clip playing.)

16 MR. FUTCH: Just basic stuff. Tell them
17 which side of the boat to put the detector on.

18 (Video clip playing.)

19 MR. FUTCH: So he's preparing them in case
20 there is going to be more than one source boat
21 coming through. They don't want to lose the
22 whole control of the choke point, chasing after
23 somebody who might be a nuclear medicine
24 patient, when the real source is coming through
25 right behind them.

1 (Video clip playing.)

2 MR. FUTCH: Okay. So the third boats have
3 got the hand-held identifiers on them, and the
4 other two boats that are on choke points are
5 the ones that have the backpacks. That's the
6 control system for the backpack. It's an LED
7 type system. More bars means more radiation.

8 (Video clip playing.)

9 MR. FUTCH: Just trying to skip ahead so
10 we get to where they're actually in the water.

11 (Video clip playing.)

12 MR. BURRESS: Do you-all have any problems
13 with these crystals cracking?

14 MR. FUTCH: Yeah, the Raytheon trucks,
15 which are the oldest ones in the inventory, are
16 already having some degradation. In fact,
17 Raytheon was supposed to be swapping out some
18 crystals in Panama City, but the guy who was
19 doing it couldn't make the trip, so they're
20 going to have to do it in a couple of months.

21 But DNDO bought scads and scads of these
22 four-by-two's, and they're all sitting in the
23 federal warehouse. And every time you talk to
24 one, they're like, "You need some crystals?"
25 And they won't ship anything less than a

1 pallet-full of them.

2 So you get -- anybody has space for eight
3 four-by-two crystals hanging around in their
4 office someplace? Let me know, because we want
5 to store some.

6 (Video clip playing.)

7 MR. FUTCH: So they're just going to go
8 out and set up a choke point. They do this on
9 land too for stadiums and all the natural
10 entrances. Oh, that's nice little traffic.

11 (Continued video playing.)

12 MR. FUTCH: So one and two are going to
13 stay there and maintain the choke point, and
14 three's going to go after him.

15 (Video clip playing.)

16 MR. FUTCH: That's convenient, right.

17 MS. BONNANO: That sandbar right there.

18 (Video clip playing.)

19 MR. FUTCH: And that little source in the
20 troxler gauge is the next most common thing
21 that people find after nuclear medicine
22 patients. And then third most common is
23 industrial radiographers doing work with
24 industrial radiography camera, x-raying tanks
25 and things and all the rest of it.

1 Well, that's all we have, folks. Hope you
2 enjoyed the film strips.

3 THE CHAIRPERSON: Thank you, everyone.

4 (The meeting concluded at 3:08 p.m.)

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CERTIFICATE OF REPORTER

STATE OF FLORIDA)

COUNTY OF ORANGE)

I, RICHARD CASTILLO, Professional Court Reporter and Notary Public, do hereby certify that I was authorized to and did stenographically report, to the best of my ability, the above proceedings, and that the foregoing transcript, pages 3 through 135, is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, or attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with the action, nor am I financially interested in the action.

DATED this 7th Day of June, 2013, at Orlando, Orange County, Florida.



RICHARD CASTILLO
Certified LiveNote Reporter
Notary Public, State of Florida at Large
Commission No. EE037170
Expiration: February 25, 2015