

**THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**

convenes the

TWENTY-NINTH MEETING

**CAMP LEJEUNE COMMUNITY ASSISTANCE**

**PANEL (CAP) MEETING**

September 11, 2014

The verbatim transcript of the  
Meeting of the Camp Lejeune Community Assistance  
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STEVEN RAY GREEN AND ASSOCIATES  
NATIONALLY CERTIFIED COURT REPORTING

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September 11, 2014

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### TRANSCRIPT LEGEND

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-- "^" represents unintelligible or unintelligible speech or speaker failure, usually failure to use a microphone or multiple speakers speaking simultaneously; also telephonic failure.

**P A R T I C I P A N T S**

(alphabetically)

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P R O C E E D I N G S

(8:52 a.m.)

PRE-MEETING - TECHNICAL DISCUSSION ON SOIL VAPOR

INTRUSION AND DRINKING WATER EXPOSURE EVALUATIONS

MR. BRUBAKER: Well, good morning folks and welcome. As you may remember my name is Matt Brubaker and I'm here filling in for Chris, and about to call to order this informal meeting designed as an opportunity to discuss, to hear some content from Rick and team and also to discuss soil vapor intrusion and drinking water evaluation material.

Before we do that, I'd like to just sort of remind you, in case you haven't become aware already, I know it sort of dawned on me as I got out of bed this morning, that we're celebrating, or I should say remembering, the 13<sup>th</sup> anniversary of the 9/11 attacks on our country, and we're nearing 9:03 a.m., which is the time in which the second jet hit the second tower of the World Trade Center. So I'd like to invite us to begin this morning with a brief moment of solemn observance and remembrance of the attack that that had on our country and the people who we know and care about.

(Moment of silence)

1           **MR. BRUBAKER:** Thank you. This morning I'll  
2 turn the agenda over to Rick to walk us through what  
3 we can expect in the next hour and a half to two  
4 hours.

5           **MR. GILLIG:** Do I need to speak into the mic?

6           **THE COURT REPORTER:** Please. If everyone will,  
7 yes, please.

8           **MR. GILLIG:** Before we get started, just a  
9 couple of housekeeping issues. The restrooms are  
10 out the back, off to the left, halfway down the hall  
11 on your left-hand side. There's also water  
12 fountains out there. We have a number of  
13 refreshments in the back. Please help yourself.

14           This morning we wanted to update you on our two  
15 projects, the soil vapor intrusion project and the  
16 evaluation of the drinking water exposures. This is  
17 a working meeting so we want to keep it very  
18 informal. This is an opportunity to ask questions,  
19 ask questions during the presentations, that's fine.  
20 We'll have discussion throughout the presentations.  
21 So please let us know what your questions are or if  
22 you have comments. Not sure I have anything else to  
23 say, I think we're probably -- are we going to do  
24 introductions, Matt?

25           **MR. BRUBAKER:** You know, I think it would be

1 helpful to do introductions. I know we have some  
2 new folks here. We'll probably do it again when the  
3 others join us.

4 **MR. GILLIG:** Okay. And I guess I'll start. My  
5 name is Rick Gillig. I'm a branch chief within  
6 ATSDR, and the soil vapor intrusion project and the  
7 re-evaluation of drinking water falls within my  
8 branch.

9 **MR. ENSMINGER:** Are you a real honest-to-God  
10 branch chief or are you acting?

11 **MR. GILLIG:** I am an honest-to-God branch  
12 chief.

13 **MR. ENSMINGER:** No kidding. Somebody is  
14 actually --

15 **MR. GILLIG:** Honest to God?

16 **MR. ENSMINGER:** I'm about to fall out of my  
17 chair. I'm Jerry Ensminger. I represent the  
18 community on the CAP.

19 **MR. PARTAIN:** Mike Partain with the CAP.

20 **MR. WILKINS:** Kevin Wilkins with the CAP.

21 **MR. BRUBAKER:** Matt Brubaker.

22 **MR. TEMPLETON:** Tim Templeton, CAP.

23 **DR. CLAPP:** Dick Clapp, CAP.

24 **MR. ORRIS:** Chris Orris, CAP.

25 **MS. FRESHWATER:** Lori Freshwater with the CAP.

1                   **MS. FORREST:** Melissa Forrest here for the Navy  
2 and Marine Corps Public Health Center.

3                   **MR. SMITH:** Gavin Smith, also with the CAP.

4                   **MR. ENSMINGER:** Who's that guy talking in the  
5 funny thing over there?

6                   **MR. GILLIG:** Again I want to welcome everyone,  
7 and Chris if you are ready, we will kick this off.

8                   **MR. FLETCHER:** Good morning. Chris Fletcher,  
9 I'm responsible for the soil vapor intrusion portion  
10 of our assessment. At the last CAP meeting, we had  
11 a pre-CAP working meeting, so a bunch of you know me  
12 from there. And the new folks, this is just an  
13 update to talk a little bit of what we talked about  
14 last time, and just kind of a summary of where we  
15 have gone since then.

16                   So as a reminder some of what we've looked at  
17 so far and what we're looking for in our documents,  
18 doing a document search of data from indoor air  
19 sampling, ambient air, subsurface air, soil vapor  
20 and gas, and shallow groundwater data. Looking for  
21 those in hopes that we find sufficient quality and  
22 quantity so we can do inhalation dose calculations.  
23 And again, if we find sufficient quality and  
24 quantity, we can do some modeling, Johnson and  
25 Ettinger modeling, or if we've got even more -- a



1 more robust data set is what we end up with, perhaps  
2 we can utilize Morris and the dose reconstruction  
3 lab to do even slightly more advanced modeling. It  
4 really just depends on what we find.

5 So you remember this slide last time I showed  
6 you. It had a lot of colors kind of indicating  
7 which source each set of data you see displayed here  
8 came from. This time I've done some shading to kind  
9 of show you what we're done with and what we have  
10 left to do. So the dark shaded sources, ODI, DART,  
11 EMD, NIRIS, that we've completed our search on. And  
12 then the four lighter gray sources of data are those  
13 that we've got left to search or are in progress  
14 searching. So just kind of a quick snapshot of some  
15 progress that we've made.

16 So the goals of our final search are obviously  
17 to gather environmental sampling data relevant to  
18 soil vapor intrusion. We want to produce eventually  
19 an accurate, complete list of all of the documents  
20 that we have in our possession, that we can share so  
21 everyone will know exactly what documents we're  
22 looking at, and then to eventually create a database  
23 from all the data we find within those documents,  
24 and make the database searchable by date, date  
25 range, building number, operable unit number,

1 section of the base, site number, and of course some  
2 of that just depends what we can find in the data as  
3 to how detailed we can make it, but certainly  
4 searchable by date, date range, building number, and  
5 kind of what you'd expect to see.

6 So now the updates. As you can see we've --  
7 with ODI, NIRIS and DART we've completed our search  
8 and have started reconciling the documents against  
9 our requested list. We want to make sure that we  
10 have indeed been sent all the documents we  
11 requested. We have received several thousand  
12 documents, so it's -- there's a lot of detail to  
13 look through but we're making progress.

14 As we're going through, we're also identifying  
15 and removing duplicate files. As you remember on  
16 this slide, a couple of slides ago, where all the  
17 circles indicated the different data sources, there  
18 was quite a bit of overlap so we know there's a lot  
19 of duplicates, and we're working through that list.

20 The UST portal, we've received all the  
21 documents from the UST portal. And everything that  
22 we've received from them, we've packaged up and sent  
23 back to the Navy. We're going to start reviewing  
24 those for public release. So we're making progress  
25 towards getting some documents out to you guys.

1           We've also completed a review of the  
2           environmental management library, the EMD portal.  
3           The base safety database, we're going to start  
4           reviewing that next week. That's one that I've  
5           actually got to get into. We'll get that up next  
6           week.

7           The update on the Camp Lejeune fire department,  
8           so we made a request for files from the fire  
9           department in the 911 call center. They sent us  
10          five files that were post-2008, none of which  
11          contain any sampling -- environmental sampling data.  
12          As you remember, the last time I explained the, the  
13          system apparently was updated in 2008 when they  
14          started a new system. Prior to 2008 they had an  
15          older system. When I requested that -- access to  
16          that specific system, the response was that the fire  
17          and emergency systems, I think what they called it  
18          firehouse reporting system was the exact title of  
19          that, no longer exists and they don't have records  
20          that they can provide. And they said their firemen  
21          have looked high and low in their facilities, and no  
22          paper documents remain of any type.

23          Okay, so for the MCI East, geospatial program,  
24          we've got all of their GIS layers here. So they're  
25          ready for us to start using and utilizing next week,

1 process the data to locate that to buildings that  
2 were, and then are no longer buildings that are  
3 there currently so we've got historical layers as  
4 well as current layers.

5 We've received all our documents from the  
6 contractor data sources that I mentioned last time.  
7 There was a bullet for, I think, TerraBase was the  
8 name of the ^ database. Anything we've requested  
9 from the contractors has also been received.

10 The Navy industrial hygiene database, we hope  
11 to have a view of that completed later this week.  
12 Some preliminary findings are that prior to 2000,  
13 you kind of see what you would expect to see, and  
14 that is most of the sampling that was done was based  
15 on job safety analysis. So in other words if  
16 someone works with VOC chemicals, gasoline and  
17 whatever, on a daily basis, they were monitoring  
18 those individuals to make sure they are aware of the  
19 levels they are exposed to, and they've got a PP in  
20 place or management in place to protect those  
21 workers. What we start seeing about late '99 to  
22 current is ^ sampling of buildings that are over  
23 known plumes or when there's a -- somebody called in  
24 and said, hey, you know, we've been smelling gas  
25 odors, they would send somebody in to do an indoor

1 air sample in that event.

2 **MR. ENSMINGER:** Yeah, they'd send the fire  
3 department. And now they're saying that they don't  
4 any of those samples?

5 **MR. FLETCHER:** Yes, sir. The, the fire  
6 department is -- we've got what they've sent us.  
7 And what they've sent us is apparently what they  
8 have.

9 So the numbers that I've mentioned last time, I  
10 think it was a few hundred samples dealing with  
11 building 1101, none of that's changed so we have to  
12 have more samples in the industrial hygiene database  
13 that we discussed last time. This is just a little  
14 bit more about those samples and what we're finding  
15 there. Like I said --

16 **MR. PARTAIN:** Chris. There's documentary  
17 evidence that the hospital hygiene unit was involved  
18 in testing in the 80s, like with the daycare and  
19 stuff. Do you have -- have you been able to  
20 identify that documentation on this website?

21 **MR. FLETCHER:** No. No, the industrial hygiene  
22 database isn't a website; it's just an Access  
23 database.

24 **MR. PARTAIN:** Okay. Sorry.

25 **MR. FLETCHER:** The industrial hygiene database,

1           it was just a database. We haven't found a  
2           tremendous amount from the 80s. Jerry?

3           **MR. ENSMINGER:** He misspoke. He's talking  
4           about the preventive medicine unit, the PMU, at the  
5           naval hospital.

6           **MR. FLETCHER:** We have not found records that  
7           you're aware of. Maybe offline you can share with  
8           me a little bit more about that, and I can kind of  
9           make a practical request for that.

10          **MR. PARTAIN:** Sure. Yeah.

11          **MR. FLETCHER:** Okay. So Camp Lejeune public  
12          works and installation development division, both of  
13          these are sources of as-built and design drawings,  
14          purposes of the building, intended uses and eventual  
15          uses of the building. So we'll make request of  
16          those. We haven't started yet. Those will be kind  
17          of ongoing. Once we get to the part with extracting  
18          the data, we'll look at each, building by building  
19          and if we need to know a little bit more detail  
20          about a construction, a crawlspace or a slab or  
21          whatever of the building in particular, that's when  
22          we'll make the request for them to get that  
23          information.

24          So US EPA documents. We've completed our  
25          review. We went through their entire CERCLA record,

1 all archived documents. There's about 40-some-odd  
2 boxes, file boxes, that we went through as well as  
3 all the documents kind of loose in their office. We  
4 compared the titles of the documents that we saw  
5 with the list of titles that we have seen from the  
6 Marine Corps and the Department of the Navy sources.  
7 We scanned and brought back a copy. We got a copy  
8 of all of the unique documents, in other words  
9 documents we hadn't seen yet.

10 So we're working on compiling our index from  
11 the, what we saw at EPA, both the documents that we  
12 didn't copy and documents we did copy, and we'll  
13 have that soon to share with you. And then that  
14 will aid your request. I'm sure you're going to  
15 make a formal request to EPA, so we'll try to make  
16 it as easy as we can for you there, including box  
17 and folder numbers where that's available for us to  
18 report.

19 With the data mining technical workgroup  
20 documents, those are a group of documents we'll  
21 include in the ultimate group of PDFs, we can start  
22 keyword searching, so nothing really for us to do  
23 with those for now, but we -- it's basically  
24 Morris's history of all the documents they've looked  
25 at and put in with everything else we did to that

1 point.

2 In North Carolina, the Department of  
3 Environment and Natural Resources database, we are  
4 currently reviewing those documents to see what they  
5 contain.

6 The petitioner documents, in other words the  
7 documents we've received from you guys in the CAP,  
8 the last thing you gave us over 15,000 documents.  
9 At first glance on those, we kind of ran a duplicate  
10 check on those. We got 6,500, approximately,  
11 documents that you gave us we've already got. What  
12 we'll do with the other documents is we will include  
13 those in with everything else that we search when we  
14 begin -- get to the keyword search portion. We'll  
15 have your -- all the unique documents you gave us  
16 including both the data mining, the workgroup, the  
17 EPA and all those documents we'll do a keyword  
18 search just like everything else.

19 So again the goals. We're looking for any  
20 environmental data that we can find. We're going to  
21 develop this list of all the document titles; there  
22 will be a comprehensive list of everything including  
23 source. You'll know whether it's an EPA document or  
24 a ^ document or one from the Marine Corps. If it's  
25 from the Marine Corps, hopefully we'll also have one



1           there that indicates whether it's NIRIS or ODI or  
2           what source from within the Marine Corps it came  
3           from.

4           And all this is done in the, in the pathway to  
5           get to the construction of a database that will  
6           contain all the data so we can do smart searches by  
7           building a date range and that sort of thing and ^  
8           into hopefully doing some exposure scenarios.

9           So the next steps what we've got left to do.  
10          We're going to complete the review of the North  
11          Carolina DENR record, which as I said is ongoing.  
12          We've got to finish our reconciliation of duplicate  
13          removal of all the documents from the Department of  
14          the Navy. Once we're done with that we'll have our  
15          group of documents that still needs to be  
16          compressed, so we'll run this through a compressor.  
17          What that enables us to do is keyword search much  
18          faster. We're talking instead of weeks, days, at  
19          most a couple days, to search the entire set for one  
20          keyword. So it's just a step in the process.

21          Once we're done with our compression we can do  
22          our keyword searches. We got our keyword list that  
23          we've been floating around, everyone in our group  
24          including environmental scientists and our vapor  
25          intrusion subject matter experts have kind of

1 approved our list of basically a list that we'll  
2 keyword search of building numbers, buildings that  
3 we know to be of interest, buildings that, in our  
4 review -- we've found some other buildings not  
5 previously identified that we maintain that we need  
6 to look further into that. Those building numbers  
7 will be included as well as VOCs, contaminant names  
8 in some of the sections of the base, basically  
9 anything of interest, we can do a keyword search on  
10 that.

11 The keyword search that we're using will  
12 produce a large document. Each keyword hit will be  
13 displayed. We'll have one of our environmental  
14 health scientists go through and look at these  
15 keywords to discern whether or not it's an actual  
16 keyword result or part of a string of regular  
17 characters; in other words, if we search 1101, as in  
18 building 1101, it could return results saying found  
19 building 1101 or it could just happen to be 1101 in  
20 a larger stream of characters. So we'll have our  
21 environmental scientists go through and  
22 differentiate there. And what the keyword search  
23 will also allow them to do is go click on a link  
24 that provides to that document where it cited that  
25 word. Go to that document, look right at it and

1 know whether or not it's a real hit or not, and then  
2 while they're in that document, they can look for  
3 data. Then they can record that document, and we'll  
4 know whether or not it has in fact environmental  
5 sampling data that we'll need to extract.

6 Once we get done with all our keyword searching  
7 and all our keyword search reviews, we'll have our  
8 list of documents and then go back through and  
9 extract all the data. So that's kind of the process  
10 we're moving through. Keyword searching,  
11 identifying the documents that we do have data,  
12 using those keyword -- because -- is it on? The  
13 green light's on.

14 **MR. ENSMINGER:** The red light's not on around  
15 the microphone.

16 **MR. FLETCHER:** Sorry. So once the -- where was  
17 I? Keywords, we'll -- using the keyword searches,  
18 we'll identify the documents that have data. Once  
19 we've got that list, we'll go through and extract  
20 all the data from those documents and then build the  
21 database. Once we got the database, we're ready to  
22 go. We can do those calculations and whatever else  
23 we want to use it ^.

24 So a few steps left but a lot of documents to  
25 go through, thousands of documents to go through.

1 But we're making good progress. We've got some  
2 contractors onboard that are going to help us go  
3 through all this. So we're, we're making good  
4 progress. At the time where we're starting to make  
5 progress. I think by the next CAP meeting we'll  
6 know what we can do, update to give to the CAP. So  
7 any questions?

8 **MR. TEMPLETON:** This is Tim Templeton, I do  
9 have a couple of questions. One, is it going to be  
10 stored in, let's say, a Microsoft Access file or is  
11 it going to be in a, like an Oracle DDMS?

12 **MR. FLETCHER:** Okay.

13 **MR. TEMPLETON:** That's, that's the first  
14 question.

15 **MR. FLETCHER:** So the plan is we're going to do  
16 a keyword search two ways, to make sure we're not  
17 missing anything. One is we're going to use --  
18 inside Adobe Acrobat, there's the advanced search  
19 features, which we'll use. Also we've got access to  
20 some really intelligent folks here who know how to  
21 use SQL Server.

22 **MR. TEMPLETON:** Okay.

23 **MR. FLETCHER:** So we're going to build a SQL  
24 Server database that also will look for keywords.  
25 We'll have it both ways.

1                   **MR. TEMPLETON:** Okay. That's fine. That was  
2 the first question.

3                   **MR. FLETCHER:** What we're going to do with the  
4 data, we're going to extract it out and put into an  
5 Excel file, because most folks here are, you know,  
6 more versed with Excel. We'll take that and load  
7 that into either SQL Server or Access. At this  
8 point we're just not really sure how we're going to  
9 do that yet. We'll make that determination based on  
10 how much data we get and how well SQL Server  
11 performs once we load all the documents in it. Most  
12 likely it's going to be a SQL Server database. It's  
13 going to be such a large data set I think it's going  
14 to be a lot better to use that way.

15                   **MR. TEMPLETON:** Right, I'd be surprised if it's  
16 not. Second question, I sent over a list, I'm not  
17 sure if you've received it, but I sent a list to the  
18 rest of the CAP of about 506 document titles of  
19 particular interest. They were ones that, as I  
20 parsed through them, it appeared that a large number  
21 of them happened to be work product from the site  
22 logs and so forth that were not -- that are of  
23 interest later on but not of interest at this point,  
24 at least in a higher level. So I sent over a list  
25 of 506 documents that we'd like to see right away,

1           and I was curious whether there's any  
2           prioritization.

3           **MR. FLETCHER:** The list hasn't made it to me  
4           yet but I'd be glad to talk with you offline here in  
5           the next break or whatever, and see what you're  
6           talking about.

7           **MR. TEMPLETON:** Great. Thank you.

8           **MR. GILLIG:** Tim?

9           **MR. TEMPLETON:** Yes, sir?

10          **MR. GILLIG:** The list of documents you sent was  
11          from the US underground storage tank program.

12          **MR. TEMPLETON:** I believe so, yeah.

13          **MR. GILLIG:** And we have given that a priority  
14          as far as completing our consolidation of those  
15          files and also providing an index and copies of the  
16          documents to the Department of the Navy.

17          **MR. TEMPLETON:** Okay. Thank you.

18          **MR. ENSMINGER:** I don't have a question; I have  
19          a statement to make about the access to these  
20          documents. You know, Camp Lejeune was declared a  
21          Superfund site in October of 1989. It remains on  
22          the Superfund list. The documents that we're  
23          talking about have nothing to do with national  
24          security. These documents relate to contamination  
25          aboard the base. In all intent and purposes, those

1 documents should be part of the Administrative  
2 Record now, so I don't understand why these  
3 documents are being withheld from the public.  
4 There's no reason for it.

5 I mean, FOUO is not a legitimate reason to  
6 withhold documents from the public; the public has a  
7 right to see. I mean, you got to understand there's  
8 another tentacle to this whole mess, and that's the  
9 judicial side to this thing, court cases. They're  
10 withholding these documents on purpose. I mean,  
11 this is akin to a criminal telling the prosecuting  
12 attorney and the judge and the court what evidence  
13 can be used against them and what can't.

14 Now, we need these documents. I'm tired of  
15 waiting. Somebody needs to release these. FOUO is  
16 not legitimate. It's not a legitimate reason to  
17 withhold these documents from us.

18 **MR. GILLIG:** Mike, can you hold on for a  
19 second?

20 **MR. PARTAIN:** Sure.

21 **MR. GILLIG:** If I can address your comments.  
22 You're right, these documents, a number of these  
23 documents, should be in the Administrative Record.  
24 ATSDR nor NCEH nor our attorneys are in charge of  
25 the Administrative Record. The responsibility for

1           populating and maintaining the Administrative Record  
2           is the Department of Navy, because -- in part  
3           because this is a federal facility site, and EPA has  
4           delegated that authority to the Department of the  
5           Navy. As far as the FOUO documents, For Official  
6           Use Only, that's a designation that the Department  
7           of Navy places on the documents. That is not  
8           ATSDR's decision. So again, it is the Department of  
9           Navy's decision. We don't have a say in that.  
10          That's strictly their decision. I guess I'll leave  
11          it at that.

12                 **MR. PARTAIN:** To add onto what Jerry was  
13           saying, which is made a comment on, first of all,  
14           Chris, this library that you guys are creating with  
15           the database and everything, are they going to be  
16           placed on a disc and made available to the public so  
17           we can go through and use that search as part of  
18           your product? Like for example with the Tarawa  
19           Terrace water modeling system, there was a disc;  
20           with the Hadnot Point system, there was a disc. I  
21           think the Tarawa Terrace system had a limited search  
22           capability with it. But I would imagine if, you  
23           know, the vapor intrusion report that you all would  
24           do, you know, a disc should be put out with those  
25           that can be searchable to back up what you guys did.



1           **MR. FLETCHER:** Honestly, that's something we  
2 haven't even thought of or discussed; we're just not  
3 that far down the road. But it's something we'll  
4 talk about. I guess it just depends what the  
5 lawyers decide as to --

6           **MR. PARTAIN:** Well, I mean --.

7           **MR. FLETCHER:** -- as to what they'll release.  
8 Once the reports are released publicly, I don't see  
9 what difference it would make, whether they are --  
10 you know, the data's on the document versus a  
11 database but that's way above my pay grade.

12           **MR. PARTAIN:** Yeah, I mean, you guys are  
13 spending all this money to create the searchable  
14 database so you can do what you're doing, and we  
15 appreciate that, but as with any type of scientific  
16 work, you've got to be able to reproduce your  
17 findings, and the only way you're going to be able  
18 to reproduce your findings is to present the data  
19 that was out there and make it accessible. So as a  
20 member of the public, I am requesting that this  
21 database that you guys are creating be available to  
22 us as the public.

23           Now, going back to what Rick was saying with  
24 this FOUO crap and everything, it seems like for the  
25 past two years, every single freaking meeting that

1           we go through, we run into this wall with these  
2           documents. And we keep saying -- it's like a broken  
3           record, we can almost quote it from memory now,  
4           about how this is a Superfund site and that the  
5           documents are part of the Administrative Record, and  
6           we keep asking and asking, and nothing gets done.  
7           The DOD is -- if EPA's delegated the authority of  
8           these documents over to the Navy and the Navy is not  
9           playing ball with ATSDR, then maybe it's time for  
10          the director of the -- or the acting director of  
11          ATSDR to do something about it, and if she cannot,  
12          then her boss. I mean, how long are we going to  
13          wait? How long is this ball going to keep going  
14          back and forth?

15                You know, the documents are the historical  
16          record. The public has a right to see them. The  
17          public has a right to make our own determinations  
18          and our own conclusions, which, in the past, we have  
19          done, and found errors and found things that were  
20          omitted and made significant contributions to  
21          ATSDR's effort. And to sit here and have to jump  
22          through all these hoops and, you know, hear about  
23          folders and boxes at the EPA that, you know, maybe a  
24          FOIA request should be sent forth, I mean, we don't  
25          even know what we're looking for but you guys have

1           it. And I'm not blaming ATSDR, but in the -- you  
2           know, in the same sense, ATSDR needs to stand up and  
3           do something as the protector of the public health,  
4           get this information out to the public, to where we  
5           can go through it ourselves.

6           I mean, I've been doing this for seven years,  
7           Jerry's doing it for 17 years, I mean, this is  
8           turning into a second career for me; Jerry's almost  
9           in retirement with his second career doing this. I  
10          mean, how long is it going to go? So in summation,  
11          as a CAP member, I would like to make a request to  
12          Robin Ikeda, acting director of ATSDR, to do  
13          something as far as write a letter, get Dr. Frieden  
14          involved with the CDC to get this roadblock removed  
15          so we can get access to the documents. I'm tired of  
16          asking for it. I'm tired of waiting for it. We  
17          need the information.

18          **MR. GILLIG:** Mike, we'll talk to Robin but  
19          again, I think it bears repeating that the release  
20          of the documents is not ATSDR's decision; it is the  
21          decision of the Department of Navy, because they do  
22          have responsibility for the Administrative Record.  
23          ATSDR does not have any authority or responsibility  
24          for the Administrative Record, and that pertains to  
25          the documents that you're interested in.

1           **MR. ENSMINGER:** You do. ATSDR does have the  
2 obligation of providing the documents for the work  
3 that they're doing. You're going to have to provide  
4 these documents when you release your public health  
5 assessment and your assessment on vapor intrusion,  
6 you're going to have to release the documents with  
7 that to support your report.

8           **MR. GILLIG:** That's correct.

9           **MR. ENSMINGER:** And that's what we're talking  
10 about. So how you going to do that? Because right  
11 now this thing's ping-ponging back and forth, and  
12 nobody wants to make a decision. It's time somebody  
13 starts making a decision about public release of  
14 these documents before you get to the point where  
15 it's holding up the release of your report.

16           **MR. GILLIG:** And again, all the documents that  
17 we base our analysis and decisions on are part of  
18 ATSDR's record, and yes, that is made available to  
19 the public.

20           **MR. TEMPLETON:** I'd like to be on record here  
21 making an informal request for FOUO to be removed  
22 from the status of those documents, and I'll be  
23 happy to make that formal if required.

24           **MR. GILLIG:** Again, FOUO is not --

25           **MR. TEMPLETON:** I'm asking him.

1                   **MR. GILLIG:** Okay, you're asking...

2                   **MR. ENSMINGER:** Now, in relationship to actual  
3 testing that was done, that's, you know, measurable  
4 tests that were conducted at Camp Lejeune, I know  
5 that the Department of the Navy and Marine Corps  
6 have come back and told you guys that, well, they  
7 didn't really do anything that was actually  
8 measurable until sometime in the early 2000s, right?

9                   **MR. FLETCHER:** I'm not sure that they've made a  
10 statement like that to me, no.

11                   **MR. ENSMINGER:** Didn't you guys tell us that  
12 you didn't find any documentation of actual  
13 measurable levels of air quality sampling in  
14 buildings until after the 1999 evacuation of  
15 building 1101?

16                   **MR. GILLIG:** We may have been talking about the  
17 actual investigation of soil vapor intrusion as a  
18 pathway based on the guidance that EPA provided, I  
19 believe, in 2001. We actually do have environmental  
20 monitoring data, environmental sampling results,  
21 prior to the late 90s. I mean, we've -- a number of  
22 the documents we've recovered in our data discovery  
23 process go back as far as I think we had some  
24 documents from the 70s.

25                   **MR. FLETCHER:** Late 70s.

1                   **MR. ENSMINGER:** Air quality sampling?

2                   **MR. MARK EVANS:** Can I say something? What we  
3 said at the last meeting was that the earlier data  
4 that we have are for the most part qualitative; they  
5 are not quantitative. Basically they're --

6                   **MR. ENSMINGER:** Positive or negative.

7                   **MR. MARK EVANS:** They're a bunch of non-detects  
8 that really don't tell us much.

9                   **MR. ENSMINGER:** All right. I have a request  
10 for the Navy/Marine Corps Public Health Center. I'd  
11 like to know when it was that the Navy Environmental  
12 Health Center purchased their first GCMS, which is  
13 cited in a document, that was used by the preventive  
14 medicine unit at Camp Lejeune to test the ambient  
15 air quality in the former daycare center. The model  
16 number and serial number of that GCMS, which came  
17 from the Navy Environmental Health Center to do  
18 those tests is in this document. I'd like to know  
19 when the Navy first purchased their first GCMS.  
20 That documents -- those tests were done in 1982.

21                   **MS. FORREST:** Just to make sure I got this.  
22 You want to know when the Navy/Marine Corps Public  
23 Health Center purchased the first GCMS that was used  
24 by the preventive medicine unit at Camp Lejeune in  
25 1982?

1           **MR. ENSMINGER:** Yes. Well, it was used in  
2 1982.

3           **MS. FORREST:** To test the air quality at the  
4 former daycare center. And you're saying that you  
5 got this information from a document?

6           **MR. ENSMINGER:** Yeah, we got a document. I'll  
7 show it to you. As a matter of fact it was a  
8 Hewlett-Packard.

9           **MR. FLETCHER:** If there are no further  
10 questions or comments for me?

11           **MR. ORRIS:** I have a question. Have you been  
12 made aware of the memorandum sent from Enrique  
13 Manzanilla, who is the director of the Superfund  
14 division of Region 9 of EPA, where she (sic) says,  
15 and I quote, We recommend that the EPA Region 9  
16 Superfund program establish health protective  
17 response action recommendations to address  
18 inhalation exposures to trichloroethylene, otherwise  
19 known as TCE, in indoor air from the subsurface  
20 vapor intrusion pathway. The purpose of these  
21 interim action levels and response action  
22 recommendations is to be protective of sensitive and  
23 vulnerable populations, especially women in the  
24 first trimester of pregnancy because of the  
25 potential for cardiac malformations to the

1           developing fetus. The approach is consistent with  
2           recommendations provided by Region 10 and with the  
3           previous actions taken in Region 9 Superfund sites.

4           **MR. FLETCHER:** I have not been made aware of  
5           that.

6           **MR. GILLIG:** Chris, we do have a copy of that  
7           memo.

8           **MR. ORRIS:** Okay. And are you incorporating  
9           this into your adverse pregnancy outcome study?

10          **MR. GILLIG:** We are incorporating the -- this  
11          is a memo related to TCE and some of the action  
12          levels that EPA Region 9 is proposing to use. We  
13          are using the studies upon which those levels are  
14          based in our analysis of the data and our evaluation  
15          of health impact of exposures.

16          **MR. ORRIS:** But are you planning on letting any  
17          potential women, who might have been exposed to TCE  
18          vapor intrusion after 1984, be made aware that they  
19          might be part of the protective and sensitive  
20          population?

21          **MR. GILLIG:** In our evaluation of exposures, we  
22          always identify populations of -- sensitive  
23          populations or subpopulations. So yes, the -- our  
24          evaluation of the drinking water exposures and the  
25          vapor intrusion will include consideration of



1 sensitive populations.

2 **MR. ORRIS:** And this going to go in effect for  
3 Camp Lejeune for any potential TCE vapor intrusions  
4 ongoing?

5 **MR. GILLIG:** We would consider those health  
6 effects in sensitive populations when looking at  
7 current exposures.

8 **MR. ORRIS:** So you're planning on notifying  
9 females of -- in the range of being able to carry a  
10 baby of potential exposure to TCE now?

11 **MR. GILLIG:** As far as identifying -- or as far  
12 as notifying females or any residents of the base?

13 **MR. ORRIS:** Yes. Who might be exposed now,  
14 currently.

15 **MR. GILLIG:** That would be a follow-up action  
16 that the Navy would take, the Marine Corps would  
17 take.

18 **MR. ORRIS:** Is the Navy and the Marine Corps  
19 going to recommend notifying any females of  
20 childbearing age of potential exposure and adverse  
21 outcomes?

22 **MS. FORREST:** I'm going to have to take this  
23 back as a question so I want to make sure I get this  
24 down right. Is the Navy and Marine Corps -- you're  
25 asking if we're planning to do any notification now

1 to people who are at Camp Lejeune, when they're at  
2 Camp Lejeune --

3 **MR. ORRIS:** Yes, who might be exposed to TCE  
4 now.

5 **MS. FORREST:** Okay. I'll have to take that  
6 back.

7 **MS. FRESHWATER:** Give her a copy of that  
8 document.

9 **MR. ORRIS:** I will give you a copy of the  
10 document. It's dated July 9<sup>th</sup>.

11 **MR. GILLIG:** Any other questions for Chris?

12 **MS. FRESHWATER:** I just wanted to know do you  
13 have a copy of the PowerPoint?

14 **MR. FLETCHER:** I don't think it's been cleared  
15 to give out but I might have some paper copies.

16 **MS. FRESHWATER:** Yeah, paper, that's all I  
17 want.

18 **MR. FLETCHER:** Rick, did you --

19 **MR. GILLIG:** I didn't bring extra copies with  
20 me.

21 **MR. FLETCHER:** I'll make some.

22 **MS. FRESHWATER:** Thank you.

23 **DR. FORRESTER:** PowerPoint, we will give them  
24 out.

25 **MS. FRESHWATER:** Thank you.

1                   **MR. GILLIG:** I'll go upstairs and print one off  
2 and make copies.

3                   **MS. FRESHWATER:** I'm here all day.

4                   **MR. GILLIG:** And Sheila, is this something we  
5 can post to the web?

6                   **MS. STEVENS:** I'll have to ask. I have no  
7 idea.

8                   **MR. GILLIG:** Okay.

9                   **MS. FRESHWATER:** That would be even better. A  
10 digital copy's always great for, you know, sharing  
11 and things.

12                   **MR. GILLIG:** And we can always get -- we have  
13 email addresses on record so we can always send it  
14 out.

15                   **MS. FRESHWATER:** Okay, thank you.

16                   **MR. SMITH:** Okay, I just wanted to add one more  
17 follow-up to Chris's question. Can you also add in  
18 the particular methods -- if they do choose to  
19 contact females on the base, can you make a list or  
20 provide us a list with exactly the types of methods  
21 that you'll follow in order to find, locate and  
22 communicate with those individuals? I'd like to see  
23 that and know that. Thank you.

24                   **MR. ORRIS:** And just as a carry-on, I'd like to  
25 make sure that you plan on notifying everybody from

1 1955 through the present day that might have been  
2 exposed. 'Cause I would bet that the exposure's  
3 ongoing now.

4 **MS. FORREST:** All right. So first you want to  
5 make sure that we're notifying or planning to notify  
6 women currently.

7 **MR. ORRIS:** Currently as well as --

8 **MS. FORREST:** And what that process will be to  
9 find, locate and communicate with the women. And  
10 then you also would like to know if we're going to  
11 include notifying -- identifying women back to 1955;  
12 is that what you said?

13 **MR. ORRIS:** From the time period of exposure.  
14 First identify them. It's basically everybody from  
15 childbearing age that served at Camp Lejeune, from  
16 either civilian, dependent or DOD function  
17 (inaudible).

18 **MS. FORREST:** So are you also planning to  
19 notify women back to 1955 who could have potentially  
20 been exposed to vapor intrusion?

21 **MR. ORRIS:** TCE vapor intrusion.

22 **MS. FORREST:** All right, I just want to make  
23 sure I've got this correctly. So you would like to  
24 know if we're planning to notify women currently at  
25 Camp Lejeune of potential ongoing exposure to TCE

1 and vapor intrusion.

2 **MR. ORRIS:** In relation to the risk --

3 **MR. ENSMINGER:** Turn your mic on.

4 **MS. FORREST:** I think it's on; I think I'm just  
5 not speaking into it.

6 **MR. ORRIS:** In relation to the risk of the  
7 potential for cardiac malformations of the fetus. I  
8 want to make sure that you're including that  
9 language from the EPA with the notification to the  
10 females onboard at Camp Lejeune presently and those  
11 who were stationed there in civilian, dependent or  
12 DOD function from 1955.

13 **MS. FRESHWATER:** I'm sorry, we still can't hear  
14 you guys.

15 **MR. ORRIS:** Okay.

16 **MS. FRESHWATER:** You have to really talk into  
17 these --

18 **MR. ORRIS:** Sorry. I want to make sure that  
19 DOD is notifying all females of childbearing age to  
20 the risk of potential of cardiac malformations to  
21 the developing fetus per the EPA memorandum from the  
22 beginning of the date of first exposure to the  
23 present. And if you do not notify them, I want to  
24 know the reasons why.

25 **MS. FORREST:** Based on EPA memorandum. All

1 right, I may work on making -- on getting this in my  
2 notes correctly and get you to look at it, so we're  
3 not sitting here going back and forth word-smithing  
4 it.

5 **MR. ORRIS:** That'll be fine. But I'd like you  
6 to ask for that, if that's possible.

7 **MS. FORREST:** I will take that back as soon as  
8 I get back.

9 **MR. ORRIS:** Thank you.

10 **MR. GILLIG:** Any other questions for Chris? If  
11 not, we'll move on to the next phase of the working  
12 session. As you know, we have two projects. We've  
13 covered the soil vapor intrusion. We also are doing  
14 the reevaluation of drinking water exposures, and  
15 Rob Robinson will lead the presentation and the  
16 discussion on that project. Rob?

17 **MR. ROBINSON:** Thank you, Rick. As Rick  
18 stated, I'm Rob Robinson. I'm the scientist who's  
19 been tasked with drafting the drinking water public  
20 health assessment. I say that but it's been a  
21 collaborative effort among many of the scientists  
22 here, and one of those you may be familiar with is  
23 Jason Sautner. He's with Morris's group and he's  
24 been assisting with the portion of the PHA that I'll  
25 be discussing today, which is the modeling effort

1 associated with the three exposure scenarios that  
2 you all brought to our attention a few meetings ago  
3 -- a couple of meetings; I think it was April.

4 So these three exposure scenarios are the  
5 individuals exposed to contaminated water in  
6 swimming pools; laundry workers who were exposed  
7 through the steaming process, steaming and ironing  
8 process, as well as the washing machines; the food  
9 preparation and dishwashing operations. Those  
10 individuals were exposed through the prewash or  
11 rinsing as well as the dishwashers themselves, and  
12 we also looked at steam tables, which is a process  
13 that allows -- or that heats the food and keeps it  
14 continuously hot.

15 And we've completed modeling runs through these  
16 three different scenarios. And so today's goal is  
17 to share the inputs that we have used and also  
18 receive any information that you may have to -- and  
19 that way we can determine if further refinement of  
20 these models is necessary. Following this working  
21 meeting, we hope to finalize the models and  
22 determine the best way to incorporate those results  
23 into our existing public health evaluation.

24 So our approach is a conservative health  
25 protective approach to estimate these exposures.

1 And it's generally the case when site-specific  
2 information isn't complete or historical information  
3 isn't all there. You want to err on the side of  
4 being protective.

5 We used one-compartment models, a box model  
6 might be a familiar term for you. These are very  
7 conservative. They generally overestimate  
8 exposures, they don't account for the ventilation of  
9 the rooms or the air transfer.

10 We also used maximum contaminant  
11 concentrations. And then being consistent with the  
12 previous exposure parameters that we've shared for  
13 our other public health evaluation, we're using  
14 historical reconstruction numbers that Morris's  
15 group has developed, its concentrations. And we're  
16 using the same exposure durations that we shared for  
17 the civilian worker or the active-duty Marine, which  
18 is 15 years or three years, respectively.  
19 Contaminants we're looking at are, again, the same,  
20 that's PCE, TCE, 1,2 trans-dDCE, vinyl chloride and  
21 benzene.

22 So for the swimming model, we looked at both  
23 active duty Marines and recreational users. For the  
24 active duty Marines we used a competitive inhalation  
25 rate, and for the different exposure times were



1           basic, intermediate, advanced and specialty levels  
2           of training. And the next slide has a table of  
3           these numbers, and we would appreciate your input on  
4           those. These values were provided by Camp Lejeune  
5           environmental management division after discussions  
6           with the pool operations personnel. But again,  
7           drill sergeant input would be greatly appreciated.

8           And then for recreational users, we used a  
9           normal inhalation rate. And for the exposure, we  
10          used the Exposure Factors Handbook, EPA's Exposure  
11          Factors Handbook for normal times that you would  
12          expect somebody to be in the water, in swimming.

13          So this is a table that describes the total  
14          hours per year, which is the farthest right column  
15          for the different levels of training, both basic,  
16          intermediate, advanced and specialty. So for  
17          instance the basic training, they communicated that  
18          there was one event per year, and that event, an  
19          individual would spend three hours in the pool of  
20          contaminated water. And so one times three makes a  
21          total of three hours per year that that individual  
22          was in the pool. And that goes up with the  
23          increased level of training.

24          Should I leave that up so you guys can digest  
25          that for a little bit longer, to see if it's

1 effective and reasonable? If there's no further  
2 questions on the swimming evaluation, we also looked  
3 at the laundry workers.

4 **MS. FRESHWATER:** Sorry. I didn't mean to  
5 interrupt; I couldn't get this on. When you --  
6 going back to the recreational use, what exactly is  
7 the rate?

8 **MR. ROBINSON:** The exact numbers we can share  
9 with you, the ones provided in the EPA's Exposure  
10 Factors Handbook for various age groups that say the  
11 average amount of hours that someone would be  
12 swimming per year.

13 **MS. FRESHWATER:** I would definitely like to see  
14 that because, again, I keep mentioning, I know I've  
15 said it to you before and other people have said it  
16 as well, a lot of the kids, especially, in that pool  
17 all summer, all day. And I would imagine that's  
18 probably quite higher than what you're using. So I  
19 mean, a lot of the families, that's what they did,  
20 you know, they just were at the pool every day.

21 **MR. ROBINSON:** Okay. So that's very good  
22 information. The EPA numbers do look to be in the  
23 95<sup>th</sup> percentile, so they have a range of times for  
24 each age group. So it's in Chapter 6, it's a table  
25 in Chapter 6 that we'd be happy to share with you.

1                   **MS. FRESHWATER:** That would be great, thank  
2                   you.

3                   **MR. ENSMINGER:** Now, there are some other  
4                   factors to take into consideration when you're  
5                   talking about these pools. The pools you're talking  
6                   about were over at Paradise Point.

7                   **MS. FRESHWATER:** And I went with my friends who  
8                   were enlisted, I can't remember where the pool was  
9                   but I know I went into other pools.

10                  **MR. ENSMINGER:** Which -- I mean, now, we're  
11                  talking about the indoor pools that are used for  
12                  training over on Mainside.

13                  **MS. FRESHWATER:** Oh, no, I didn't go to that  
14                  one.

15                  **MR. ENSMINGER:** Yeah, see and that's -- your  
16                  worst contamination was at Hadnot Point, not Holcomb  
17                  Boulevard.

18                  **MS. FRESHWATER:** Right.

19                  **MR. ENSMINGER:** So what we need to key on  
20                  here -- now, they had recreational swimming in these  
21                  pools at lunch time and in the evenings and on days  
22                  that there was no training scheduled.

23                  **MR. ROBINSON:** Were they used in the weekends  
24                  as well?

25                  **MR. ENSMINGER:** Yes.

1                   **MR. ROBINSON:** Recreational.

2                   **MR. ENSMINGER:** Yes.

3                   **MS. FRESHWATER:** Yeah, I think I did that when  
4 they were -- not to the amount of the Paradise Point  
5 one.

6                   **MR. ENSMINGER:** I mean, and these are indoor  
7 pools.

8                   **MS. FRESHWATER:** Right.

9                   **MR. ENSMINGER:** They're not outdoors, where  
10 this stuff is going to outgas and be blown away or  
11 diluted by the wind.

12                   **MS. FRESHWATER:** Right.

13                   **MR. ENSMINGER:** This stuff was inside.

14                   **MR. ROBINSON:** So for the laundry workers,  
15 civilian workers were the only ones that took care  
16 of the laundry operations. We used inhalation rates  
17 from the EPA Exposure Factor Handbook for similar  
18 types of activities. For the washing machines, we  
19 assumed a 90 percent volatilization rate, which is  
20 basically just 90 percent of the contaminant that is  
21 in the water enters the air, and that's what someone  
22 would breathe.

23                   The steam presses, we assumed total  
24 volatilization or 100 percent of the contaminant in  
25 the water would go to the air. And there are

1 different flow rates for the steam presses and the  
2 washing machines.

3 So on to the dishwasher operations -- oh, and  
4 also for the laundry operations, we assumed an  
5 eight-hour work day, 240 days of the year, which is  
6 standard for the occupation.

7 **MR. ENSMINGER:** I know for a fact, from  
8 discussions with former civilian employees at Camp  
9 Lejeune, that the people that used to commute to  
10 work with my source, they would drive to his house,  
11 the people that worked in the laundry, and they  
12 would share rides from his house, 'cause he lived  
13 outside of Jacksonville, and they would commute back  
14 and forth, taking turns on who drove each week.  
15 Every one of those people that worked at the base  
16 laundry, the industrial laundry, are now dead.  
17 Every one of them died of cancer.

18 **MR. ROBINSON:** So for the dishwasher  
19 operations, and this is an image for those of you  
20 who have had the joy of working in a commercial  
21 dining facility, this is what a large-scale  
22 dishwasher looks like. So we looked -- and they  
23 would -- currently on Camp Lejeune, they would have  
24 either a large exhaust pipe, silver, like you would  
25 see in this photo, or a large exhaust hood stationed

1 over the dishwasher to help moisture be evacuated  
2 from the building. However, we've been told by Camp  
3 Lejeune that during the time of contamination, those  
4 large exhaust hoods were not present. Yeah, so we  
5 accounted for that in our model.

6 And so basically before the operations, a  
7 prewash would occur where somebody would have a wand  
8 and rinse dishes prior to going into this  
9 dishwasher. They would go through the dishwasher  
10 and the clean dishes would come out the other end,  
11 so pretty straight. So for the inputs that we  
12 used --

13 **MR. TEMPLETON:** Excuse me, just a quick  
14 question. On dishwasher workers are you also  
15 considering enlisted personnel that worked in the  
16 mess halls?

17 **MR. ROBINSON:** Correct.

18 **MR. TEMPLETON:** Okay, perfect.

19 **MR. ROBINSON:** Yeah, for the dishwashers, both  
20 civilian and active duty Marine workers were  
21 considered.

22 **MR. ENSMINGER:** Now, take into consideration  
23 that during the period of contamination, there  
24 weren't any civilian workers.

25 **MR. ROBINSON:** Okay.

1                   **MR. ENSMINGER:** None.

2                   **MR. ROBINSON:** All right.

3                   **MR. ENSMINGER:** The, the mess halls were not  
4 contracted out 'til after 1985.

5                   **MR. ROBINSON:** Okay. Base told us differently  
6 but...

7                   **MR. ENSMINGER:** They're full of crap.

8                   **MR. TEMPLETON:** Yeah, I can attest -- I served  
9 129 days in a mess hall.

10                  **MR. ROBINSON:** Excellent. That's good  
11 information, thank you, appreciate it.

12                  **MR. ENSMINGER:** You must have been bad.

13                  **MR. TEMPLETON:** That was before I picked up  
14 (inaudible).

15                  **MR. ROBINSON:** All right, we'll make that  
16 adjustment. So our inhalation rates were again from  
17 the EPA Exposure Factor's Handbook doing similar  
18 types of activities. And an Andelman's study  
19 measured that 90 percent of the contaminant in the  
20 water enters the air during dishwasher operations.

21                  **MR. ENSMINGER:** Same as in washing.

22                  **MR. ROBINSON:** Yes, exactly. The flow rates of  
23 the dishwashers in pre-rinsing were taken from the  
24 manufacturers. And again, for them we assumed an  
25 eight-hour work day, 240 days a year.

1                   **MR. ENSMINGER:** You're saying that the steam  
2 tables are 90 percent also?

3                   **MR. ROBINSON:** Let's see, what were the  
4 defaults?

5                   **MR. ENSMINGER:** Now, you had steam kettles  
6 also.

7                   **MR. ROBINSON:** Steam kettles.

8                   **MR. ENSMINGER:** Yeah, they used steam kettles  
9 in the galley. They had these huge kettles that got  
10 steam jackets on them that cooked large quantities  
11 of, you know, huge, huge quantities of food.

12                  **MR. ROBINSON:** These models are really, they're  
13 generally conservative enough to account for  
14 different types of exposures like that. So if we  
15 don't get every specific one, our inputs are  
16 generally conservative to account for things like  
17 that.

18                  **MR. ENSMINGER:** And then hopefully people that  
19 are food service people that are food handlers are  
20 washing their hands quite often.

21                  **MR. ROBINSON:** Correct. We have --

22                  **MR. ENSMINGER:** Yeah, yeah, really? I hope so.

23                  **MR. ROBINSON:** If they're preparing my food I  
24 hope so, for sure.

25                               So our next steps based on input we receive



1           today, we would like to finalize our models and  
2           incorporate these results into our existing public  
3           health evaluation. And once we do that, we can  
4           resume the internal review of the public health  
5           assessments with this new information incorporated.  
6           So that's it.

7           **MR. ENSMINGER:** The people that you want to  
8           really strictly pay attention to as far as the mess  
9           halls went, are people who had the 3300 MOS.

10          **MR. ROBINSON:** 3300 MOS.

11          **MR. ENSMINGER:** That's cooks and bakers.

12          **MR. TEMPLETON:** If you don't mind, to add to  
13          that, for enlisted personnel that are non-rates  
14          during the time of the contamination, they typically  
15          would end up serving 30 days per year at the mess  
16          hall too, some of them in the pound shack, some of  
17          them on the serving line, exposed to steam and so  
18          forth. But that was the general practice. That's  
19          how I got the 129 days.

20          **MR. ROBINSON:** Thirty days per year?

21          **MR. TEMPLETON:** Thirty days per year.

22          **MR. ROBINSON:** Okay. Thanks. Okay, so that's  
23          the next steps. I believe we are still on track for  
24          the timeline that we presented last time. The  
25          internal review we expect to finish this fall. The

1 peer review, is the first time that you will be able  
2 to see the document, will be in winter. And the  
3 public comment period will follow that after we  
4 receive their comments and make adjustments to the  
5 document.

6 **MR. ENSMINGER:** Now, winter of 2014 is --  
7 that's in December.

8 **MR. ROBINSON:** It should be, yes. It's winter.  
9 And based on the input we receive, how much tweaking  
10 models require.

11 **MR. ENSMINGER:** So would you be safe saying  
12 winter 2014, slash, 15?

13 **MR. ROBINSON:** Yeah, that's winter. You know,  
14 again, we're working as fast as we can to get this  
15 document out. But these types of technical  
16 documents take a lot of review and are scrutinized  
17 by a lot of different people. It takes a long time.

18 **MR. PARTAIN:** Now, we're going to be sent, I'm  
19 assuming, a formal peer review copy for us as the  
20 CAP?

21 **MR. ROBINSON:** Correct.

22 **MR. PARTAIN:** Okay.

23 **MR. ROBINSON:** If there's not any further  
24 questions, I guess I'll turn it back over to the  
25 moderator, or Rick. Do you have closing remarks?

1           **MR. GILLIG:** Yeah, if anyone else has any  
2           questions for Rob, now is the time. If not, we are  
3           at a breaking point in the agenda. We have lots of  
4           drinks and snacks in the back. Please help  
5           yourself. We don't want to carry it back upstairs  
6           or haul it home. Thank you, everyone.

7           **MR. BRUBAKER:** And we'll reconvene at 10:45.

8                     (Meeting in recess at 9:55 a.m.)

9  
10       **WELCOME, ANNOUNCEMENTS, AND INTRODUCTIONS** (10:45 a.m.)

11           **DR. IKEDA:** So good morning and welcome. My  
12           name is Robin Ikeda. I serve as the acting center  
13           director for National Center for Environmental  
14           Health and the Agency for Toxic Substances and  
15           Diseases Registry, which I think is the longest  
16           center title at CDC. And today is September 11, so  
17           I did want to just take a moment to remember folks  
18           who either lost their lives or were injured on this  
19           day back in 2001. But also it's a day where we  
20           recognize service and sacrifice of veterans and  
21           first responders, and we have many veterans here in  
22           the room. So just thank you very much for your  
23           service; we are forever in your debt.

24                     This morning I am pleased to welcome two new  
25           CAP members. We have Tim Templeton and Gavin Smith,

1           and I know they'll probably say a little bit more  
2           about themselves as we go around and do  
3           introductions. But just a little bit, Tim was  
4           stationed at Camp Lejeune between February 1984 and  
5           December 1986. He lived in the French Creek  
6           bachelor enlisted quarters and worked as an  
7           electronics repair technician in the Hadnot Point  
8           industrial area. He's a telecommunications engineer  
9           and works as a regional technical manager for a  
10          cable company. He also serves as co-administrator  
11          of a Facebook group, Contaminated Marines of Camp  
12          Lejeune. And then on a personal note, Tim is  
13          married and has three children and an incredibly  
14          cute grandson whose picture I saw at dinner last  
15          night who's two years old. He loves music, which he  
16          writes and records, and he also plays the guitar.  
17          So welcome, Tim.

18                 And then Gavin is a native of Emerald Isle,  
19          North Carolina. His father was a civilian DOD  
20          supervisor at Camp Lejeune for 25 years between 1973  
21          and 1998. His father passed away in 2008 from acute  
22          myeloid leukemia. And Gavin is a media expert and  
23          consultant and he's designed many websites including  
24          civilianexposures.org which works to raise national  
25          awareness of civilian exposures to toxic water and

1           contamination at Camp Lejeune. And Gavin recently  
2           graduated with distinction, beta gamma sigma, from  
3           the Thunderbird School of Global Management, and  
4           he's also a recent MBA graduate from the College of  
5           William and Mary Mason School of Business. Welcome  
6           Gavin. Welcome to both of you. We look forward to  
7           your perspectives and thank you very much for your  
8           service on the CAP.

9           I wanted to provide a few updates about what's  
10          been happening at CDC. It's certainly been a very  
11          busy time for us since our last meeting in June. As  
12          many of you know, we had two laboratory safety  
13          incidents at the CDC, one involving anthrax and the  
14          other involving H5N1 influenza. And these incidents  
15          have been taken very seriously by the agency and by  
16          the director, and have resulted in a number of  
17          immediate actions including a moratorium on transfer  
18          of specimens from our BSL-3, the highest security  
19          labs, and BSL-4; a detailed review of both incidents  
20          by both an internal panel and an external panel; the  
21          formation of two working groups focused on  
22          laboratory safety, again, one is internal and one is  
23          external; and then the identification of a single  
24          point of accountability for lab safety here at CDC.  
25          And although the NCEH laboratory was not involved in

1           either incident, improving lab safety is an  
2           agency-wide priority at the moment and always has  
3           been and will continue to be. And Dr. Jim Pirkle,  
4           who is the director of our Division of Lab Sciences  
5           here at NCEH/ATSDR, is on the internal CDC work  
6           group for lab safety.

7           The outbreak of Ebola has also kept the agency  
8           very busy. Just the numbers from this week, earlier  
9           this week, the total number of cases more than 4,000  
10          with the number of deaths more than 2,100. Dr.  
11          Frieden, our CDC director, visited West Africa a  
12          couple weeks ago, and when he came back he did not  
13          mince words about what he saw. He said that it's  
14          bad. It's really bad. And he talked about the  
15          exponential increase in cases. You've probably read  
16          all this in the newspapers but it's, you know, the  
17          largest outbreak in history. It's the first that  
18          involves multiple countries and also the first that  
19          involves urban areas, so it's, it's terrible, and we  
20          have been very busy and very engaged.

21          Right now CDC has 100 staff deployed to West  
22          Africa and there are many hundreds more who are  
23          working in our emergency operation center here in  
24          Atlanta. And even though this is an infectious  
25          disease outbreak, the entire agency is involved.

1 NCEH/ATSDR has 20 individuals who are currently  
2 working on the response. They're all based here in  
3 Atlanta. And Christopher Stallard, who many of you  
4 know from his work in the past as our CAP  
5 facilitator, is scheduled to travel to the region  
6 next week.

7 I wanted to provide a quick update on the  
8 search for the permanent NCEH/ATSDR director. I'm  
9 pleased to report that we had a number of highly  
10 qualified candidates apply for the position, both  
11 internal and external. We've completed the initial  
12 telephone interviews and have recently finished the  
13 in-person interviews for a select number of  
14 candidates, and there's a number of reference checks  
15 and other things ongoing right now but we hope to  
16 make an announcement in the next coming months. And  
17 we are of course very eager to move forward with the  
18 process, and certainly keep all of you in the CAP  
19 informed as decisions are made. Thank you --

20 **MR. ENSMINGER:** Are they given psych evals?

21 **DR. IKEDA:** Psych evals? No. Thank you to  
22 those of you who are able to attend this morning's  
23 technical discussion on the characterization of soil  
24 vapor intrusion pathways at Camp Lejeune. We'll  
25 hear from Rick a little bit later about those

1           discussions.

2           And then I think, as many of you already know,  
3           we convened a two-day expert panel at the end of  
4           July to begin planning the cancer incidence study.  
5           Both Dr. Clapp and Dr. Cantor participated as panel  
6           members and CAP representatives, and Jerry and Kevin  
7           were also in attendance at the meeting. We had a  
8           productive two days of discussion about the most  
9           efficient and methodologically sound way to conduct  
10          a national cancer incidence study, and Jimmy and  
11          Frank will provide an update and discuss next steps  
12          later this morning. So I will turn it over to Matt  
13          now for introductions and discussion on the ground  
14          rules for the CAP meeting today. Thank you.

15                 **MR. BRUBAKER:** Well, thank you, and again, my  
16                 name is Matt Brubaker, serving in an interim  
17                 capacity while Christopher is otherwise deployed, as  
18                 Robin mentioned. Because there are some new members  
19                 today, I think it would benefit all of us to go  
20                 around the room and provide introduction not only of  
21                 your name but a sentence or two about where you're  
22                 from and your role on the CAP as a way of  
23                 introducing ourselves and also to the folks who will  
24                 join us on the phone. You want to start, Frank?

25                 **DR. BOVE:** I'm Frank Bove. I'm with the ATSDR



1 and I've been working on this issue for many years.

2 **MS. RUCKART:** Perri Ruckart, ATSDR, also  
3 working on Camp Lejeune issues for about 12 years.

4 **MR. TEMPLETON:** Tim Templeton, I was, as you  
5 heard, stationed at Camp Lejeune between 1984 and  
6 1986. I have several health issues that result from  
7 it.

8 **DR. CLAPP:** I'm Dick Clapp, retired professor  
9 from Boston University School of Public Health but  
10 have been on the CAP for eight years.

11 **MR. ORRIS:** I'm Chris Orris. I was born at  
12 Camp Lejeune. Many health issues.

13 **MS. FRESHWATER:** Lori Freshwater. I lived at  
14 Camp Lejeune from '79 to '83 and lost two siblings  
15 to neural tube defects and my mother to two types of  
16 acute leukemia.

17 **MS. FORREST:** I'm Melissa Forrest from the Navy  
18 and Marine Corps Public Health Center, and I'm here  
19 to listen to the CAP discussions and make sure I  
20 capture all the action items and questions to take  
21 back to the Marine Corps.

22 **MR. SMITH:** And I'm Gavin Smith. I think you  
23 heard a little bit earlier but I'm interested mainly  
24 in the civilian side of this as well due to my  
25 father's involvement for years and also in media

1 outreach and getting the word out and making sure  
2 everyone knows about this.

3 **MR. WILKINS:** Kevin Wilkins, I'm a CAP member,  
4 Marine Corps veteran.

5 **MS. STEVENS:** Hi, I'm Sheila Stevens; I'm the  
6 Camp Lejeune CAP coordinator and with the ATSDR.

7 **MR. ENSMINGER:** Jerry Ensminger, I've been  
8 working on this issue since 1997. I'm probably --  
9 well, I am the only original CAP member left.  
10 Anyhow, going back to this significant date, which  
11 was horrific, I sat in my livingroom and watched  
12 that happen live. And am in no way downplaying what  
13 happened on 9/11 but Camp Lejeune is another 9/11,  
14 only this 9/11 is happening in slow motion and not  
15 being played out in every livingroom on people's  
16 TVs. This is being played out in private hospital  
17 rooms, private homes, hospice centers. When you  
18 have nearly a million people or more that were  
19 exposed to the levels of contaminants that we were  
20 exposed to at Camp Lejeune, when the death toll is  
21 finally counted, it will be more than what we lost  
22 in New York and in Pennsylvania on that tragic day.

23 **MR. PARTAIN:** My name is Mike Partain. I'm a  
24 dependent child from Camp Lejeune diagnosed with  
25 male breast cancer roughly seven years ago. And I'd

1           like to take a moment to remember a fellow male  
2           breast cancer survivor who passed away several weeks  
3           ago. Pete Devereau was one of the 85 men whose  
4           single commonality was time on the base and exposure  
5           to the contaminated drinking water, had male breast  
6           cancer. Pete was diagnosed shortly after I was with  
7           the identical size tumor as me in the same breast.  
8           Unfortunately Pete's cancer had metastasized. He  
9           was originally given a death sentence for 2010 but  
10          he was able to survive, and did a lot of great work  
11          helping people out and getting the word out about  
12          male breast cancer, and also advocating on behalf of  
13          the Marine veterans. He's one of the few Marine  
14          veterans who has received VA benefits for his -- and  
15          service connection for his service and exposures,  
16          and sadly, as I mentioned, he passed away at home  
17          due to his disease.

18               **MR. ENSMINGER:** Pete's goal was to live long  
19               enough to see his little girl graduate from high  
20               school, and he fell short. She's only 16. Pete's a  
21               good man. It's a shame.

22               **DR. STEPHENS:** Hi, I'm Jimmy Stephens, I'm the  
23               acting deputy director of NCEH/ATSDR.

24               **MR. GILLIG:** Good morning. My name is Rick  
25               Gillig, and I am a branch chief under which the

1 vapor intrusion project and the re-evaluation of the  
2 drinking water exposures is taking place.

3 **MR. SAMPSEL:** My name is Jim Sampsel. I work  
4 for the VA in Washington DC. I work for Department  
5 of Veteran Affairs for compensation service, which  
6 is part of the Veterans Benefits Administration, and  
7 I think Dr. Terry Walters will join by voice later  
8 on. She works for the Veterans Health  
9 Administration. So we'll have a presentation later  
10 today.

11 **MR. CLAY:** Yes, my name is Bob Clay, I also  
12 work for the Department of Veterans Affairs,  
13 Veterans Benefits Administration, out of the  
14 Louisville regional office, where the compensation  
15 claims for Camp Lejeune-related illnesses are  
16 centralized by the Department. Thank you.

17 **MR. BRUBAKER:** And we have our phone connection  
18 established. Are there any participants on the  
19 phone to introduce themselves?

20 (No response)

21 **MR. BRUBAKER:** Not hearing any. As we're about  
22 to begin with today's agenda, I want to first  
23 acknowledge this group, many of them have been  
24 working together for many years. And one of the  
25 things that's made this group work well is

1           agreements and ground rules about how we operate. I  
2           was not involved in establishing those but I know  
3           that many of you were, and so as a way of preparing  
4           for our agenda today, I would like somebody to  
5           refresh us. How would we agree we're going to  
6           operate together in a way that makes this time  
7           together productive? Would somebody clue me in to  
8           how this is supposed to work? Perhaps, Jerry.

9           **MR. ENSMINGER:** Turn your phones off, if you  
10          haven't already done so, or put them on stun, as  
11          Chris would say, which is vibrate.

12          **MR. BRUBAKER:** Any others?

13          **DR. CLAPP:** Don't talk over one another,  
14          respect one another.

15          **MR. BRUBAKER:** Thanks. The respect piece and  
16          the not talking over is valuable because we're  
17          trying to transcribe this as well so it's helpful  
18          to -- and always remember to use your button to turn  
19          your microphone on.

20          **MR. ENSMINGER:** Talk into your mic. Chris.

21          **MR. BRUBAKER:** So with those reminders, I think  
22          we're ready to begin the agenda. We'll turn to  
23          Sheila for action items from the previous meeting.

24  
25          **ACTION ITEMS FROM PREVIOUS CAP MEETING**

1           **MS. STEVENS:** Good morning. I'm going to go  
2 over -- we got several of -- several this morning so  
3 I'm going to try to go through them. Start with the  
4 first item: The CAP would like the identifying  
5 numbers of the 128 UST documents, UST stands for  
6 understorage tank, documents provided to the  
7 judiciary committee. And also to confirm that the  
8 entire library was provided unredacted to the  
9 committee, and this was assigned to Melissa Forrest.

10           **MS. FORREST:** Okay. In a 10 July 2012 email to  
11 the Department of the Navy, the Senate Judiciary  
12 Committee refined a previous request for Resource  
13 Conservation and Recovery Act documents to just  
14 those contained in the attached index. The index  
15 includes the requested unique identifying numbers  
16 for the 128 UST documents that were transferred  
17 unredacted to the Senate Judiciary Committee on 15  
18 August 2012. And we did provide a copy of that  
19 index in the response provided via email.

20           **MS. STEVENS:** The next item: The CAP requested  
21 an index of the data sources for which an index is  
22 not available. And that was also assigned to  
23 Melissa Forrest.

24           **MS. FORREST:** Okay. The Marine Corps requests  
25 that ATSDR identify the data sources with no index

1           that are relevant to their vapor intrusion  
2           investigation at Camp Lejeune and also that ATSDR  
3           feels need to be indexed to complete their work.

4           **MS. STEVENS:** Third item: The CAP has  
5           requested that the VA verify the number of decided  
6           claims for male and female breast cancer patients.  
7           This was assigned to Brad; however, I'm going to  
8           wait 'til 1:15. We do have members of the VA here  
9           to answer that question.

10           The next item is also to Brad Flohr: The CAP  
11           requested that a representative from the Louisville  
12           office was -- who is responsible for deciding claims  
13           to attend the next CAP meeting. Again, we will also  
14           defer that to the 1:15 part of our agenda where the  
15           VA will be speaking.

16           The next item is the CAP requested an index  
17           copy of all documents on vapor intrusion that were  
18           provided to the ATSDR -- provided to ATSDR by the  
19           DOD, Department of Defense, and that was assigned to  
20           Rick Gillig.

21           **MR. GILLIG:** As we discussed in this morning's  
22           working meeting, we are in the process of putting  
23           that index together and expect to have it finished  
24           by the end of the calendar year.

25           **MS. STEVENS:** ATSDR will continue to keep the

1 CAP updated on health assessments activities.  
2 Updates will be provided on the monthly CAP phone  
3 calls. This was also assigned to Rick Gillig.

4 **MR. GILLIG:** And we are doing that.

5 **MS. STEVENS:** Okay. The next CAP item was the  
6 CAP requested that ATSDR provide an index of 439  
7 documents that were added to the UST portal since  
8 the last request. This was also assigned to Rick  
9 Gillig.

10 **MR. GILLIG:** And on August 14<sup>th</sup> ATSDR did  
11 provide a list of all the UST files. We made that  
12 available to the CAP as well as providing that to  
13 the Department of Navy.

14 **MR. PARTAIN:** Sheila, can I jump in here real  
15 quick? On the documents, at the break I had a brief  
16 conversation with Dr. Ikeda concerning the  
17 availability of the documents from what we were  
18 discussing at the pre-meeting, and she did confirm,  
19 and I don't want to speak for you, but that there  
20 was -- well, actually, can you explain? I don't  
21 want to put words in your mouth, so.

22 **DR. IKEDA:** So Mike and I were speaking about  
23 the Administrative Record and what authority seats  
24 he does or doesn't have about the Administrative  
25 Record. And I mentioned to him that we have spoken



1 to our legal counsel here at CDC. We have no  
2 authority over the Administrative Record. We also  
3 don't have any ability to dictate what's included in  
4 the Administrative Record. And Mike asked whether  
5 we could provide a statement from our legal counsel  
6 saying just what I explained, and I said, yes, that  
7 we could do that. So we will take care of that  
8 ASAP.

9 **MR. PARTAIN:** Thank you.

10 **MS. STEVENS:** Okay, the next item is ATSDR will  
11 check on whether or not there is a data source on  
12 the base's laboratory quality control results. That  
13 was assigned to Rick Gillig.

14 **MR. GILLIG:** We have made a request of the  
15 Department of the Navy, and our contact at Camp  
16 Lejeune about this database, and they are not aware  
17 of such database as this.

18 **MS. STEVENS:** The next item: ATSDR will get  
19 clarification on whether the Camp Lejeune fire  
20 department files for more than three years ago are  
21 available, and if so, ATSDR will review and add  
22 those files. Again, Rick Gillig.

23 **MR. GILLIG:** As we discussed earlier today,  
24 we've obtained five files from that database. The  
25 database before 2008 does not exist.

1           **MS. STEVENS:** The next item is assigned to the  
2 CAP members. The CAP will develop a language for  
3 requesting the development of a relational database  
4 for the Camp Lejeune data sources.

5           **MR. PARTAIN:** Yeah, we talked about that but we  
6 did not -- it was discussed at the last CAP meeting.  
7 And we have not gotten together to do that.

8           **MS. STEVENS:** Okay. I will put it for the  
9 next -- we'll put it in either as a parking lot item  
10 for the next call or we can wait 'til the January  
11 time frame.

12           The next item is the CAP requested that ATSDR's  
13 assessment of vapor intrusion exposures includes --  
14 I cannot say this word -- cumulative exposures.

15           **MR. GILLIG:** And that was an item for my  
16 follow-up.

17           **MS. STEVENS:** Yes, thank you, Rick.

18           **MR. GILLIG:** And yes, we are doing that.

19           **MS. STEVENS:** The next item is ATSDR will look  
20 for information on water complaints so that vapor  
21 intrusion can be analyzed from temporal and spatial  
22 aspects. Rick Gillig.

23           **MR. GILLIG:** We did talk about that earlier  
24 today in the working session. We will compile all  
25 of the information, put it in a large database so

1           that we can look at spatial and temporal trends.

2           **MS. STEVENS:** The next item: In the drinking  
3           water evaluation, ATSDR will check on the exposure  
4           parameters to account for workers in dining halls,  
5           laundry facilities, medical personnel and Marines in  
6           training as well as recreational use of the water by  
7           Marines and family members. This was assigned,  
8           again, to Rick Gillig.

9           **MR. GILLIG:** And again, earlier today we did  
10          discuss the different parameters for using the  
11          models for those exposure pathways. We've had good  
12          input from the CAP and we're moving forward with  
13          those models.

14          **MS. STEVENS:** The next item: The CAP requested  
15          that ATSDR determine if the current school at Tarawa  
16          Terrace is being exposed to vapor intrusion. Rick  
17          Gillig?

18          **MR. GILLIG:** So far we haven't looked at -- or  
19          haven't found any sample results that indicate there  
20          are any ongoing exposures in these buildings.  
21          Again, when we do our analysis of the data, we will  
22          use these building numbers as one of the keyword or  
23          a couple of the keywords that we search the data on  
24          so we can compile and look at the data, then the  
25          soil.

1           **MS. FRESHWATER:** I just had someone else come  
2 on to the -- via the Facebook group saying that she  
3 was a teacher at TT-2, and she's sick. And I still  
4 have not been able to get any concrete information  
5 on is the new school built on the site of the old  
6 school or not. Do you -- do we know that? I mean,  
7 I know we've got it marked on Google Maps and all of  
8 that but I feel like this is a kind of a precise  
9 thing we should be able to know. And I'm sorry I  
10 haven't been able to find out. It's right on the --

11           **MR. ENSMINGER:** It's right within the same  
12 footprint.

13           **MS. FRESHWATER:** So what would we need to do to  
14 get testing in there tomorrow? You know what I  
15 mean? Like to get current testing in the schools on  
16 that site?

17           **MR. GILLIG:** We would have to check with our  
18 contacts to see if testing has already been done.  
19 It may have been done already but I am not sure.

20           **MS. FRESHWATER:** I would like anything at  
21 all -- you know, I understand that this is a  
22 personal thing for me, because that's where I went  
23 to school, but I am asking that we make sure that  
24 some current samples, if they have not been done,  
25 that we get those done and make sure that those kids

1 are not being exposed in that school.

2 **MR. ENSMINGER:** The school was a point of --  
3 became an issue when the Tarawa Terrace water model  
4 was released back in 2007. ATSDR, Morris and his  
5 team, basically took a look at the plume and  
6 annotated that there was a possible risk involved  
7 with vapor intrusion at the school. And the EPA was  
8 running around with their hair on fire after that  
9 allegation or that point was made. I do believe the  
10 testing was done in 2007, if I'm not mistaken, but  
11 we'll have to check that. I think 2007 there was  
12 testing done, and it was after June.

13 **MR. GILLIG:** And I can follow up on that.

14 **MS. FRESHWATER:** Jerry?

15 **DR. BOVE:** Yeah, Morris would know.

16 **MS. FRESHWATER:** Do you know anything about  
17 there was an underground tank that they dug up from  
18 that site?

19 **MR. ENSMINGER:** That was a 10,000-gallon  
20 leaking fuel oil tank, heating oil tank that was --

21 **MS. FRESHWATER:** Right there under the school,  
22 right?

23 **MR. ENSMINGER:** Yeah.

24 **MS. FRESHWATER:** Yeah.

25 **MS. STEVENS:** Okay, the next item was assigned

1 to Angela Ragin; she's not here but the CAP  
2 requested that Tim Templeton be added to the CAP,  
3 and right over there we have Tim Templeton.

4 The next item is assigned to Kathy Harben, and  
5 I think Christian Scheel will be standing in for  
6 her. So ATSDR needs to disseminate study results  
7 and key messages to the affected community and other  
8 stakeholders.

9 **MR. SCHEEL:** So ATSDR had a conversation with  
10 Ms. Freshwater, and it was discussed how we would  
11 promote study results and reach out to the affected  
12 community and other stakeholders. We committed to  
13 continuing to work with Ms. Freshwater on our  
14 communication efforts here going forward.

15 **MS. FRESHWATER:** And we're also going to have a  
16 meeting today, right? We're still on for that?

17 **MR. SCHEEL:** That's correct.

18 **MR. ORRIS:** I would just like to point out that  
19 the current Google news search still only shows two  
20 hits for the civilian mortality study, and that is  
21 absolutely unacceptable.

22 **MS. STEVENS:** The next item: ATSDR needs to  
23 synthesize information from the Camp Lejeune studies  
24 and distribute to stakeholders. This was assigned  
25 to Jimmy Stephens.

1           **DR. STEPHENS:** Yeah, so we haven't done that  
2 yet but we think it's a good idea and we've had some  
3 discussions with Angela and Frank about how to do  
4 that and what would be the best timing. And I think  
5 the thought at this point is that we've got these  
6 other studies in the pipeline that should be coming  
7 out relatively soon or be done relatively soon, and  
8 at that point that would be a good time to kind of  
9 step back and try to summarize it. Frank, I don't  
10 know if you want to add anything to that?

11           **MS. STEVENS:** Okay, I actually skipped one.  
12 Christian Scheel, you're back on for this next one.  
13 ATSDR -- I'm wrong. I'm sorry, let's go back. The  
14 CAP -- and still Christian, I'm sorry, the CAP  
15 requested that ATSDR send out Google alerts for when  
16 Camp Lejeune is mentioned, check to verify that  
17 reported information is correct, and if not, notify  
18 the author.

19           **MR. SCHEEL:** We've set up Google alerts and  
20 we've made it part of our daily media monitoring  
21 process. So taking care of that.

22           **MS. STEVENS:** Thank you. The next item is  
23 assigned to Melissa Forrest. A CAP member would  
24 like the DOD to respond to how they plan on  
25 notifying children, now adults, who were exposed

1           when they lived on base.

2           **MS. FORREST:** Department of Navy does not have  
3           access to records that would indicate the  
4           present-day contact information of persons who were  
5           a dependent child during the exposure time period;  
6           however, between 1999 and 2002, as part of ATSDR's  
7           birth defects study effort, ATSDR, with the help of  
8           the Marine Corps, was successful in contacting the  
9           parents of 12,598 Camp Lejeune children born between  
10          1968 and 1985, using available birth certificates  
11          and subsequent referrals. In addition to these  
12          efforts directly note -- in addition to these  
13          efforts to directly notify the parents, the Marine  
14          Corps has engaged in an ongoing national media  
15          campaign to contact former Camp Lejeune residents  
16          and workers. Today we've collected more than  
17          230,000 registrations which have received direct  
18          notification. Moving forward, we plan to include a  
19          routine reminder in our outreach information to  
20          encourage registrants to have their children or  
21          other family members register independently.

22          **MS. STEVENS:** The next item: A CAP member,  
23          Lori Freshwater, requested that an expert in  
24          immunotoxicology give a presentation at a future CAP  
25          meeting -- sorry, I really messed up that.



1                   **MS. FRESHWATER:** I do it every time. We were  
2 laughing about it.

3                   **MS. STEVENS:** So what we -- last week Angela  
4 Ragin and I had a call with Lori, and we discussed  
5 having a proposal put together that would be  
6 reviewed by our ATSDR leadership, so we'll wait for  
7 the proposal and we'll have our leadership look at  
8 that. Lori, do you have anything else you'd like to  
9 add to that?

10                  **MS. FRESHWATER:** I just want to, you know, for  
11 anyone watching or reading the transcript, I want  
12 them to know that we are moving forward on it and it  
13 is -- you know, we are placing an important  
14 priority. And I had a good opportunity to talk with  
15 Dr. Clapp so I'm going to make a few revisions. And  
16 I told Angela earlier I'll be getting that to you  
17 guys probably tomorrow instead of today, if that's  
18 all right. And hopefully we'll be able to move  
19 forward with this in the next year.

20                  **MS. STEVENS:** Thank you. And the final item is  
21 the CAP requested that Dr. Portier's October 2010  
22 letter refuting the NRC report be put on the ATSDR  
23 Camp Lejeune website. And as of, I think, about,  
24 what is it, 21 days ago, we actually did post that  
25 to our website, and you can find that on our ATSDR

1 site. And the title of it is the June 2009 NRC  
2 Report Frequently Asked Questions. So this  
3 concludes the after actions from the June 12<sup>th</sup>  
4 meeting.

5  
6 **PRESENTATION OF CIVILIAN WORKER MORTALITY STUDY**

7 **DR. BOVE:** I'm going to hand out copies of this  
8 to the CAP members. I don't think I made enough  
9 copies for everybody. So this was just published  
10 last month. In fact the slides don't even show when  
11 it was published but believe me, it was published  
12 last month. I have a few more.

13 (Handing out material.)

14 **DR. BOVE:** Okay, so this, as I said, was just  
15 published so it's -- wasn't just submitted. Okay,  
16 so it was published last month, and this slide shows  
17 all the people that we want to acknowledge. The  
18 first six names are members of Morris's water  
19 modeling group. Couldn't do the study without them.  
20 The next two names, Dana Flanders and Kyle  
21 Steenland, are Emory epidemiologists who we  
22 consulted with during the analysis. Westat was the  
23 contractor and of course the Camp Lejeune CAP and  
24 Dick Clapp were very important during all these  
25 steps.

1           So this is a data linkage study, which means we  
2           didn't contact anybody. We used what data that's  
3           available from the Defense Manpower Data Center,  
4           which has personnel records, and from databases that  
5           we can use for -- to determine vital status and  
6           whether the person lived or died and cause of death.  
7           So because of that, the cohort is defined pretty  
8           much by what data are available.

9           In the case of the Defense Manpower Data Center  
10          data, there are some issues with it. They have --  
11          their first data is available for the last quarter  
12          of 1972, and then there's a gap. And then after  
13          that in the second quarter of '73 it starts being  
14          quarterly. And they also have -- and by '74, late  
15          '74 they had codes for when the person was hired or  
16          promoted but there's a lot of missing data and a lot  
17          of different codes that are in error, so we couldn't  
18          really use that, so we were -- we had a choice to  
19          make. We could've included anybody in the database  
20          that we had but we wouldn't know, for the people who  
21          were in the database in December of '72, how long  
22          they were employed, so we wouldn't have been able to  
23          do cumulative exposure for them. So we decided to  
24          just focus on those whose first in the database, at  
25          least the database we had, in second quarter of '73.

1           So the cohort at Camp Lejeune is defined, then, as  
2           if you're in the database as employed at Camp  
3           Lejeune any time from the second quarter of '73 to  
4           December of '85, and there's 4,647 civilian workers.

5           Okay. And then we had a comparison group, and  
6           we do this because we want to have a worker  
7           population that's very similar to Camp Lejeune  
8           except for the drinking water exposures. I'll talk  
9           later about the problems with comparing these  
10          cohorts to the general public. But we decided it  
11          was important to have a comparison group. We did  
12          the same thing for the Marine study too. And it's  
13          the same definition of that cohort as Camp Lejeune  
14          cohort except none of them could have been employed  
15          at Camp Lejeune.

16          So with the DMDC database what we have are --  
17          it's not as good as the Marine part of the personnel  
18          data. We don't have full name until close to the  
19          end of the study actually, the beginning of 1981.  
20          But we do have Social Security Number, and that's  
21          the variable for matching with vital records and  
22          with the National Death Index, which I'll talk about  
23          in a second. We have where they were employed so we  
24          can tell whether they were at Pendleton or Lejeune,  
25          date of birth, sex and so on, and their occupation.

1           So these are important things that we can use.

2           Okay, so in this case, this is different from  
3           the Marine study because these people are not  
4           exposed at their residence. They live off base for  
5           the most part. There are some that might live on  
6           base but we have no information on that. But what  
7           we have is information from the Marine Corps which  
8           was that most of the work places were at Main Side,  
9           not all of them but most of them. So we just  
10          assumed that the work places at Camp Lejeune were at  
11          Mine Side, and for those who weren't we're going to  
12          be in error. But these people also probably moved  
13          around the base quite a bit and probably were at  
14          Main Side at some point, possibly during the working  
15          day, if not for lunch for other reasons. So I don't  
16          think it's a terrible assumption. And we used the  
17          water modeling results like we did with the other  
18          studies to determine what their cumulative exposure  
19          was.

20          Now, the exposures changed drastically. This  
21          was true for the Marine study too but even more so  
22          for this study 'cause we go back to '73 in this  
23          study. Between '73 and, let's say, '75 there's a  
24          steady increase in the TCE, but really it starts  
25          skyrocketing sometime after '75, I think, if you

1 look at the documents that are out on our website.  
2 So and you can see from here, from '72 to '79 TCE is  
3 high. The mean is 280 parts per billion but it's  
4 much higher, 455, by the later part of the study.  
5 So there is this increasing exposure -- increasing  
6 levels of contaminants as the time went on.

7 So the vital stat databases that we used, same  
8 as the mortality study, these are from the Social  
9 Security Administration. They're used by other  
10 researchers to do these kinds of studies. But we --  
11 and also many ^ now use a personal tracing service  
12 as well. I'm talking about what we did for each one  
13 of them. And then we have the National Death Index,  
14 which everyone uses when they do these kinds of  
15 studies. They started collecting data in 1979.  
16 It's run by the National Center for Health  
17 Statistics, which is part of CDC. And they had  
18 complete data up to December of 2008 when we were  
19 doing these studies, the same as the other mortality  
20 study.

21 So the way it works is this. We send in the  
22 names to the Social Security Administration, look at  
23 their death master file and this other file called  
24 ORES, which is the second bullet there, the SSA  
25 service to epidemiologic researchers, and find out

1           if whether the person's alive or dead. But if we  
2           don't have a complete match on Social Security  
3           Number and date of birth, sex, which we probably do,  
4           but usually date of birth and Social Security Number  
5           and name, and we had it. We didn't have a complete  
6           perfect match. Or if we did the matching but if it  
7           was unknown, for some reason there was no data from  
8           the Social Security Administration on that person,  
9           then we would send that to the tracing, which was in  
10          this case LexisNexis, to see if we could get any  
11          information on that person.

12                 So after doing this, the searches through  
13          Social Security Administration and using LexisNexis  
14          as well, then anyone who had died or anyone where  
15          the stat -- vital status is still unknown, we send  
16          to the National Death Index and find out if they  
17          died and what they died of, okay. So that's how  
18          that works.

19                 Okay, so that's how follow-up was done. Given  
20          that the National Death Index did not start 'til  
21          1979, we started follow-up in 1979, just like the  
22          other study. So deaths occurring before 1979 are  
23          not included in the study. But we followed up from  
24          1979 on.

25                 Now, the -- the diseases that we -- we did the

1 same thing in the mortality study of Marines. We  
2 divided the diseases -- causes of death, into two  
3 categories, primary interest based on how strong the  
4 evidence was. And for these cancers here the  
5 evidence was pretty strong. So this became our  
6 first tier, our primary interest.

7 And then we had done a literature review, and  
8 these diseases here, there was less information on.  
9 Or there were studies done in the occupational  
10 literature, which is where most of this information  
11 comes from, that said that it's general -- it's  
12 solvent exposure. They couldn't figure out what  
13 solvents but solvent exposure was related. So we  
14 thought we'd cast our net wide and include diseases  
15 where there was any evidence whatsoever, and that  
16 would be the second tier of diseases.

17 Now, I want to spend a little time on this  
18 because there have been some issues raised. We hear  
19 in the media a lot about the issues of significance  
20 and I want to talk about that in a second. The way  
21 we're interpreting our findings is we're focusing on  
22 the size of the effect, the actual relative risk or  
23 risk ratio, whatever you want to call it, that we  
24 get. We also looked to see what kind of trend we  
25 get with cumulative exposure. You know, as the risk



1 increases the exposure increases. Okay, and then we  
2 look and see if what we're finding is consistent  
3 with other studies including our previous mortality  
4 study on the Marines. And then we look at the  
5 confidence interval. But for the confidence  
6 interval what we were mainly interested in, or only  
7 interested in really, is how wide it is to give us  
8 some sense of how uncertain the estimate is. So  
9 here's what I want to get, to deviate a little bit  
10 from the presentation and talk a bit about this.  
11 Because we don't use significance testing to  
12 interpret our data in these studies. We haven't  
13 done that for any of the studies. And that  
14 approach, although somewhat controversial, is also  
15 the approach recommended by the main textbook and  
16 reference book in the field. It's called *Modern*  
17 *Epidemiology*. So our approach is actually supported  
18 by that textbook.

19 The debate around significance testing has gone  
20 on in this country for like 75 years, so I'm not  
21 going to get into all the issues there. Probably  
22 the debate in Europe goes even further back. But in  
23 general there is a lot of problems with significance  
24 testing, and I'm not going to go into all of them.  
25 I don't think it's a very good decision rule. There

1 are other approaches. And if you try to make a  
2 decision based on one study you're probably not  
3 doing justice to the evidence, if you're deciding on  
4 one study whether it's important or not and not  
5 include other evidence. Significance testing tends  
6 to get you to do that.

7 The other thing is that people think that it's  
8 an objective approach. And there's a lot of  
9 subjectivity, though, that the researcher isn't  
10 maybe aware of. The P-value .05 is the cutting  
11 point is an arbitrary choice, and there are a lot of  
12 assumptions built into this using that as your cut  
13 point. Other researchers sometimes look at a  
14 95 percent confidence interval and see a null value  
15 or the null effect value or a value of 1 which is,  
16 and they use the confidence interval the same way  
17 they use the key value. In either case, it's not a  
18 good approach and it's not a good decision rule, and  
19 it's a very arbitrary choice. If you ask a  
20 researcher why they choose .05 as the cut point or  
21 why they're using a 95 percent confidence interval,  
22 if they're honest, they'll say because everyone else  
23 is doing it. And if that's a good enough reason for  
24 you, then fine. But one of the -- and there's a lot  
25 of other issues, and I don't want to get into all of

1           them so I'm just going to get into one, that I think  
2           is very important. And that is the P-value and the  
3           confidence interval do not take into account biases.

4           And I'm going to be talking quite a bit about  
5           bias in this study. For example, let's -- I'm -- my  
6           background is -- my ancestors are from Italy so I  
7           use my hands, okay. If we have no bias, right, in a  
8           study, let's say, okay? So we have a confidence  
9           interval of -- we have a -- the risk is here and the  
10          confidence interval's around it, right? No bias.  
11          Let's say we're absolutely sure. Okay, now, that's  
12          the true -- let's say that's what's truly happening.  
13          If there's bias, for example, if the Camp Lejeune  
14          cohort smoked more than the Camp Pendleton cohort,  
15          for some reason, and we're looking at lung cancer,  
16          well, that would not only shift the point estimate,  
17          it shifts the whole curve over, okay? Or if they  
18          smoked less. Instead of being here, now we're over  
19          here, okay? So the whole -- not only the point  
20          estimate but the whole curve gets shifted over. So  
21          you can't really be confident with the confidence  
22          interval. What the confidence interval can give  
23          you, and this is the good news about a confidence  
24          interval, is that it gives you some sense of how  
25          uncertain the estimate is. If you have a lot of

1 deaths in your study the confidence interval is  
2 narrow. If you have few deaths, like in this study,  
3 it's going to be wide. But keep in mind the deaths,  
4 that's the best thing you can get out of a  
5 confidence interval, because we know there's bias in  
6 studies so that confidence interval is probably in  
7 the wrong place. So just keep that in mind. When  
8 people then look to see if one is included in a  
9 confidence interval, they're not thinking clearly  
10 because there are biases in all these studies, and  
11 I'll talk about a couple in particular as we go on.  
12 And so if you have any questions about that, we'll  
13 talk about that later.

14 But let me move on now to comparing Camp  
15 Pendleton and Camp Lejeune. The first thing we look  
16 at is demographics, how different are they. And  
17 there are some differences here. They differ on  
18 most of the factors here, not a lot but there are  
19 some differences. But roughly they have -- there's  
20 a similar percentage of those with at least a high  
21 school graduation but there are more college  
22 graduates at Lejeune than at Pendleton.

23 And this -- these aspects, the types of  
24 occupations, the months employed and so on, there's  
25 a lot more similarity in the two groups, okay. So

1           they're not that different on many of these  
2           occupational and other factors, in this slide, okay.

3           So the first thing we did -- and by the way,  
4           that table that I just showed is on page 6 of the  
5           handout if you want to follow along. And this is  
6           also, this is on page 7, table 3. So here we're  
7           starting to compare the cohorts. And in this case  
8           we're comparing them not to each other but comparing  
9           them to the US population. So it answers the  
10          question of how different is the mortality situation  
11          at Camp Lejeune, or at Camp Pendleton, among the  
12          workers there, with the general population. And  
13          here's where bias starts to come in right away.  
14          There's one thing that you know about the general  
15          population: There are a lot of people there who are  
16          too sick to work, okay, whereas the workers are  
17          healthy enough to work; that's why they're employed.  
18          So right off the bat that confidence interval's  
19          going to go this way. And if you look, you'll see  
20          that the SMRs, which is a -- the measure of the risk  
21          difference or mortality rate difference between, in  
22          this case, Camp Pendleton or Camp Lejeune versus the  
23          US, you see that most of the SMRs are below 1. If  
24          they were the same as the US population they would  
25          be 1, okay?

1           So there's this bias we call the healthy worker  
2 effect, which is just what I said, that the US  
3 population is not as healthy as the working  
4 population. And you can see it from almost all the  
5 outcomes here, except for a few, they're are below  
6 one. So and the confidence interval goes along with  
7 it, okay. All right, but there actually are some  
8 that are above one, which makes you think that in  
9 reality there are probably a lot more than what  
10 you're seeing; in other words, we're probably  
11 underestimating, okay, because of the healthy worker  
12 effect. And a key one here is the Camp Lejeune  
13 kidney cancer that stands out at 1.3. And also what  
14 we call the hematopoietic cancers, in this case  
15 multiple myeloma and the leukemias, are also  
16 elevated. The leukemia is also elevated in Camp  
17 Pendleton cohort compared to the US population but  
18 not as high as Camp Lejeune. And at Camp Pendleton  
19 liver cancer, for some reason, seems to be elevated  
20 too; who knows why but that's -- that answers that  
21 question.

22           And of course the assumption here in this -- in  
23 any comparison between Camp Lejeune and Camp  
24 Pendleton as well, is that everybody at Lejeune is  
25 exposed, okay. And we know that may not be true

1 here, especially for workers. We don't know if  
2 they're drinking the drinking water or washing their  
3 hands. There may be some workers who don't use the  
4 water at all for any purposes. I don't think that's  
5 likely but there is -- it's possible, I guess, okay.

6 So these are the diseases of primary interest.  
7 The diseases of secondary interest, we also compared  
8 them to the US population. And for this there are a  
9 few more that are elevated. I don't have a pointer  
10 but some of the more interesting ones, rectal cancer  
11 at Camp Lejeune, laryngeal cancer, lung cancer,  
12 prostate cancer and Parkinson's disease in  
13 particular, based on five cases but still very  
14 interesting. On the Pendleton side, there are a few  
15 that are also elevated; pancreatic cancer is  
16 elevated, brain cancer and ALS. ALS is high in the  
17 military population in general. So that's that  
18 comparison.

19 And it's interesting but the real interest was  
20 to compare Pendleton and Lejeune so that's what  
21 we're talking about here. And for this we do a  
22 different approach in modeling. We take a better  
23 account of age at death as a factor, and we can --  
24 we have more flexibility in using continuous  
25 variables in this equation, okay. I won't get into

1           that any further than that unless you have any  
2           questions.

3           Okay, so in these analysis -- in the SMR  
4           analysis we were testing for age, sex and race. In  
5           here we were able to also adjust for other factors  
6           such as occupation, blue collar versus white collar,  
7           and their education level, and we were able to lag  
8           exposures by ten years. What we mean by that is  
9           there's a latency period for cancer, and so the  
10          exposure you have now will affect your cancer --  
11          development of cancer ten years from now, let's say.  
12          So what we want to do is lag and so that the  
13          exposure reflects reality in a sense. And again I  
14          can talk more about that if you're interested. So  
15          in this analysis, we compared the mortality rates  
16          between Lejeune and Pendleton, and the hazard ratio  
17          tells you if it's above one that Lejeune had a  
18          higher mortality rate for that disease.

19          And so what you see here is that a particular  
20          kidney cancer and again, multiple myeloma and the  
21          leukemias are above 1 and are of interest. And  
22          again, the confidence intervals are wide because  
23          we're dealing with a small number of deaths in the  
24          study.

25          For the disease -- diseases of secondary



1 interest, there were a number of them that are also  
2 elevated at Lejeune and some that aren't. Among the  
3 ones that are interesting here, rectal cancer was  
4 above 1.5 percent, oral cancers, which we associate  
5 with PCE mostly, and Parkinson's disease which was,  
6 again, pretty dramatic, I thought.

7 Now, we also included in our studies, we  
8 evaluated three smoking-related cancers and diseases  
9 that weren't related at all, as far as we know, to  
10 solvents. So stomach cancer and cardiovascular  
11 disease and COPD are those three cancers --  
12 diseases. We did that in the other study too. We  
13 have that information on smoking, and so therefore  
14 we're trying to get a sense of maybe -- whether  
15 there is a smoking effect on line here, whether that  
16 could be a bias again, okay. And if you look at  
17 COPD, it looks like there might be some smoking bias  
18 in some of these figures, okay. But if you look at  
19 stomach cancer and cardiovascular disease, there  
20 isn't. And if you look at, again, if you go back up  
21 there and look, lung cancer's elevated and so that  
22 might point you in one direction. Oral cancers are  
23 related to smoking as well but there are others that  
24 are related to smoking that aren't elevated,  
25 pancreatic cancer, for example, is not elevated.

1           And so -- and there are several others that are not,  
2           esophageal cancer is not either. And so, okay, and  
3           then there's liver cancer. So what do you get out  
4           of this is that it's not clear that smoking is an  
5           important factor.

6           But if, in the worst case, if you look at COPD,  
7           it would affect the risk estimates we think around  
8           17 percent. That's not too much. That's what you  
9           see in other studies with smoking and occupational  
10          exposure. So either there is no confounding of  
11          smoking, because we see all this conflicting  
12          evidence here, or at worst, if you just focus on the  
13          finding for COPD, there's about a 17 percent  
14          difference. Again, it would be nice to have smoking  
15          information but that -- you'd have to contact people  
16          for that, and that's impossible for these studies.

17          So that was the comparison between Pendleton  
18          and Lejeune. And now we decided to, like the other  
19          mortality studies, look within Camp Lejeune for  
20          cumulative exposure, okay. But because of the small  
21          numbers of deaths in this cohort, it was very  
22          difficult to do that. We could look at a few  
23          outcomes where we could break it up into medium  
24          exposure, high exposure versus, you know, very low  
25          exposure. And we could do that for leukemia, and we

1 saw what we call a monotonic exposure response  
2 trend. That is that the risk increases with every  
3 increase in exposure. So we see it for PCE. We see  
4 it for vinyl chloride. TCE we really don't because  
5 the medium exposure's below 1. But we do see it for  
6 the other two. And again, we may not see it because  
7 of errors in the way we determine exposure, and  
8 there's really no way around that. That's a problem  
9 in all studies but in particular it would be a  
10 problem in this study.

11 The -- we also do this approach that helps us  
12 get a sense of how the exposure response  
13 relationship is occurring. It's a flexible  
14 approach, it's called blind, sounds awful, but  
15 that -- it allows the curve to have a much more  
16 flexible shape to match what the data is actually  
17 saying. There are assumptions in this too but there  
18 are fewer assumptions than any regression approach  
19 to the problem. So as you can see, this is where  
20 you typically see with exposure misclassification  
21 errors or it could also be that you -- the exposures  
22 had wiped out the susceptibles at lower levels and  
23 the only people left are people who won't get the  
24 disease no matter how much they get exposed. There  
25 are all kinds of reasons to see curves like this but

1           it's actually pretty typical of the kind of curves  
2           you see in occupational exposures. So anyway it  
3           seems to go up to around a relative risk of 2 and  
4           then starts to tail off in that higher exposures.

5           So we could do that for a few kidney --  
6           leukemia was the only one where it had a nice  
7           pattern like that. Kidney cancer we couldn't do  
8           'cause we only had seven cases. We couldn't really  
9           divide them up. But we did see that most of the  
10          cases, in this case all the kidney cancer deaths,  
11          were in the higher grouping of exposures, above the  
12          median for several of the contaminants. So that's  
13          interesting and it supports that finding.  
14          Esophageal cancer was interesting too because most  
15          of them were in the higher cumulative exposure  
16          group. For multiple myeloma, we didn't see it for  
17          cumulative exposure but for average exposure. We  
18          did look at both average exposure and cumulative  
19          exposure. The study did focus mostly on cumulative  
20          exposure, but in this case it looked interesting for  
21          average so we reported, for what it's worth.  
22          Parkinson's disease they were all -- four out of  
23          five were above the median cumulative exposure for  
24          all the contaminants. And so that supports that  
25          finding. Prostate cancer similarly in most of the

1 cases were above the median and that's also true for  
2 rectal cancer. So that helps gives us some support  
3 for what we saw in the comparison between Lejeune  
4 and Pendleton.

5 Okay, so I already talked briefly about  
6 exposure misclassification but it's occurring in all  
7 our studies because, you know, it's hard to know  
8 what people did at their work place. In the case of  
9 the previous studies with Marines we had information  
10 on residence to some extent, even though that was  
11 kind of spotty, but they also got exposed in the  
12 field, and we don't have any way of capturing that  
13 information. So there's plenty of exposure  
14 misclassification in all of our studies but that's  
15 true of most environmental occupational studies so  
16 it's not unusual.

17 And what it does, in the comparison between  
18 Pendleton and Lejeune, it tends to bias your results  
19 towards no effect. But with exposure response  
20 situations, it can give you curves of all kinds of  
21 shapes.

22 Similarly disease misclassification. It's  
23 probably much less of a problem here but we know  
24 that some cancers were underreported or over-  
25 reported on death certificates. If you have kidney

1 cancer and get run over by a truck, you died of  
2 being run over by a truck not by kidney cancer. So  
3 the only way to handle that is to do a cancer  
4 incidence or disease incidence study, which we'll  
5 talk about later.

6 Confounding. A lot of people talk about  
7 confounding all the time although sometimes they  
8 don't present any evidence that it actually exists.  
9 But smoking is one that people always bring up, and  
10 we talked about that earlier. It doesn't seem to be  
11 clear that there is a smoking issue here. But  
12 without smoking information you can't be absolutely  
13 sure. And the bias can go in any which direction,  
14 whether Camp Lejeune people smoked more or smoked  
15 less or whatever. And there are other risk factors  
16 that we don't have information on, alcohol  
17 consumption. Some of the diseases are related to  
18 alcohol consumption. Not kidney cancer, not  
19 Parkinson's but there are some cancers that are  
20 related to alcohol consumption. When you look at  
21 the data we find that there were -- for example,  
22 there were elevations at Camp Lejeune for oral  
23 cancer, breast cancer among females. By the way,  
24 there were no male breast cancer cases in either  
25 study. And rectal cancer. So those are the cancers

1           that are related to alcohol consumption, and they  
2           were elevated at Lejeune. But on the other side of  
3           the ledger there's liver cancer, esophageal cancer,  
4           colon and cardiovascular disease and so on, which  
5           are also related to alcohol consumption that weren't  
6           in that comparison. So you get conflicting  
7           information here too which seems to me to say  
8           alcohol is not going to be an issue here either,  
9           either smoking or alcohol. But without, you know,  
10          actual information you never can be sure, as they  
11          say.

12                 And the confidence intervals are wide and the  
13                 reason the confidence intervals are wide, it's a  
14                 small cohort. That's the first reason. Second  
15                 reason is that there's the healthy worker effect.  
16                 And the third reason is that most of them are young  
17                 and very few had died. So that combines to give you  
18                 small numbers of deaths and wide confidence  
19                 intervals. Now with the confidence intervals a  
20                 function of the number of deaths in the study.

21                 So what's the key message from this study?  
22                 Again, there's a lot of uncertainty in this study.  
23                 As I said, the confidence intervals are wide but we  
24                 did see these elevated hazard ratios or risk ratios  
25                 and we think that's interesting. And the other key

1 message is that there's still a lot of people in  
2 this cohort that haven't died yet. So what happens  
3 after this is anybody's guess. Will we continue to  
4 see these elevations or will we see new elevations  
5 in different diseases? That remains to be seen,  
6 okay.

7 Now, one of the things that's interesting, and  
8 we did it in the paper, was try to compare the two  
9 studies, the two mortality studies. And so what  
10 were the similarities and what were the differences  
11 in the findings between the Marine study and the  
12 civilian worker study? Of course a lot of you can  
13 expect some differences probably just because, for  
14 one thing, Marines are living on the base and  
15 getting exposed that way, and training in the field.  
16 Civilian workers are coming on the base, may or may  
17 not be using the water. There's one difference  
18 right there. Civilian workers tend to be there  
19 longer than the Marines. There are a lot of Marines  
20 that have been there a long time and a lot of  
21 civilian workers are there for a short time. Okay,  
22 so you can expect some differences right off the  
23 bat.

24 But we actually saw some similarities, which is  
25 interesting, and in particular for kidney cancer,



1           rectal cancer, lung, prostate, leukemias and  
2           multiple myeloma, they're elevated in both studies  
3           at Camp Lejeune. And we didn't see any elevation in  
4           both studies at Camp Lejeune for cancers of the  
5           bladder, colon and brain and non-Hodgkin's lymphoma.  
6           The last one is a little surprising because TCE has  
7           been associated with non-Hodgkin's lymphoma pretty  
8           strongly but we're not seeing it yet, but that could  
9           be also because we're looking at the mortality, not  
10          cancer incidence.

11                 So the differences, there are differences. We  
12          saw elevated risk of cancers of the liver, esophagus  
13          and soft tissue and pancreas in the earlier study  
14          but we don't see it in the civilian worker study.  
15          And the other side, we saw a risk for female breast  
16          cancer, oral cancers in the civilian worker study  
17          but not the Marine mortality study. So what do we  
18          make of this? Among the other reasons that I just  
19          said, that there are differences in the exposure  
20          scenarios. We're still looking early at these  
21          cohorts. Most of them haven't died yet, and so  
22          things may change as time goes on.

23                 So that's all I have to say and I probably went  
24          too long. If you have any questions about the  
25          studies, both -- either study, either mortality

1 study, let me know.

2 **DR. CLAPP:** This isn't really a question. I  
3 just want to, you know, reiterate or second what you  
4 were saying about the statistical significance,  
5 Shibboleth, you might call it, that scientists use.  
6 I think you are handling it really well; I think you  
7 explained it really well, and that the textbook  
8 monitor Epidemiology is of the standard in the field  
9 right now. So I really endorse the way you  
10 presented that in both the presentation this morning  
11 and also in the written papers.

12 **MR. PARTAIN:** And Frank, we got two mortality  
13 studies that are completed, and, you know, a lot of  
14 scientific numbers and things that kind of glaze  
15 over after a few minutes. You know, science is not  
16 just one eureka moment where everything comes into  
17 focus; it's a body of evidence that flows. And, you  
18 know, we have agencies like the VA here today and we  
19 have Congress that are making policy decisions based  
20 on what you guys do. As a layperson sitting here  
21 looking at the results, and there's a lot of  
22 similarities and there seems to be, you know, for  
23 me, findings that there is an association between  
24 exposure or potential association between exposure  
25 and disease. For the -- I mean, can you articulate

1           that more in a lay sense what these studies mean as  
2           far as what -- you know, 'cause we got -- we have a  
3           water model, we have the in utero study, we have the  
4           Marine mortality study and the active duty mortality  
5           study and now the employee mortality study, what  
6           does that, in layman's terms, saying, those four  
7           things?

8           **DR. BOVE:** Well, I mean, that's why I put these  
9           slides up about the comparisons between the two  
10          mortality studies. It kind of makes sense that  
11          we're seeing some consistent findings in the two  
12          studies. And I think that we are, for --  
13          particularly for kidney cancer, we have a lot of  
14          evidence and we're pretty confident that kidney  
15          cancer's caused by trichloroethylene, so that's,  
16          that's interesting. And as I said, we're not sure  
17          what to make of the non-Hodgkin's lymphoma findings  
18          at this point. But again, we're going to be talking  
19          about another study, and maybe that study's the  
20          answer to the question for that outcome.

21          So you know, I think that we can say that you  
22          can expect to see kidney cancer in populations that  
23          are highly exposed to trichloroethylene, and we are  
24          seeing it. And I think that's pretty clear.

25          You know, and as for the birth defect and

1 childhood cancer study, again, you know, there is  
2 other evidence that -- you know, other drinking  
3 water studies, in particular one that I always  
4 associate with New Jersey where we found some  
5 similarities between that and what we're seeing at  
6 Lejeune, even though the exposures are much  
7 different, much higher, at Camp Lejeune than they  
8 were in New Jersey. So I think the body of work so  
9 far is that there are cancers and other diseases  
10 that we've seen elevated and we can relate it to  
11 drinking water exposure, with the caveats that, you  
12 know, there are some issues with these studies, like  
13 other environmental and occupational studies. But  
14 even so a lot of these biases make it harder to see  
15 something, so the fact that we're seeing them,  
16 again, give some strength to the evidence, even  
17 though the evidence is still, as I have to say, on  
18 its own, if we just look at the Camp Lejeune studies  
19 on their own, without remembering that there are  
20 other studies out there, that there's other  
21 information out there, the Camp Lejeune studies  
22 won't be definitive in and of themselves. But we do  
23 have other information. That's the point of using  
24 the information from other studies and other  
25 research, including animal studies, whatever you

1 have, to then make a conclusion. And it's one of  
2 the reasons that even with the meta analysis and  
3 using significance testing, you don't get that kind  
4 of bringing together of evidence. You really have  
5 to bring together disparate types of evidence to  
6 make a case. But again, I think that there are  
7 outcomes here and there are effects here. But we're  
8 still in the early stage of mortality to know what's  
9 down the pike.

10 **MR. PARTAIN:** Well, that brings me, Frank, to  
11 Dr. Portier's October of 2010 letter. And in that  
12 letter he was refuting the NRC report findings, and  
13 he mentioned that -- and he said -- and I can't  
14 remember the exact words but let me make it  
15 perfectly clear that there was -- or you know, there  
16 was an exposure and --

17 **MR. ENSMINGER:** There was a risk.

18 **MR. PARTAIN:** And a risk, okay. Well, now that  
19 we have the studies, is ATSDR prepared to clarify  
20 that risk? We've got studies now and we have a  
21 letter that is four years old where this agency is  
22 saying that there is a risk. So are we going to  
23 translate that so agencies like the Veterans  
24 Administration can look at this instead of using a  
25 flawed NRC report for the basis of their dissidence?

1           **MR. ENSMINGER:** And let me make this clear. In  
2 Title 42 of the United States Code, whenever anybody  
3 within ATSDR, especially the director, declares that  
4 there is a risk involved at a contamination site, it  
5 triggers all types of actions that need to be taken.  
6 You need to look at it.

7           Now, on non-Hodgkin's lymphoma, my personal  
8 experience, which is very lengthy, non-Hodgkin's  
9 lymphomas and kidney cancers, people contacting me  
10 with those diseases has been rampant. The kidney  
11 cancers do survive for a period of time but  
12 eventually it comes back and gets them. I have not  
13 heard of many of the people that I am familiar with  
14 and contacted by with non-Hodgkin's lymphoma who  
15 have passed. It's very survivable and the treatment  
16 protocols have improved, and this is exactly why we  
17 need the cancer incidence study to be done. If  
18 we're going to get the true picture of the effects  
19 of this contamination and these contaminants on  
20 human beings, which everybody should be scrambling  
21 for 'cause this is science, then we need that cancer  
22 incidence study. And that cancer incidence study --  
23 I am determined that that cancer incidence study  
24 will become the most telling study that has been  
25 done on Camp Lejeune.

1           **MR. BRUBAKER:** That's actually a good segue,  
2           Jerry. Our next item on the agenda is an update  
3           from the expert panel.

4           **MR. PARTAIN:** I know Frank may not be able to  
5           the answer to that but my question to Frank about  
6           the studies and Dr. Portier's letter remains  
7           unanswered.

8           **DR. BOVE:** Well, let me just say this, not  
9           speaking necessarily for the Agency but we do -- we  
10          do have these studies. We have -- and the VA's  
11          aware of them, and they're aware of Dr. Portier's  
12          letter. And if -- and I'm always available to  
13          discuss the issues that they may have with the  
14          studies, and that's the best I think I can answer on  
15          that one. I think, you know, this, this is the  
16          Agency's statement, these studies and Dr. Portier's  
17          letter, in terms of the NRC report and on the  
18          issues. So again, if the VA has some issues with  
19          the studies or questions, we're -- Perri and I are  
20          always available to discuss that with you.

21          **MR. SMITH:** And I think that's also where doing  
22          the summary, I think, could be helpful as well.

23          **MR. PARTAIN:** What type of summary are you  
24          referring to, Gavin?

25          **MR. SMITH:** It's the summary that was in the

1           action item before, in terms of summarizing where we  
2           stand with the existing studies.

3           **MR. PARTAIN:** Okay. And going back to Frank,  
4           what is the difference between your work and what  
5           the NRC did in 2009? I mean, just to -- it comes  
6           out to -- I mean, this NRC report, which we thought  
7           was gone and buried and discredited, keeps rearing  
8           its ugly head. And so we have to come back and kind  
9           of tap the dirt here to make sure it's still dead.  
10          But there's a difference between what ATSDR's done  
11          and the NRC's review of scientific literature as  
12          directed by the peer review coordinator.

13          **DR. BOVE:** Yeah, it's the difference between  
14          apples and oranges. They simply did a literature  
15          review. We did a literature review too but our  
16          literature review's a little bit different from  
17          theirs. But that's what they did. They did a  
18          literature review. And they used what the Institute  
19          of Medicine has done for the Gulf War study which is  
20          come up with categories of, I forget, the top  
21          category is definite causality or whatever, and then  
22          suggestive or whatever -- I can't remember the --  
23          but they have -- and they look at all diseases.

24          **MS. RUCKART:** Limited or suggestive ^.

25          **DR. BOVE:** Yeah, limited or suggestive. And,



1           you know, we did some -- we didn't do something like  
2           that. What we did in our review was: Is there any  
3           evidence? And if there is, then we'll put them in  
4           this group. And then if there's stronger evidence  
5           we'll put them in the primary group, and that's how  
6           we evaluated the mortality study and how we'll  
7           probably do other studies. So -- just, the  
8           differences are large. I mean, we're doing  
9           epidemiologic studies here. That was not an  
10          epidemiologic study. It's also outdated. You know,  
11          since that came out, IARC and EPA and now NTP, have  
12          said kidney cancer's caused by TCE; there's no  
13          question about it in their -- in those agencies'  
14          minds, and yet the NRC report had it as limited  
15          evidence or something of that sort. So there -- you  
16          know, it's outdated, you know, as well. So you  
17          know.

18               **MS. RUCKART:** But there's another important  
19          difference that I think they also looked at animal  
20          studies, didn't they? So we're looking -- our  
21          study's obviously just done on people so they're  
22          looking at evidence in people and animals.

23               **MR. PARTAIN:** So, Frank, as a scientist, would  
24          you -- what value would you put into utilizing a  
25          review of literature versus a study done on a actual

1 exposed population with, you know, using the  
2 scientific method?

3 **DR. BOVE:** It's very important to summarize the  
4 evidence from other studies; there's no question  
5 about that. The issue is whether it was done well  
6 or not, whether it's credible. It's, you know, but  
7 it's a different endeavor. I mean, you can't do a  
8 literature review if you don't have studies to  
9 review in the first place, so we have to do these  
10 kinds of studies to include them in the scientific  
11 literature. You can't do a meta-analysis if you  
12 can't do a literature review, right? Okay. So --  
13 but a good literature review is very important.  
14 That's how IARC and EPA were able to make those  
15 decisions about kidney cancer and TCE.

16 I'll give you another example of a problem with  
17 the NRC report was that liver cancer is not even  
18 part of the cancers under consideration for medical  
19 care, and yet liver cancer is one of the three  
20 cancers, kidney, non-Hodgkin's and liver, that have  
21 been strongly related to TCE, both in the IARC  
22 documents and EPA's documents. So again, you know,  
23 the NRC report, you know, that endeavor needs to be  
24 updated. There's no question about it because of  
25 the recent work that's done by these entities.

1           **MR. PARTAIN:** And your agency.

2           **DR. BOVE:** And yeah.

3           **MR. PARTAIN:** And that's the whole point of  
4 what I'm getting at is we have scientific studies  
5 now. And you have an outdated report that's over  
6 five years old, that doesn't include these studies  
7 that is the primary -- that appears to be the  
8 primary basis for the VA to review these cases. And  
9 we keep seeing it appearing over and over again in  
10 your literature and we keep seeing it appearing in  
11 these PowerPoints. And out of curiosity, Frank --  
12 or Dr. Ikeda, has the VA contacted you all to have  
13 you explain your studies to them and what it means  
14 for them?

15           **DR. IKEDA:** So we did have a conversation with  
16 the VA about the PowerPoint presentation and pointed  
17 out the things that we thought were a  
18 misrepresentation of our work or are outdated, and  
19 they have responded to those.

20           **MR. PARTAIN:** Have they asked you to provide a  
21 summary or explanation of the four studies that have  
22 been completed by ATSDR today?

23           **DR. IKEDA:** No.

24           **MR. PARTAIN:** Why not, VA?

25           **MR. SAMPSEL:** Well, first of all, we work for

1 the Veterans' Benefits Administration. Dr. Terry  
2 Walters would have to address that. I can give you  
3 a little summary later on the difference between the  
4 various parts of the Veterans' Health  
5 Administration. There's a group run by Dr.  
6 Koopmeiners who would be the recipient -- who should  
7 be the recipient of the studies that you're speaking  
8 of, not necessarily Dr. Terry Walters. But if this  
9 is important, I can bring it up to them, for sure.

10 **MR. ENSMINGER:** Is Koopmeiners the guy up in  
11 Minnesota?

12 **MR. SAMPSEL:** Yeah, that's where he -- I  
13 believe he stays there but he works for the central  
14 office in Washington.

15 **MR. ENSMINGER:** Pedophile.

16 **MR. SAMPSEL:** And a Dr. Cross -- this group  
17 that Dr. Koopmeiners is associated with does  
18 compensation and pension examinations. They're the  
19 ones that determine whether there's at least as  
20 likely as not the current disabilities associated  
21 with the Camp Lejeune water.

22 The group I work with at the Veterans' Benefits  
23 Administration relies on their evaluation, their  
24 medical evaluation, to determine whether  
25 compensation is given. So if he cited the report, I

1 can make sure that they are aware of it.

2 **MR. ORRIS:** Why isn't that group here? Why  
3 isn't there a representative from that group here?

4 **MR. SAMPSEL:** As to why there isn't a person  
5 like that here representing the compensation and  
6 pension service examinations, I don't know. I was  
7 asked to come here to substitute for Brad Flohr, and  
8 I don't know about that. But I can look into it and  
9 get back to you.

10 **MR. PARTAIN:** Please do. I mean, there are  
11 veterans here in the audience today, one with  
12 prostate cancer as a second primary cancer, who's  
13 been denied, and another veteran, his wife is here,  
14 who had rectal cancer, which we both saw appear on  
15 these slides. And yet to go through the VA process  
16 is a nightmare.

17 On the eve of our trip down here, there was a  
18 story that appeared on the wire for a veteran in  
19 Alabama who was recently denied for his exposures  
20 and his subsequent cancer. And Jerry mentioned that  
21 we get emails on a daily basis and people sending in  
22 their denial letters, their nexus letters and it's  
23 just a bunch of bogus denials on the VA's part. I  
24 had a lady contact me here, her husband died of  
25 pancreatic cancer. Just two letters from her

1 doctor. She was denied. Actually he was denied  
2 before he died. And, you know, it just goes on and  
3 on and on. And here we are, we've got scientific  
4 studies that are completed and you guys aren't  
5 utilizing them; that's a problem.

6 **MR. SMITH:** I'd just like to add in too from  
7 the civilian perspective, you know, it's  
8 interesting, I looked at the studies and the  
9 elevated risks, and I just have to say that I saw  
10 four out of the six elevated risks in my father. So  
11 he had four of those, so when I look at this report,  
12 I see my dad in it. And so I think they're very  
13 important; I think it's very important to include  
14 these and to have updated information and to make  
15 sure people are aware of what's going on and to make  
16 sure that, you know, they're finding out the right  
17 details and getting the guidance that they need  
18 that's realtime and not outdated.

19 **MR. TEMPLETON:** I've had a chance to review all  
20 of the studies too, in fact, several times, gone  
21 through every one of them front to back, and the one  
22 thing that just screams out of all of the studies in  
23 summary is the cancer incidence study is necessary.  
24 Because these people are no, they're not dead yet,  
25 but they are suffering from these illnesses. And

1 thanks to the wonders of modern medicine, they're  
2 still alive. So that just jumps right out of the  
3 studies to me. So I'd like to second what Jerry  
4 asked for.

5 **MS. FRESHWATER:** Could we hear more about liver  
6 cancer and can anyone give me a better idea as to  
7 why liver cancer isn't being covered as far as the  
8 science goes? Because I have someone who has liver  
9 cancer and was just denied.

10 **MR. ENSMINGER:** The list of effects -- health  
11 effects in the law was taken directly from, as Frank  
12 annotated earlier, directly from the 2009 NRC  
13 report. When that bill was in draft, I was up on  
14 Capitol Hill on another endeavor, and I got a call  
15 to come over to the VA committee to review that  
16 document, the draft, and the first thing that jumped  
17 out at me was the fact that non-Hodgkin's lymphoma  
18 wasn't on there, and I failed to recognize that  
19 liver cancer was not on there. Had I done -- had I  
20 noticed that, I would have dug my heels in on that.  
21 But they did go ahead and include non-Hodgkin's  
22 lymphoma, which had the second highest evidence for  
23 reclassifying TCE as a known human carcinogen. It  
24 slipped through the cracks. I mean, and liver  
25 cancer should be added to that law. And that's an

1 amendment we're going to have to take a look at.  
2 And the law will have to be amended. And you know  
3 what that takes.

4 **MR. ORRIS:** I think it needs to have congenital  
5 heart disease added as well from what we know from  
6 the TCE (inaudible).

7 **MR. ENSMINGER:** We don't have enough cases. We  
8 don't have enough -- I mean, as, as -- we'll talk  
9 about this later.

10 **MR. BRUBAKER:** All right. A quick agenda  
11 check. We're due to break in about five minutes for  
12 the cancer incidence so we've got two choices: We  
13 could go into it now or we could add it to the list  
14 of updates on health studies that we would hear  
15 after coming back from break.

16 **MS. FRESHWATER:** I'd rather work through. I  
17 have a flight.

18 **DR. BOVE:** I think we can do it in like -- and  
19 break at 12:30 for lunch.

20 **MR. BRUBAKER:** Okay. I tell you what, I'll  
21 just go ahead and let you take the -- Frank, 'cause  
22 I don't need to take up the time.

23  
24 **CANCER INCIDENCE STUDY UPDATE**

25 **DR. BOVE:** Okay. Well, the expert panel --



1 Perri and I will be doing this. The expert panel  
2 was held July 29<sup>th</sup> and 30<sup>th</sup>, and here in Atlanta, as  
3 you've heard. There were panel members from the  
4 NCI, National Cancer Institute, from the CDC Cancer  
5 Control and Prevention, from the VA we had a  
6 representative, and from academia. And the  
7 academics who were at the meeting all have  
8 experience in one way or another in getting cancer  
9 incidence studies, including one person who's done  
10 the study looking at how difficult it is to do these  
11 studies and get -- and enroll the cancer registries  
12 into a study and get personal identifying  
13 information from them. So it was very helpful to  
14 have her there. And there was also someone who was  
15 the first author on the Gulf War study, which was  
16 another study that used 24 cancer registries but did  
17 not get --

18 **MR. ENSMINGER:** Twenty-eight.

19 **DR. BOVE:** Twenty-eight, I'm sorry, yeah. The  
20 first study, the methodology study, that I just  
21 mentioned used 24. The VA used 28 -- I mean, the  
22 Gulf War used 28. And did not get personal  
23 identifying information. We'll talk about those  
24 differences and they were -- it was good to have all  
25 those people at the meeting.

1           So the key issues that were raised was Camp  
2       Lejeune cohorts, both the Marine/Navy cohort and the  
3       civilian worker cohort, was it a sufficient size for  
4       a cancer incidence study. Is it worthwhile to  
5       continue to use Camp Pendleton as a comparison  
6       group? What is the best approach to get information  
7       from the state cancer registries? They all have  
8       different requirements. Can we ask them for  
9       personal identifying information? If not, what are  
10      our other options? When should we start follow-up?  
11      And this becomes an issue with Camp Pendleton  
12      because if you include Camp Pendleton as a  
13      comparison group, well, those people may, may reside  
14      and get their cancer in different states than Camp  
15      Lejeune. And the state registries don't all start  
16      at the same time. There's a wide variability in  
17      when the cancer registry starts, so that's an issue.  
18      It could be a bias. So there's good things about  
19      having a comparison like Camp Pendleton but there's  
20      also negatives as well. So how to address those.

21           And then Ken Cantor in particular was bringing  
22      up an approach called the nested case control study  
23      as an interesting approach. We did discuss it,  
24      although I don't think we discussed it in the light  
25      that we needed to. I think we sort of petered out.

1 After two days it got tired but I'll bring up some  
2 issues about that in a minute.

3 Okay, so the first question was what about the  
4 Camp Lejeune Marine/Navy cohort that was used in the  
5 mortality study; is that large enough? And they all  
6 said yes. That's large enough. So that was easy  
7 for them to answer.

8 And so we moved on to the next question: What  
9 about the civilian workers? And they only said they  
10 wanted to see the results of the study. The study  
11 hadn't been out yet. And we couldn't really go into  
12 the results of the study until it was published by a  
13 journal. So they didn't know what you know now. So  
14 I don't know what they -- how they feel about it  
15 now. It is a small cohort. We could expand it by  
16 including the people I left out in the mortality  
17 study, those people who were in the database in  
18 1972. There are pluses and minuses to do that but  
19 that may be what we might do if -- you know, but we  
20 still need to explore that issue further.

21 Then the issue of Pendleton as a comparison  
22 group likely used for the mortality studies. And  
23 again, the issue here is, again, the cancer  
24 registries across the country started at different  
25 times. Some, like Connecticut, started in the 30s,

1 I think, something like that, whereas other cancer  
2 registries maybe not -- didn't start until '95 or  
3 even later. So you have this wide range. So if,  
4 say, all the -- a lot of Camp Lejeune people reside  
5 in, say, North Carolina, but a lot of Pendleton  
6 people reside in some other state, and they differ  
7 in when they started up, you could have a bias. You  
8 get more cancers maybe from North Carolina than from  
9 the other state or vice versa, so it's complicated.  
10 So what we -- we still thought that it was good to  
11 have a comparison population that's similar to  
12 Lejeune.

13 You can't compare Lejeune to the general  
14 population. We have a healthy veteran and a healthy  
15 worker effect. So they are supportive of continuing  
16 to use Pendleton as a comparison group, but then  
17 trying to figure out ways to minimize any biases.  
18 One way is to make sure that we get enough states  
19 that we have almost everybody in both -- we cover  
20 the states that cover most of the populations of  
21 both those cohorts, something like 90 percent. And  
22 to do that about 36 states would have to be  
23 recruited into the study plus the VA's cancer  
24 registry. So these are the kinds of things that  
25 we're discussing, and I think, you know, we came to

1           some agreement that that would be a target, to try  
2           to get about 36 states in the study. I'm jumping  
3           around here 'cause I'm trying to move quickly.

4           One other question was could we expand these  
5           cohorts? The Marine Corps is digitizing the muster  
6           rolls, but it's not going to be a computerized  
7           database. It's going to be something we have to  
8           search each person individually. And it's based on  
9           a lot of microfiche and other poor quality  
10          documents. And so they're not sure how good this  
11          database is going to be. I shouldn't call it a  
12          database, a searchable whatever you want to call it.  
13          I guess you could call it a database.

14          So there are issues about trying to expand the  
15          Marine cohort. And the group felt that we really  
16          don't need to. Okay, so this is something we can  
17          explore again. I want to see how good this database  
18          is, and it'll be ready either by the end of this  
19          year or early next year. So we'll look at it and  
20          see whether it makes any sense to use it at all.

21          So then comes to the key element of the  
22          meeting, how to get this information from the cancer  
23          registries, and in particular trying to get up to 36  
24          or more registries onboard. And every -- now, keep  
25          in mind every state has its own requirements for

1            confidentiality. They have their state laws that  
2            may prevent them from cooperating or at least  
3            providing personal identifying information along  
4            with their data. So we're going to have to deal  
5            with each state and each state's requirements, okay.

6            But the first option was to just send the  
7            information to all of the cancer registries and get  
8            back the cases that they have with the personal  
9            identifying information, with the Social Security  
10          Number, with the name, with the date of birth, and  
11          so on. Just give them the data and get it back  
12          after they've done the matching using those key  
13          variables I just mentioned. So that's the  
14          preferred -- that's what we really would like to do,  
15          and the panel really encouraged us to do that for as  
16          many states as possible, because that would also  
17          allow, maybe in the distant future, a follow-up,  
18          'cause you'd have all the information you'd need to  
19          redo the study if you wanted to do it 20 years or 30  
20          years from now or whatever. But also it gives you a  
21          lot of flexibility in your analysis. So that's the  
22          preferred method.

23          The least preferred method, but if your back's  
24          up against the wall and you can't get a cancer  
25          registry to cooperate unless you do it, is the

1           approach of the Gulf War where they sent -- you have  
2           all the information, the Social Security Number, the  
3           name, date of birth and so on, they send it to the  
4           cancer registries but what they -- and they also  
5           sent categorization of the person's exposure, in  
6           this case Gulf War, yes/no, also a categorization of  
7           the person's age and other information like that.  
8           And they asked -- and what they got back was that  
9           categorization, how many cases were male, white,  
10          cancer at age 46, 54, whatever. They had these  
11          kinds of categories so all they could do is a  
12          categorical analysis. They couldn't look at  
13          continuous variables at all. And it was complicated  
14          to even get that done, and they could only get 28  
15          states to even agree to that. They did have a time  
16          limit; they had two years they wanted to get this  
17          information, and that was a very tight timeline.

18                 So that's the least preferred approach. We all  
19                 agreed, the panel and we agreed that that was the  
20                 least -- but possibly necessary if we can't get a  
21                 cancer registry to cooperate in any other way.

22                 The third option was something in between, and  
23                 this is going to be a little complicated -- and  
24                 maybe I should wait 'til they stop applauding in the  
25                 next room. The third way is a little complicated;

1 I'm going to try to explain it. We have all our  
2 personal identifying information, sex, Social  
3 Security Number and so on, this is what we're going  
4 to send to the cancer registry. And then we have  
5 this other thing called a subject I.D. that's linked  
6 to this, and linked to that subject I.D. we have all  
7 their exposure information, any other information on  
8 risk factors like age, sex -- whatever, well, age is  
9 actually there, but any exposure information that  
10 linked to that I.D. We send all that information.  
11 We send subject I.D. and their personal identifying  
12 information to the cancer registry. The cancer  
13 registry does the matching, sends back to us the  
14 subject's I.D. and the cancer. But before they send  
15 that to us, we destroy the link between subject I.D.  
16 and the personal identifying information. So we no  
17 longer have the personal identifying information  
18 linked to the cancer case but we have this thing  
19 called a subject I.D. that's linked to their  
20 exposure information. This will allow us to do the  
21 same analyses as if we got the personal identifying  
22 information. We think it might satisfy some cancer  
23 registries that may be a little scared of giving  
24 this personal identifying information, because as  
25 long as they trust us to destroy the link, that's



1 sort of a middle ground. That's a little  
2 complicated but that's -- it's never been done  
3 before but the panel was interested in that  
4 approach, and they thought that that would be a  
5 useful approach, again, if you can't get personal  
6 identifying information, and a much better approach  
7 than the Gulf War study. So those are the options,  
8 okay.

9 Let's see, there's one other issue besides the  
10 nested case control. There were a couple of other  
11 issues that were raised but I think in the interest  
12 of time, I want to move on to that 'cause that was  
13 raised by Ken Cantor. The nested case control  
14 situation would be that you get the case -- you  
15 still have to get the cases of cancer but you could  
16 evaluate a smaller number, just the cases of cancer  
17 in a sample of the people who didn't have cancer,  
18 and do an analysis of that.

19 The advantage of that is that if you wanted to  
20 do a lot of work up on a smaller group, this is the  
21 best way to sample, okay. And then if you wanted to  
22 contact the people, to get smoking information for  
23 example, the problem is that cancer registries would  
24 then require us to get permission from the person's  
25 physician, so this would be a much more difficult

1           thing to do, and a lot of the panel were not crazy  
2           about that at all. I was thinking of, just  
3           recently, that it may be something to think about if  
4           we wanted to include those Marines and maybe people  
5           that were excluded from the mortality study. If we  
6           want to include some of those using the muster  
7           rolls, that may be an interesting way of sampling  
8           that group. But again, we don't know how good the  
9           muster rolls are. Until we see how that is, it  
10          really is premature to think about. So we'll put  
11          the nested case control approach aside for now. It  
12          may be useful if we want to expand the cohort but it  
13          depends on the muster rolls. And so I think I've  
14          covered -- do you have anything?

15               **MS. RUCKART:** Yeah. Well, I just wanted to  
16          clarify why we have to consider several approaches  
17          to working with the cancer registries. It's because  
18          we're talking about a data linkage study and we  
19          wouldn't have contact with the people so we wouldn't  
20          be able to have informed consent where they give  
21          permission to get their information. That's what we  
22          had in the health survey; that's why we didn't have  
23          to have this issue about could the cancer registry  
24          supply us with personal data, personal  
25          identifying -- so that's the real issue, that we

1 don't plan to have contact with these people so  
2 we're trying to figure out how can we work with the  
3 registries given that we're not going to have any  
4 signed consent forms.

5 **DR. BOVE:** One other point about that is that  
6 for the mortality studies there is a national  
7 database, the National Death Index. There's no such  
8 thing, as we have pointed out a couple of times, for  
9 cancer incidence or for any other incidence of  
10 disease. So that is why we have to go the route  
11 we're talking about, and the difficulty. It would  
12 be impossible to get consent from hundreds of  
13 thousands of people. That is just totally not  
14 feasible. So we have to do a data linkage type  
15 approach, and we have to get as many cancer  
16 registries as possible. And I think one other thing  
17 the panel did recommend that we prioritize which  
18 registries we start with. Those that had to cover a  
19 large percentage of either cohort and who might have  
20 an easier way of getting through the IRB and other  
21 requirements that have to be done. Then the next  
22 steps, Perri was going to go through those.

23 **MS. RUCKART:** Right. So where are we now? We  
24 prepared a summary of the meeting. We want to share  
25 that back with the panel, just to get their review

1 and concurrence, make sure we captured it correctly.  
2 As Frank was talking about some of the approaches,  
3 they suggested working with the registries that have  
4 the greatest amount of population, so we have  
5 scheduled some conference calls with some of the key  
6 registries that are going to begin next week to  
7 float by them these approaches, find out which ones  
8 they are most amenable to.

9 Then after we get this feedback we want to  
10 develop the protocol. We want to share that back  
11 with our expert panel to get their feedback on the  
12 protocol. Finalize that, the internal draft, submit  
13 that for our review processes. There's some  
14 internal review, external peer review and other  
15 agency approvals that we need before we can embark  
16 further on that. We need to develop a statement of  
17 work, and to do that we need to work with our  
18 procurements and grants office, and figure out the  
19 mechanism of how we would get this work done,  
20 contract, grant, et cetera. And these are some of  
21 the issues that is more under ATSDR's control in  
22 terms of how that would function and how quickly we  
23 can get that done.

24 Then there's some additional steps after we get  
25 to the point of being able to move forward which is

1           gaining access to the registries' data. We've  
2           talked about the difficulties there. Let's say we  
3           do all of that. Then we would receive a final  
4           aggregated data set from all of the registries. We  
5           would then begin the process of cleaning and editing  
6           the data which leads to analyzing the data, drafting  
7           the final report, and then getting all the necessary  
8           peer review and approval for that report. And those  
9           are some of the activities that are not really as  
10          much under ATSDR's control in terms of a timeline  
11          and when these things can happen.

12                 And Frank briefly touched on this. There is  
13          one other study, the panel -- the panel included a  
14          person who conducted this study. And she worked  
15          with 24 state cancer registries, and she did get the  
16          PII, personal identifying, information. That study  
17          was initiated in January 2003 and completed in  
18          December 2008. Keeping in mind we plan to work with  
19          about 36 registries, so that could take additional  
20          time, based on what she found. So basically we're  
21          saying this is not some quick effort. We just  
22          wanted to share this with you so everything --  
23          everyone was on the same page and there were no  
24          unrealistic expectations.

25                 **DR. BOVE:** And the panel sort of reached a

1 consensus that it would take at least four years to  
2 get all the data from the cancer registries; it's  
3 that difficult. And it's based on this study,  
4 'cause it's the only one that's out there, that  
5 looked at how difficult it was. And so some thought  
6 four was even too short, and they thought maybe  
7 five. But I think most people thought it was  
8 possible to do -- to get the data in four years. So  
9 we're talking a long period of time in order to do  
10 this study, because there's no national cancer  
11 registry.

12 **MR. ENSMINGER:** With all this being said I have  
13 a few questions here. And one of them is has there  
14 been any discussions with the Department of the Navy  
15 and Marine Corps about the funding of it? And if  
16 not, why not?

17 **DR. IKEDA:** So you have annual plan of work  
18 every year with the Navy, and there was discussion  
19 about having this meeting. They were present so  
20 they're aware that we want to move forward in this  
21 direction.

22 **MR. ENSMINGER:** Well, I mean, have they said  
23 anything back about funding it?

24 **DR. IKEDA:** We have not heard back  
25 specifically.

1           **MR. PARTAIN:** Well, I imagine that you won't  
2 hear back until at least the -- if you go by past  
3 behavior, there's going to need to be a letter on  
4 behalf of the Agency to the Navy requesting funding.

5           **DR. IKEDA:** Okay, and we still need to do more  
6 work, as you heard. This is early in the process,  
7 we need to develop the protocol. You know, we need  
8 more specifics before we can put a price tag on it  
9 and go back with a request.

10          **MR. ENSMINGER:** Going back to the data analysis  
11 and the reporting of the data, I voiced my concerns  
12 about attempting to contract out this entire  
13 project, and the analysis of data and the reporting  
14 are inherent governmental functions. They are not  
15 to be part of any contract where there might be a  
16 bias involved. So with that being said, have you  
17 come up with a decision on how you're going to  
18 execute the study?

19          **DR. IKEDA:** So the contract is just one option  
20 and there are other options that we've been  
21 considering, but again, I think we need more detail  
22 about what it is we're going to do. We need to  
23 determine what expertise is needed, and then we'll  
24 figure out the most appropriate way and mechanism to  
25 move forward.

1           **MR. ENSMINGER:** Well, how long before we start  
2 seeing some contracting, you know, going out for  
3 bids and stuff on it?

4           **DR. IKEDA:** So is it you want to talk about --  
5 you talked a little bit about what the next steps  
6 are. I don't have specific timelines for the next  
7 steps that you mentioned, but again, those are the  
8 first actions that need to happen before we --

9           **MR. ENSMINGER:** Are we having a second expert  
10 panel meeting or are you going to do this by phone  
11 or what?

12           **MS. RUCKART:** Well, that hasn't been fully  
13 determined yet. We definitely want to see feedback  
14 from the panel on our protocol, and we could  
15 possibly do that by phone and receive email  
16 comments, so we're not sure if we'll bring them in  
17 in-person or not, it just depends. But we  
18 definitely want to seek their feedback on our draft  
19 protocol and incorporate any comments that we get.  
20 We plan to begin drafting the protocol pretty  
21 quickly here after we get concurrence on the summary  
22 notes that we want to provide them with, and after  
23 we start having the conference calls with the  
24 registries, which will start next week, and we plan  
25 to do that by the end of this year on the draft;



1           that's our plan.

2           You look like you still have questions. And  
3           then after that once we have our protocol in place  
4           and we get some necessary agency approvals, which,  
5           you know, is --

6           **MR. ENSMINGER:** Takes forever.

7           **MS. RUCKART:** -- internal and external peer  
8           review, then we begin to develop the statement of  
9           work, and just developing the statement of work, in  
10          and of itself, isn't a lengthy process but we have  
11          to work with PGO in terms of funding, and if it is a  
12          contract going out for bids and that can take some  
13          time and there's a lot of reviews that come back on  
14          the contract proposals, and they get, you know,  
15          thoroughly reviewed, and I'll just say this is  
16          probably going to be expensive so it's going to have  
17          a lot of scrutiny; we're not just going to award it  
18          lightly, and so those things take some time.

19          **MR. ENSMINGER:** Let's go to lunch.

20          **MR. BRUBAKER:** Hearing no other questions we'll  
21          break for lunch. We'll return at 1:15 and the  
22          agenda will shift slightly. We'll have the VA  
23          update directly at 1:15 and everything else we'll  
24          need to move back. See you in 45 minutes.

25                 (Lunch recess, 12:32 till 1:23 p.m.)

**VA UPDATES**

**MR. BRUBAKER:** By moving the VA update to this section, I believe we have Dr. Walters on the phone with us who will lead us off.

**DR. WALTERS:** Hi, this is Dr. Walters. Sorry I couldn't be there in person but I'm going to be ^ right now. So I have excellent news, that the veterans regulation and the family member regulations have been approved by OMB. The veterans regulation was published yesterday. And actually we've been providing care to veterans since the day the law was signed. This regulation provides important definitions such as constitute Camp Lejeune.

The family member regulation will be operational on October 15<sup>th</sup>. What this means is that family members will be able to apply online or they'll be able to fill out a patient form and send it to us, and we will start accepting claims. We will be providing claims reimbursement for out-of-pocket costs for these 15 conditions for medical care retroactive to March 2013.

So how this is going to work is family members will send in an application that will document that

1           they were family members, that they lived on Camp  
2           Lejeune for at least 30 days or more between 1957  
3           and '87. They'll also have -- take a form to their  
4           physician who will document whether they have one of  
5           these 15 conditions. Once they've been accepted  
6           into the program, they'll be given identification  
7           cards and a full set of instructions. So when the  
8           family member has received care or treatment for one  
9           of these 15 conditions, they will submit or their  
10          doctor will submit the bills to their regular  
11          insurance, and any out-of-pocket costs will be  
12          reimbursed by VA.

13                 I think this process will initially be not  
14                 especially quick because we're going to be learning  
15                 how to do this, 'cause this is new business for the  
16                 VA. And we'll have, I expect, many, many years of  
17                 back, back claims to deal with. But as the -- after  
18                 the initial surge as we get to a steady state, I  
19                 think it will be probably a pretty expeditious  
20                 process.

21                 The rule that was published by OMB is called an  
22                 interim file. What this means is that the public  
23                 can still comment on the rule, and after a period of  
24                 six months, I believe, the rule will become final  
25                 and it will be amended by the comments, the

1 successive comments that we get. The reason VA went  
2 to an interim final rule is it's much more  
3 expeditious than a final rule, which would have  
4 taken another year to two years or so. So with  
5 that, I think it's important to understand that this  
6 is about medical care, and that claims are totally  
7 independent of this process. What are your  
8 questions?

9 **DR. CLAPP:** Dr. Walters, this is Richard Clapp.  
10 I have a question not about this but about the  
11 training that is provided to VA healthcare providers  
12 and in particular the training PowerPoint that you  
13 presented last May, I believe it was. Have you  
14 amended that? Because it's got lots of errors in it  
15 and I wondered if you'd -- I understand you've had a  
16 conversation with ATSDR, and you may have made some  
17 corrections. I'd like to know what those were.

18 **DR. WALTERS:** Well, first of all, I disagree  
19 with your characterization of those as inaccuracies.  
20 PowerPoints are always, by their nature, not  
21 complete. I have amended those past ones, there's  
22 the new ATSDR ^ and this -- I mean, it's an internal  
23 matter actually. And I've discussed it at length,  
24 as you all know, and I'm really not prepared to  
25 comment on it anymore.

1           **MR. ENSMINGER:** Really.

2           **DR. CLAPP:** Let me just say one factual error  
3 was that you were referring to a retrospective  
4 cohort study of male breast cancer. There is no  
5 such study, and I think, as you must know, it's a  
6 case control study, so at least on that level, it  
7 needs to be corrected.

8           **DR. WALTERS:** Okay. Point taken, but it is the  
9 original study on male breast cancer going on. And  
10 again, that's not germane to applying the law, as  
11 what I've been charged to do.

12           **MR. ENSMINGER:** Well, you also listed TCE as a  
13 possible carcinogen. TCE was reclassified in  
14 September of 2011 as a known human carcinogen.

15           **DR. WALTERS:** And it is -- that is, as I said,  
16 not everything in that PowerPoint is 100 percent  
17 published everything because PowerPoints don't --  
18 and a lot of this has been taken out of ^. I'm not  
19 going to answer any more questions on that  
20 PowerPoint. Just about the law.

21           **MR. ENSMINGER:** Well, you use this PowerPoint  
22 to train the clinicians that are going to be  
23 screening these people coming to the VA, and when  
24 you present them with incorrect information it's  
25 going to affect the screening process.

1           **DR. WALTERS:** No, it has nothing to do with the  
2 screening process. We're not screening veterans  
3 coming to the VA. If you were at Camp Lejeune 30  
4 days between 1957 and 1987, you are eligible for  
5 care.

6           **MR. ENSMINGER:** So I take it that's why you're  
7 not here at the meeting.

8           **DR. WALTERS:** No, because I have three jobs  
9 right now.

10          **MR. ENSMINGER:** Oh, okay.

11          **MR. SAMPSEL:** Dr. Walters, hey, this is Jim  
12 Sampsel; I'm here. I will explain to the people  
13 here the difference between what you're doing and  
14 what the C&P examiners do.

15          **DR. WALTERS:** Thank you, Jim.

16          **MR. SAMPSEL:** I'm going to give a little  
17 presentation.

18          **DR. WALTERS:** And as I said to Senator Burr,  
19 there were no C&P examiners taught.

20          **MR. ENSMINGER:** Well, what about this IOM study  
21 you got going?

22          **DR. WALTERS:** Okay. So the -- the law has  
23 eight cancers, scleroderma, miscarriage,  
24 infertility, and it has a couple of conditions which  
25 are not full medical diagnoses. One of them is

1           neural behavioral effects and another is kidney  
2           toxicity. These are not ICD-9 diagnoses, so because  
3           the IOM characters came up with these words, I have  
4           asked them to provide further definitions of what  
5           they exactly mean.

6           **MR. ENSMINGER:** Okay. Why the IOM?

7           **DR. WALTERS:** Because they came up with the  
8           words to begin with.

9           **MR. ENSMINGER:** They became what?

10          **DR. WALTERS:** They defined the words to begin  
11          with in a 2009 report.

12          **MR. SAMPSEL:** That was actually the National  
13          Research Council but the IOM is very similar to  
14          that. They both come from the National Academy of  
15          Sciences.

16          **DR. WALTERS:** Yes. And I went with the IOM  
17          because IOM does medical issues and the National  
18          Research Council does research issues. I thought  
19          that the IOM was a better qualified to provide  
20          clinical definition of these terms.

21          **MR. ENSMINGER:** Why not use the National  
22          Institutes of Health?

23          **DR. WALTERS:** The National Institute of Health  
24          doesn't do this kind of review.

25          **MR. ENSMINGER:** Oh, really?

1                   **DR. WALTERS:** Yeah.

2                   **MR. PARTAIN:** Dr. Walters, is the IOM subject  
3 to public review? Can we request their documents?  
4 Is their peer review process open to the public?

5                   **MR. SAMPSEL:** Absolutely.

6                   **DR. WALTERS:** I'm not sure that the peer review  
7 is open to the public. You can contact them. I  
8 went with the IOM because they're completely  
9 independent of the government. And they usually do  
10 this kind of thing for, say like the Agent Orange  
11 reviews, Gulf War reviews. So VA uses the IOM on a  
12 routine basis to provide an independent scientific  
13 aeration.

14                   **MR. ENSMINGER:** Well, their peer review process  
15 is clandestine. They do not release their peer  
16 review comments at all. And, you know, I don't see  
17 that as being an objective entity. I don't know how  
18 anybody can even look at them as being a valid  
19 scientific entity.

20                   **DR. WALTERS:** Well, that's something you can  
21 bring up with the IOM.

22                   **MR. ENSMINGER:** And they don't come under the  
23 Freedom of Information Act, so you can't request  
24 information from them on a legal basis. They just  
25 tell you no, we're not giving it to you, and there's



1 nothing you can do.

2 **DR. WALTERS:** Mr. Ensminger, as you well know,  
3 Senator Burr has requested everything that I sent to  
4 the IOM and was sent to Senator Burr, including the  
5 contract and any ^ was sent to the IOM, and I'm sure  
6 you'll be getting a copy.

7 **MR. ENSMINGER:** Yeah, I mean, you want to talk  
8 about objectivity in using the IOM, but then you go  
9 into the Department of Defense's pediatric  
10 neurologist for information concerning neurological  
11 effects on children --

12 **DR. WALTERS:** Yeah, this is a specialist. I  
13 don't have, you know, pediatric specialists in the  
14 VA.

15 **MR. ENSMINGER:** Well, but you're going to the  
16 perpetrator of this for advice. I mean, is that, is  
17 that --

18 **DR. WALTERS:** I am sure that the pediatric ^ is  
19 not the perpetrator. They are independent  
20 scientists.

21 **MR. ENSMINGER:** Yeah, they work for the  
22 perpetrator. Their paycheck comes from DOD.

23 **DR. WALTERS:** I think you have the conspiracy  
24 theorists on the mind.

25 **MR. ENSMINGER:** No, I don't. I mean, I've seen

1           what happens. What has happened and what has  
2           conspired in this situation for 17 years.

3           **DR. WALTERS:** Well, the same thing, I'm not  
4           prepared to address that. I'm assigned to apply the  
5           law as fairly and quickly as possible.

6           **MR. PARTAIN:** And Dr. Walters, one other  
7           question concerning IOM. We have an agency by this  
8           government called the ATSDR that is designed to  
9           determine toxic effects of chemicals and health --  
10          assess health effects and everything. Why have they  
11          not been consulted?

12          **DR. WALTERS:** Because I don't believe they have  
13          the medical expertise to provide a clinical  
14          definition of neural behavioral effect or kidney  
15          toxicity. And they did not initiate the term.

16          **MR. PARTAIN:** And --

17          **DR. WALTERS:** IOM did.

18          **MR. PARTAIN:** By what authority do you have to  
19          make these decisions? You're the one -- it seems  
20          like you're the one here that's making decisions  
21          who's relevant and who's not. By whose authority do  
22          you have to make these decisions and are your  
23          decisions being reviewed by your supervisors?

24          **DR. WALTERS:** I have no authority to make these  
25          decisions. These decisions were made by the

1 Undersecretary of Health, Dr. Petzel, and they were  
2 seconded by the Secretary of the VA.

3 **MR. ENSMINGER:** And they're both gone now,  
4 right?

5 **DR. WALTERS:** That would be true. But again,  
6 this is not germane to applying the law.

7 **MR. PARTAIN:** Well, it affects the law because  
8 this information is being used to determine when  
9 veterans go for a benefits --

10 **DR. WALTERS:** No, it is not. There, you are  
11 wrong. This is only for healthcare, and I repeat,  
12 veterans who were at Camp Lejeune for 30 days or  
13 more are eligible for healthcare, whether or not  
14 they have these conditions.

15 **MR. PARTAIN:** Then why are we seeing in these  
16 denial letters some of the veterans coming back out  
17 of Louisville references to the NRC report and  
18 actually sometimes they can't even get that right,  
19 but continual references to the NRC report?

20 **DR. WALTERS:** I have nothing to do with what  
21 program I run. I am applying the law, and it has  
22 nothing to do with benefits.

23 **MR. PARTAIN:** So none of your training material  
24 has reached Louisville or anybody in Louisville  
25 that's making these decisions?

1           **DR. WALTERS:** I do not believe so, no. The VBA  
2 is a totally separate arm than the VHA, which is who  
3 I work for.

4           **MR. ENSMINGER:** Well, why was Brad Flohr at  
5 your training sessions?

6           **DR. WALTERS:** Because Brad Flohr is our -- is  
7 the liaison between the VBA and VHA.

8           **MR. ENSMINGER:** Yeah?

9           **DR. WALTERS:** That's his job.

10          **MR. ENSMINGER:** So there's a cross-over there.

11          **DR. WALTERS:** Yeah, but he's not a clinician.  
12 He's not making any clinical decisions.

13          **MR. ENSMINGER:** Well, I asked you before have  
14 you updated this training PowerPoint?

15          **DR. WALTERS:** Yes, I have, and Senator Burr has  
16 a copy.

17          **MR. ENSMINGER:** Okay.

18          **MR. TEMPLETON:** Dr. Walters, I'd like to point  
19 out -- I'm on the CAP now; my name is Tim Templeton.  
20 I was denied care and I've been there for 30 days;  
21 I'm not the only one.

22          **DR. WALTERS:** Okay. Now, if you've been denied  
23 care, that is my problem, and I would like you to  
24 send me your contact information and I will forward  
25 that to the health benefits center and make sure

1           that you are eligible for care.

2           **MR. TEMPLETON:** Will do. Thank you very much.

3           **DR. WALTERS:** Now, --

4           **MS. FRESHWATER:** Excuse me, I'm sorry. This  
5           is --

6           **DR. WALTERS:** I need to make one point before  
7           the next person because I'm going to have to go to  
8           another meeting at 1:45 and it's close.

9           **MS. FRESHWATER:** But this is a follow-up very  
10          quickly to the last question. Aside from Tim, can  
11          we also forward you other names of people --

12          **DR. WALTERS:** Absolutely.

13          **MS. FRESHWATER:** -- who are very sick.

14          **DR. WALTERS:** And I want those names.

15          **MS. FRESHWATER:** Okay, thank you.

16          **DR. WALTERS:** There is a gentleman who has  
17          contacted me; he lives here in DC, has scleroderma,  
18          which is one of these conditions on the list. He  
19          was at Camp Lejeune for six to seven months in the  
20          early 80s. Unfortunately he was on active duty for  
21          training as a reservist, and equally unfortunately,  
22          because he was on active duty for training as a  
23          reservist, he is not considered a veteran according  
24          to the current laws. And I think this is unfair,  
25          and I think it needs legislative change because I

1 don't think there's any way that I can make an  
2 exception or the Secretary can make an exception.  
3 And unfortunately because of the Feres Doctrine he  
4 cannot sue the government. He's not eligible, like  
5 Department of Defense workers, to go through the  
6 Department of Labor. So he's turned out in the  
7 cold. I cannot provide him -- the VA cannot provide  
8 him care. And so if any of you can advocate for  
9 this gentleman, and his cast of people, reservists  
10 who were at Camp Lejeune on active duty training,  
11 that would really help.

12 **MR. ENSMINGER:** That would require an amendment  
13 to Title 36, correct?

14 **DR. WALTERS:** I'm not sure what the title is.  
15 I could send you the -- I've got a list of the laws.  
16 But this is a real problem that I have -- we have  
17 not been able to work our way through. And this  
18 particular gentleman has got really bad scleroderma  
19 and I'm kind of frustrated that I cannot help him.

20 **MR. ENSMINGER:** We'll check into that.

21 **DR. WALTERS:** Okay. I'm sorry, I have to go to  
22 another meeting so if there's one more question.

23 **MR. ORRIS:** Dr. Walters, I have one more  
24 question. This is Chris Orris on the CAP. Will you  
25 be matching the TCE assessment for EPA for illnesses

1 in covering those illnesses that EPA recognizes are  
2 illnesses on their 2014 EPA assessment for  
3 trichloroethylene?

4 **DR. WALTERS:** We are bound by the 15 conditions  
5 in the law. And again, you've got to separate the  
6 healthcare law versus the VBA claims. If there is  
7 an amendment to the law that adds conditions, sure,  
8 but right now we have to follow the conditions of  
9 the law.

10 **MR. TEMPLETON:** If you don't mind, I would like  
11 to just follow up real quick with that because it  
12 seems like that that almost seems like an unfair  
13 process because now you're taking -- normally a  
14 veteran would come your way and they wouldn't  
15 necessarily be restricted by the 15 conditions.  
16 You'd be looking at a little wider. Instead you're  
17 only looking at 15, and if they don't fall within  
18 that 15, then --

19 **DR. WALTERS:** Yeah, but, and see, that's the  
20 issue, any veteran, even if they don't have any  
21 physical problems, if they were at Camp Lejeune for  
22 30 days or more in that time period, they get the  
23 full VA benefit, healthcare benefit. So they don't  
24 have to be sick; they get healthcare.

25 **MR. ORRIS:** But civilian workers do not,

1 correct?

2 **DR. WALTERS:** No, because we don't provide  
3 civilian workers -- that's not our mandate. So if  
4 you have a veteran who was at Camp Lejeune for 30  
5 days or more in 1980, and they have diabetes, and  
6 they make a million dollars so they're not  
7 eligible -- you know, they make too much for VA  
8 care, they are still eligible to enroll in the VA  
9 under this law and receive full medical care. Sure,  
10 they will pay a copayment for conditions that are  
11 not related to the 15, but they still receive full  
12 healthcare.

13 **MR. ORRIS:** Okay. Thank you very much.

14 **DR. WALTERS:** Okey-doke, bye-bye.

15 **MR. BRUBAKER:** Thank you. Moving on to the  
16 second part of the VA presentation. We'll turn it  
17 over to James and Robert.

18 **MR. SAMPSEL:** You know, there are a couple  
19 issues that Terry Walters raised that maybe I can  
20 comment on. Number 1 is the Institute of Medicine  
21 of National Academy of Sciences, I've worked with  
22 them several times on several different studies and  
23 probably would be beneficial for you to know what  
24 their procedure is, and the reason they're  
25 considered to be independent. And that's because



1           when they form a committee, it's not the Institute  
2           of Medicine staff that does the reviews. They bring  
3           in people from universities, outside organizations,  
4           and they develop a panel, a committee of people who  
5           are not part of the VA, not part of any particular  
6           point of view. They're the ones that come up with  
7           the decisions, not some government agency. So I  
8           just wanted to bring that up. And that's why  
9           Congress created the IOM, to be an independent  
10          scientific organization --

11                 **MR. ENSMINGER:** Abe Lincoln created it.

12                 **MR. SAMPSEL:** Well, whatever, somebody did. So  
13           I personally believe they're relatively independent  
14           to these things as they can be.

15                 **MR. ENSMINGER:** Whoa, whoa, whoa, whoa, whoa.  
16           Let me give you a little history on the national  
17           academies, okay? The national academies took a  
18           charge from the Department of the Navy back in 2007  
19           to execute a literature review and write a report on  
20           Camp Lejeune.

21                 **MR. SAMPSEL:** I'm going to address that.

22                 **MR. ENSMINGER:** Okay. They did their report.  
23           They assigned a peer review coordinator, Dr. George  
24           Rush, who was responsible for sending out the peer  
25           review to peer reviewers of that report, collect all

1 the peer reviewers' comments, and then he made the  
2 decision on which peer review comments got addressed  
3 in the final report.

4 Dr. George Rush, at that time, was an employee  
5 of Honeywell Limited, who was running a close second  
6 with the Department -- the United States Department  
7 of Defense for the most Superfund sites relating to  
8 TCE in the United States. That is objective?

9 Now, wait a minute, wait a minute. And now the  
10 National Academy refuses to release their peer  
11 reviewers' comments where the federal government  
12 requires peer review comments to be released. How  
13 the heck do you know whether a peer review's being  
14 done or if there are reports at all?

15 **MR. SAMPSEL:** Well, I suspect there's some kind  
16 of confidentiality involved because maybe the --

17 **MR. ENSMINGER:** Well --

18 **MR. SAMPSEL:** -- peer review --

19 **MR. ENSMINGER:** Confidentiality has no place in  
20 science, okay? Number one. Either it's legitimate  
21 and their comments are legitimate or their comments  
22 are out of line. And I know for a fact, because I  
23 know a person that was tagged to do a peer review of  
24 that report and not one of their comments were  
25 addressed in the final report.

1           **MR. PARTAIN:** And I just want to jump in real  
2 quick 'cause I've got to leave, and Dr. Clapp and I  
3 both have to leave, and this is the part -- I really  
4 wanted to be here for this.

5           But to address the objectivity of the panel  
6 members, yes, these are scientific people who are  
7 from universities, but they are not subject to the  
8 conflict of interest requirements of, say, IARC.  
9 Jerry and I, and this was documented in *Semper Fi*,  
10 walked into one of the National Academy review  
11 committees that you're talking about that was being  
12 done on perc, and it's laughable.

13           And I went through and was doing my own  
14 independent research on the different scientific  
15 members, and you know what? A lot of them had  
16 undisclosed conflict of interest, receiving funding  
17 from the industry. And one lady found me, she  
18 looked like a mad woman from Canada, was getting  
19 funding from an industrial supported group. And she  
20 was totally disrupting the meeting and preventing  
21 any type of meaningful progress. These are  
22 consensus meetings, and the whole process is flawed  
23 and it has to do with the peer review and it also  
24 has to do with the conflict of interest because  
25 these people are not being fully vetted or disclosed

1 in who they represent or where they're getting their  
2 money from and what possible problems they may have  
3 in their objectivity. And I'm sorry I'm not going  
4 to be here for your response but I just want to  
5 point that out before you go further.

6 **MR. SAMPSEL:** I'm sorry you won't be 'cause I  
7 wanted to talk about the VA in general.

8 **MR. ENSMINGER:** Well, the VA paid \$681,000 for  
9 this short report by the IOM on Camp Lejeune? Okay,  
10 let's --

11 **MR. SAMPSEL:** Actually --

12 **MR. ENSMINGER:** Wait a minute. Let's look  
13 at --

14 **MR. SAMPSEL:** -- I didn't want to dwell on the  
15 IOM. I just wanted to bring that up --

16 **MR. ENSMINGER:** Well, I'm talking about the  
17 National Academy. You guys want to keep talking  
18 about -- you keep going to the National Academies  
19 and so do other people who have a vested interest in  
20 getting a report that says what they want it to say.  
21 And it all depends on how you write the charge to  
22 these people on how you -- and the fact that you  
23 don't get to see the peer review comments. I know  
24 for a fact that several reports that were written by  
25 committees, put together by the National Academies,

1           their final report in draft went against the charge  
2           that was given for that committee. And the National  
3           Academy took the peer reviewers' comments and  
4           rewrote their own committee reports.

5           **MR. SAMPSEL:** Well, what you're saying may be  
6           true; I really don't know about that.

7           **MR. ENSMINGER:** Well, I do.

8           **MR. SAMPSEL:** But I don't know where you're  
9           going to find the perfectly unbiased group that  
10          you'd like to find. I don't know where that would  
11          be.

12          **MR. ENSMINGER:** Within government.

13          **MR. SAMPSEL:** I don't know about that.

14          **MR. ENSMINGER:** Because there's transparency  
15          laws in place. Any peer review that's done on any  
16          governmental work, it has to be released, the peer  
17          review comments.

18          **MR. SAMPSEL:** All right, well at any rate,  
19          okay, I didn't want to dwell on the IOM. I just  
20          wanted to comment on that. I think they're  
21          relatively neutral. And I know some people don't  
22          think that.

23          **MR. ENSMINGER:** They're scientific hired guns.

24          **MR. SAMPSEL:** The other thing, I did want to  
25          comment on the National Research Council report.

1 And you know, if I've got a few minutes here.

2 **MR. BRUBAKER:** I do want to draw attention to  
3 the agenda. We have probably ten to 15 minutes to  
4 complete the remainder of your --

5 **MR. SAMPSEL:** Okay. I want to give you a  
6 little historic -- you got concerns about denial  
7 rates and you got concerns about the difference  
8 between the compensation process and the healthcare  
9 treatment process. So I wanted to just kind of lay  
10 out some of the stuff so it would be easier to  
11 understand. I think Terry Walters was in a hurry;  
12 she didn't have the chance to explain it all.

13 So okay, I just want to say that the VA is not  
14 a monolithic organization; there are different  
15 sections to it. We work for the Veterans' Benefits  
16 Administration, and we provide compensation payments  
17 for the disabilities that are related to some  
18 veterans' period of service. That's different from  
19 healthcare. There's a huge number of medical  
20 centers that treat people. They treat veterans for  
21 various things based on their service connection,  
22 based on their income. There's a whole criteria for  
23 treating veterans, but that's what they do.

24 Now, Terry Walters is part of the Public Health  
25 Office. She is charged with implementing Senator

1 Burr's statute, that you had a large part in  
2 producing. She is not involved with the  
3 Compensation of Pension Examinations. That's a  
4 different section of the Veteran Health  
5 Administration. That is run by Dr. Cross and this  
6 Dr. Koopmeiners; it used to be Dr. Cassano. They  
7 are the ones that are charged with evaluating our  
8 people who claim disability and the VBA, if they  
9 meet the criteria and the criteria for service  
10 connection is: There has to be a current  
11 disability; there has to be an event in service, and  
12 in this case there was an event in service and that  
13 would be exposure to the toxic chemicals in that  
14 water; and there has to be a medical nexus, what we  
15 call a medical nexus, that connects the current  
16 disability to the service period. That's what these  
17 CP examiners do, compensation and pension. They,  
18 when VBA, when a comp service or a regional office  
19 gets a claim, if they need to serve a criteria, if  
20 they have the current disability and they were at  
21 Camp Lejeune, they're going to get an examination.  
22 That's where Dr. Koopmeiners comes in.

23 And to give you a little quick historical  
24 background, I've been involved with this Camp  
25 Lejeune issue for many years. In fact I wrote the

1 training letter for the adjudicators that are now  
2 consolidated in the Louisville office, where Bob  
3 Clay works. He can comment on them in a minute.  
4 And that was back in 2011 or 2010. And at that time  
5 we had the National Research Council's statement.  
6 And we wrote it up and, you know, I was basically  
7 charged with figuring out what to do, and the  
8 original C&P examination process was, I accumulated  
9 all the -- well, not all but to a great extent, EPA,  
10 ATSDR, American Chemical Association data on health  
11 effects from these chemicals, TCE, PCE, and then  
12 benzene was added.

13 And I put those into a website that was sent to  
14 examiners around the country. And so if somebody  
15 was in California, they got an examine in  
16 California, and the examiner was not necessarily  
17 trained in environmental medicine. And they did the  
18 exams. And they were supposed to take a look at the  
19 websites, the effects of these chemicals, and then  
20 take a look at the claimant, the veteran claimant,  
21 and then come up with an opinion. So we were  
22 getting inconsistency around the country. So that's  
23 when Dr. Cassano and then subsequently Dr.  
24 Koopmeiners determined that they should have expert,  
25 so-called expert medical examiners who were trained



1           in environmental medicine. And they had several  
2           meetings in locations where they trained these  
3           people, and they used, I might say that, the fact  
4           that the National Research Council came up with  
5           these 15 disabilities, this process occurred before  
6           Senator Burr passed the statute. He took the 15  
7           from the National Research Council and put that in  
8           his statute. That is in law right now. That's why  
9           it's not possible to add to that right now unless  
10          Senator Burr changes the law as written.

11                 Same thing with the inactive duty for training  
12          -- active duty for training, inactive duty for  
13          training. In DOD law and VA law, they're not  
14          treated the same. They're not treated as veterans.  
15          And I don't think you would necessarily have to  
16          change those statutes but you could have Senator  
17          Burr put into that law that they are -- they fall  
18          under that law. You can have him do that. You can  
19          have him add disabilities, diseases -- particular  
20          diseases. That would be the best way to do it. So  
21          I just want to comment on that. So now what we have  
22          is all the claims -- the claims go to Louisville,  
23          and there's an electronic system where they -- first  
24          of all, they determine -- you know, you were  
25          wondering about denial rates, okay? Denial rates

1 are a problem, of course, for people. You have to  
2 have some -- when those examiners take a look at the  
3 evidence, they look at how long was this person in  
4 Camp Lejeune. Were they there for three years? Did  
5 they go there to get separated from the service and  
6 they were only there for a couple days? Where did  
7 they live? Did they live on base? Did they live  
8 off base? What was their MOS? What were they  
9 doing? Those are things that they're supposed to be  
10 looking at.

11 And then they look at other risk factors,  
12 whatever they might be, the person's weight, the  
13 person's age, I don't know exactly. But they have a  
14 formula for doing this. And they are the ones that  
15 determine medical -- and by the way they're supposed  
16 to -- their criteria is supposed to be at least as  
17 likely as not, which is a neutral standard. It's  
18 50/50. If there's a 50/50 chance, then they'll  
19 grant it. They'll say yes, I think it's a 50/50  
20 chance.

21 So we in the VBA, we take what they write and  
22 we then determine whether service connection is  
23 granted. So it's Dr. Koopmeiners' group. And if  
24 you have additional evidence for him, I will make  
25 sure he gets it. And I will make sure Dr. Cross,

1           who runs that section, gets this.

2           **MR. ENSMINGER:** Now, the law for healthcare  
3 requires the threshold for healthcare --

4           **MR. SAMPSEL:** Senator Burr, you're talking  
5 about, right? Senator Burr's public law?

6           **MR. ENSMINGER:** It's not Senator Burr's; it's  
7 the United States Government's.

8           **MR. SAMPSEL:** Yeah, he initiated, but yes.

9           **MR. ENSMINGER:** The threshold is 30 days or  
10 more.

11          **MR. SAMPSEL:** That's what they came up with,  
12 right.

13          **MR. ENSMINGER:** I mean, so now for VBA, for  
14 service connected disability benefits you're raising  
15 the bar?

16          **MR. SAMPSEL:** No, no, I'm not.

17          **MR. ENSMINGER:** Well, you said because -- no,  
18 they're taken into consideration; they're re-  
19 measuring how long the person was there. If they  
20 were there for 30 days or more, they qualified for  
21 healthcare. Right?

22          **MR. SAMPSEL:** Right. Yeah, and it's important  
23 to note that the healthcare law is not the benefits  
24 law; it's two different things.

25          **MR. ENSMINGER:** Well, I know that. I know.

1 But we already have this hurdle, this threshold for  
2 30 days.

3 **MR. SAMPSEL:** That's for treatment.

4 **MR. ENSMINGER:** That's right, that's right. So  
5 now, what magic finger are you guys using in your,  
6 in your formula to figure out, well, yeah, this guy  
7 was there for six months, no, denied?

8 **MR. SAMPSEL:** Well, that's up to the expert --  
9 you know, I mean, you can dispute their expertise,  
10 but they're medical doctors trained in environmental  
11 medicine. If they see that someone was there for  
12 like two weeks or whatever or 30 days or whatever,  
13 it's up to them to determine whether there are other  
14 risk factors in their mind that have contributed to  
15 this disease.

16 **MR. ENSMINGER:** Then how do you explain the  
17 disparity between female breast cancer claims and  
18 male breast cancer claims? There is a 52 percent  
19 disparity in approval.

20 **MR. SAMPSEL:** And I am aware of that. You  
21 know, I, I --

22 **MR. ENSMINGER:** How, how do you explain that?

23 **MR. SAMPSEL:** I can't explain that. I'm not a  
24 scientist or a medical doctor. Although I was a  
25 medic in the Army, but I'm just not a medical

1 doctor.

2 **MR. ENSMINGER:** Well, I mean, have you gone  
3 back and asked these people? Hey, I mean --

4 **MR. SAMPSEL:** Well, as a matter of fact I had a  
5 one case I dealt with, I can't go into, that I did  
6 change their opinion. But I'm well aware that  
7 there's opinions involved and I will be very happy  
8 to bring this up to Dr. Cross, if -- you know, if we  
9 have additional data that they should be  
10 considering.

11 **MS. FRESHWATER:** Just, just to let you know, we  
12 brought this up with Brad Flohr as well at the last  
13 meeting, the breast cancer disparity. So I know  
14 he's not here but again, this is stuff you would  
15 hope we would hear back something on, because it's a  
16 really big issue. And Chris, I know you've been  
17 waiting to say something.

18 **MR. ORRIS:** I would also -- I'd like to point  
19 out that your public health website,  
20 [publichealth.gov/exposures/camp-lejeune/research.asp](http://publichealth.gov/exposures/camp-lejeune/research.asp)  
21 (sic), still references the 2009 National Research  
22 Council literature and does not mention any of the  
23 work that has been done and completed here at the  
24 ATSDR. And I would like to know why? You know,  
25 you're still -- you're saying that your scientists,

1           your doctors are going off of the information you  
2           provide them. Well, the information you're  
3           providing them is from the 2009 Research Council,  
4           'cause that's what's on your website.

5           **MR. SAMPSEL:** No, no. Let me clarify  
6           something. That website is a public website, and  
7           honestly I think it's probably behind times. I  
8           think people are too busy to change it maybe or  
9           something like that; I don't know.

10          **MR. ORRIS:** I don't think that's an acceptable  
11          answer, and I think what people are researching,  
12          what they should at the VA, they should be able to  
13          access the most current, the most reliable  
14          information that is out there, not information that  
15          definitely does not put their issues into the light  
16          that it should be.

17          **MR. SAMPSEL:** Okay. The C&P examiners, the  
18          medical doctors that do the examinations, don't pay  
19          any attention to that website.

20          **MR. ORRIS:** Our veterans do.

21          **MR. SAMPSEL:** Well, then I'll do my best to  
22          update that and give some kind of ATSDR -- I'm not  
23          involved in the public health arena; that's TerRy  
24          Walters' area but I will make a point of seeing if  
25          they can update this and connect in with ATSDR on

1 additional information. I agree with you. I don't  
2 know what that says because I haven't looked at it,  
3 but that, that National Research Council report is  
4 the basis for the current public law.

5 **MR. ORRIS:** Well, we know that there are many  
6 errors in that.

7 **MR. SAMPSEL:** Well, I'll bring it up. I'll  
8 definitely bring it up, I'll do that. And I don't  
9 know -- it's not my -- I'm not in control of it but  
10 I will bring it up.

11 **MR. TEMPLETON:** And one thing, and I'm going to  
12 try to be as helpful as possible and respectful as  
13 possible about this but here's a couple of things  
14 that I would like to mention. One is that that  
15 study happens to be used -- I've seen several  
16 denials including my own, that that study was used  
17 for the basis of the denial. This was last year.  
18 This was last year.

19 **MR. SAMPSEL:** Well, you know what?

20 **MR. TEMPLETON:** Well, if you don't mind, let me  
21 go ahead and finish here. The, the problem that I  
22 see, the way I see it here, is from all of the  
23 denials that I've seen, it appears that there's  
24 really no connection; there's really -- does not  
25 seem to be -- it's either -- well, I won't go in,

1 but what I will say is that what they do say in  
2 there does not have any applicability or even remote  
3 sense of being able to discern blatant health  
4 issues. Because one of the things that's listed in  
5 many of these denials is that, well, the veteran  
6 didn't report the issue when they were on-duty.  
7 They didn't report it within a few years after duty.  
8 And that seemed to be the main basis for the denial  
9 so -- well, let me add to that real quick, and then  
10 if you would, I'd like to hear why, why this is  
11 happening. And it probably contributes to as high  
12 of a denial rate as we have right now. But because  
13 of that denial rate and because of not incorporating  
14 some of the additional information we have here,  
15 we're doing our veterans a disservice. They need  
16 your help, and you need to step up to help them. So  
17 I'd like to know first off, why, why there's such a  
18 gap in the understanding on latent health issues  
19 with the claims process, with the C&P claims  
20 process. Every one of them I have seen, it almost  
21 looks blatantly like it was shared between several  
22 different denials.

23 **MR. SAMPSEL:** Well --

24 **MR. TEMPLETON:** And that it shows either -- I  
25 will go there -- it's either a willful ignorance or



1           just a -- of latent health effects. I mean, how  
2           could you look at that and see the health effects  
3           that these guys are talking about, and then say,  
4           well, they didn't report it within five years after  
5           they left the service, and so denied. That's the  
6           basis of the denial. It's not service connected.  
7           That makes no sense.

8           **MR. SAMPSEL:** That's not the basis for the  
9           denial.

10          **MR. TEMPLETON:** That's what I'm seeing. That's  
11          what I'm --

12          **MR. SAMPSEL:** Okay, that language that you see  
13          in there is language that's in regulations. When we  
14          produce a narrative on a denial, you have to  
15          state -- you have to cover several bases as to why  
16          you're denying by law, by the court. The court has  
17          mandated that we do that. One of them is it didn't  
18          appear in service. That has to be stated. Another  
19          one is it wasn't claimed within a certain time  
20          frame. That's another thing that has to be in  
21          there. Now, these denials get that language because  
22          that's required by regulation. The real denial is  
23          not those reasons. All those things state is that  
24          we considered those things. The real reason is  
25          because the medical examiner determined that it was

1 not at least as likely as not that this current  
2 disability was due to that Camp Lejeune exposure.  
3 The medical examiner gave the report. The report  
4 should be in there. And it's available to the  
5 veteran to look at.

6 **MS. FRESHWATER:** But how, how is it that we are  
7 supposed to tell the veterans it did not carry any  
8 weight? We're just supposed to say, oh, they just  
9 put that in there because it's regulation but it  
10 didn't really carry any weight in your denial? It's  
11 very difficult to explain that to them.

12 **MR. SAMPSEL:** Well, you know -- one of the  
13 problems is the volume of cases that the VA has to  
14 deal with, there are so many cases that they can't  
15 get the individual attention in a narrative that you  
16 might like to see there. I would like to see it too  
17 but as you may know, there's a huge backlog.  
18 There's a lot of complaints about that. So there's  
19 standard language that's related to the, to the  
20 regulations that go in there.

21 **MR. ORRIS:** I think Congress has addressed this  
22 backlog, and I think the government and the United  
23 States as a whole has said that veterans dying or  
24 being sick due to a backlog is unacceptable --

25 **MR. SAMPSEL:** Well, it may be unacceptable --

1           **MR. ORRIS:** I don't accept it.

2           **MR. SAMPSEL:** -- but I don't know what to do.  
3           There's a huge number of claims, a huge number, and  
4           there's limited resources to deal with it. I can't  
5           do anything about that.

6           **MR. TEMPLETON:** Is a C&P exam required for a  
7           claim?

8           **MR. SAMPSEL:** Is a what?

9           **MR. TEMPLETON:** Is a C&P exam required for a  
10          claim?

11          **MR. SAMPSEL:** A C&P exam is required when we  
12          can't grant under our current policy. Other than  
13          Camp Lejeune, there are claims where we can grant if  
14          there's a medical opinion and there's an event in  
15          service, you know, somebody broke their leg in  
16          service. Twenty years later they file a claim, they  
17          have a doctor who says I think this is related,  
18          they're going to get service-connected without a C&P  
19          exam.

20          **MR. TEMPLETON:** Okay. I personally know of one  
21          particular person that did not receive a C&P exam.

22          **MR. SAMPSEL:** Denied or granted?

23          **MR. TEMPLETON:** And they got denied.

24          **MR. SAMPSEL:** Well, in order to get a C&P exam,  
25          you have to have some kind of evidence that

1 something happened in service, and if you don't have  
2 that -- now, in the case of Camp Lejeune, it's  
3 there. If you were there, that's your event of  
4 service. But there are a number of people who get  
5 denied and there's no evidence for anything in  
6 service when we look at the record.

7 **MS. FRESHWATER:** But we're only talking about  
8 Camp Lejeune here.

9 **MR. SAMPSEL:** Camp Lejeune.

10 **MS. FRESHWATER:** Yeah, we're only referring to  
11 Camp Lejeune here.

12 **MR. SAMPSEL:** Yes, I'm aware -- okay, I realize  
13 that. So the claims process is a standard process.  
14 Camp Lejeune is special because in a way if you were  
15 there, that's your event. You don't have to prove  
16 anything else. If it's in the record you were at  
17 Camp Lejeune, you're going to get evaluated for  
18 that. That's not the same as the other claims.

19 But as I said, the language may look a little  
20 standard to you in the denials but every one of them  
21 gets an examination; although, if they were not at  
22 Camp Lejeune or if they claim something like a  
23 musculoskeletal problem, which has no bearing on  
24 toxic chemicals --

25 **MR. TEMPLETON:** It does. It does. It's not in

1 the 15 but it does.

2 **MR. SAMPSEL:** Well, I don't know. I'm not a  
3 medical person to evaluate that. But and even if  
4 you -- even if you have a musculoskeletal problem,  
5 you still -- if you're not one of those 15, then  
6 you're going to have to have some medical doctor or  
7 private doctor providing a little bit of evidence  
8 for that before you get the C&P exam, so that's the  
9 claims process.

10 **MR. TEMPLETON:** And that's my next point. It  
11 is actually the nexus letters is that that appears  
12 to be a pretty high bar. I know that's probably  
13 pretty standard for you to have a nexus letter but  
14 the majority of doctors out there won't write a  
15 nexus letter, even if they do feel like it might be  
16 connected. They would be hesitant to write a letter  
17 and when they do write a letter, several of the  
18 claims that I've seen that had multiple nexus  
19 letters on them were denied. And there were some  
20 pretty good nexus letters from some doctors that  
21 were well respected within that area. I don't see  
22 that bar being able to be met by the majority of the  
23 veterans that were exposed, so we're failing them.

24 **MR. SAMPSEL:** Well, maybe -- I mean, apparently  
25 there is failure or we wouldn't have all this, but

1           you know, I don't know what the remedy is, the  
2           immediate remedy. I think there's a remedy going on  
3           now by virtue of this meeting and by virtue of the  
4           ATSDR being involved and you know, I'll do what I  
5           can. I'll talk to Dr. Cross about this. And you  
6           know, I suggest that, for your next CAP meeting you  
7           request somebody from Dr. Cross's staff to come here  
8           and explain to you their formula or their broad  
9           criteria for evaluating individual claims, because  
10          I'm not sure what it is, frankly.

11                 **MR. ENSMINGER:** Well, you've made some --

12                 **MR. SAMPSEL:** You know, maybe Bob would like to  
13           comment on that.

14                 **MR. TEMPLETON:** I'd like to thank you for, for  
15           your responses. Thank you very much; I appreciate  
16           your time.

17                 **MR. CLAY:** Just to kind of touch on that, I'm  
18           not a medical professional either but I have been  
19           involved with this. I was at Camp Lejeune. I've  
20           run a VA office at Camp Lejeune. I'm very aware  
21           with this issue; I've dealt with Senator Burr's  
22           office, and then I got to Louisville, and now the  
23           people that make these decisions are my people. And  
24           I'm very cognitive of the depth of this issue and  
25           the pain and suffering that it causes. My people

1           are very dedicated and they try every day very hard  
2           to do the best they can for the people filing those  
3           claims. The productivity of those people, and I  
4           know that's not going to be what you want to hear  
5           because there's still a high denial rate, but the  
6           productivity of those people is higher than some of  
7           the people that work in the rest of the office,  
8           because they're trying to get these out. We have  
9           over 3,600 of these claims pending despite the fact  
10          that we just decided already about 6,800 of them.  
11          So it's a high volume of work. We have taken  
12          resources which were not allocated to this mission  
13          and redirected them to this mission to try and  
14          take -- cut the time lines on this and get decisions  
15          to people. While a negative decision is not the  
16          favorable outcome that we'd all like to see, it does  
17          open other resources up for veterans when they have  
18          that in hand and they say, look the VA's already  
19          denied me. Then they get help from some other  
20          organizations. In terms of the medical --

21               **MR. ENSMINGER:** Well, let me ask you a  
22               question.

23               **MR. CLAY:** Okay.

24               **MR. ENSMINGER:** Have you been given a ceiling  
25               as to how many people you can approve for service

1 connection --

2 **MR. CLAY:** Absolutely not.

3 **MR. ENSMINGER:** Because I'll tell you what, it  
4 is, it is almost automatic that the claims approval  
5 process hovers within a few tenths of 25. I mean,  
6 straight across the board, with the exception of  
7 female breast cancer.

8 **MR. CLAY:** And I'm aware of that. We have  
9 actually not been given any guidance on what claims  
10 to approve and what claims to deny or how many of  
11 each.

12 **MR. ENSMINGER:** And where does this Koopmeiners  
13 come into the process?

14 **MR. CLAY:** Okay.

15 **MR. ENSMINGER:** What's he do?

16 **MR. CLAY:** Dr. Cross is the head of the  
17 disability exam medical office. They are  
18 responsible for VHA for the compensation of pension  
19 exam process, not just for Camp Lejeune but for the  
20 whole compensation exam process.

21 **MR. SAMPSEL:** Which is different than Terry  
22 Walters' section.

23 **MR. CLAY:** Right, 'cause that's another whole  
24 animal. Dr. Koopmeiners works for him and he is the  
25 head of what we call the subject matter expert



1           medical teams. He is an occupational specialist,  
2           who's licensed, okay, and certified in that field.  
3           And the people that we work -- that he has working  
4           for him, which number, I believe, is 24 active  
5           medical examiners right now that provide these  
6           opinions, are all either occupational exposure  
7           specialists or they're people who have been  
8           certified in a secondary occupational exposure  
9           special --

10           **MR. ENSMINGER:** And where are they located?

11           **MR. CLAY:** They are located in medical centers  
12           all across the nation, spread out geographically.  
13           And those people have all received centralized  
14           training by the disability exam medical office  
15           specific to Camp Lejeune claims before they can  
16           work --

17           **MR. SAMPSEL:** Let me say one thing, Terry  
18           Walters' PowerPoint has nothing to do with this  
19           training for these medical doctors.

20           **MR. CLAY:** Correct. That is not used in their  
21           training.

22           **MR. ENSMINGER:** So who got trained with this --

23           **MR. CLAY:** The 24.

24           **MR. ENSMINGER:** -- this PowerPoint?

25           **MR. CLAY:** Oh. I don't have any answer to

1           that.

2           **MR. ENSMINGER:** That she created.

3           **MR. CLAY:** I believe, from what I heard y'all  
4 saying earlier today, I believe it's the treating  
5 physicians at the medical centers. But that's not  
6 compensation and pension.

7           **MR. SAMPSEL:** I think it's an informative  
8 PowerPoint more than anything else.

9           **MR. ENSMINGER:** I would recommend that you  
10 gentlemen go back on the ATSDR's website and read  
11 the transcript for the September 2013 CAP meeting,  
12 because that's not the explanation we got, okay?

13          **MR. SAMPSEL:** Well, I can guarantee you that  
14 Dr. Cross's staff of medical doctors is not trained  
15 by Terry Walters' PowerPoint.

16          **MR. SMITH:** Well, let me ask, can you answer a  
17 question? Can you provide or share what they are  
18 trained with? Since they provided this PowerPoint.  
19 Can we get some documentation of what they received?

20          **MR. CLAY:** I can request that. We don't do the  
21 training. That's VHA's training material. We can  
22 see if we can get a copy.

23          **MR. SAMPSEL:** And that's why I think that you  
24 should invite Dr. Koopmeiners or some representative  
25 from Dr. Cross's office to come here and explain to

1           you their specific procedures or their strategy for  
2           evaluating these claims.

3           **MR. ENSMINGER:** Well, to be very point blank  
4           and blunt, I wouldn't want to be near  
5           Dr. Koopmeiners. The man is a convicted sex  
6           offender, okay? And I mean, and --

7           **MR. SAMPSEL:** I can't believe that to be true.

8           **MR. ENSMINGER:** I do. I looked him up. I do  
9           my research before I make a statement. He is  
10          convicted pedophile. Look it up. And that is  
11          offensive to me, that you got a convicted sex  
12          offender working in the VA.

13          **MR. SAMPSEL:** I don't know that to be true and  
14          I can't really comment on that. But if you'd rather  
15          have somebody other than him, I think we can  
16          probably arrange it.

17          **MR. ENSMINGER:** Well, I think the VA ought to  
18          take a look at who the hell they're hiring.

19          **MR. CLAY:** To get back to what we were talking  
20          about, while I'm not a medical professional, these  
21          24 that are scattered throughout the country have  
22          been specifically trained to do this.

23                 And Mr. Ensminger, while you were talking about  
24                 the time period, that does come into play to some  
25                 extent. For our purposes in the VBA, we only have

1           to put you at Camp Lejeune, we just put you -- it  
2           doesn't matter how long, and we will go ahead and  
3           concede the exposure. But where it comes into play  
4           is when these medical examiners are looking at the  
5           medical record, because obviously the longer you're  
6           there, the more cumulative exposure you've had to  
7           the water. And the more cumulative exposure,  
8           normally the higher the risk factors for some of  
9           these diseases. So that's where it comes into play  
10          and that's what they're looking at when they're  
11          writing these opinions, among other things, where  
12          did you live, where did you work, what was your MOS.  
13          Obviously if you were a fuel handler you're going to  
14          have much higher exposure to some of these than if  
15          you're someone that worked in the hospital, you  
16          know.

17                They look at your post-service exposure. You  
18          know, if you were a food prep worker there, but then  
19          you get out and you work as a hazardous chemicals  
20          waste disposal expert for some waste management  
21          company, you know, obviously that length of exposure  
22          may have been more significant than the exposure  
23          that -- they have to weigh all these things in,  
24          because as y'all are all aware, at least I assume  
25          you are, this is not like Agent Orange. There

1           aren't any presumptive conditions. Those 15 aren't  
2           presumptive. We have to decide each of these cases  
3           on an individual case-by-case basis, taking into the  
4           fact the person's exposure, the length of time there  
5           and the other, as Mr. Sampsel said, the other  
6           comorbidity factors that could have made them more  
7           susceptible to the disease.

8           **MR. ENSMINGER:** Well, I was discussing this  
9           with some members up on Capitol Hill the other day,  
10          this very issue. And one thing that we have for  
11          Camp Lejeune is documented exposure levels, okay.  
12          So you've got a guy comes in, C&P exam. Okay, you  
13          were at Camp Lejeune, you were there for a couple  
14          years and you were exposed to benzene, TCE, PCE,  
15          vinyl chloride, DCE, okay? And then they look and  
16          they say, whoa, what else did you do after you got  
17          out of the service? Well, I worked at a gas  
18          station. Oh, well, that could be a contributing  
19          factor to your leukemia or whatever you got. Well,  
20          the guy pumped gas. He wasn't drinking it like he  
21          was at Camp Lejeune, okay? So you have verified  
22          exposures that took place. The benefit of the  
23          doubt, correct me if I'm wrong, is supposed to go to  
24          the veteran, right?

25          **MR. CLAY:** It does, all other things being

1           equal. We do apply that. But the medical opinion  
2           process -- again, I think you'd get better  
3           information on this from ^ 'cause I don't have  
4           occupational exposure training. I know what they're  
5           supposed to be doing and it's supposed to provide a  
6           rationale for why they weighted this exposure  
7           greater than this exposure or this other comorbidity  
8           element, like maybe 40 years of smoking as opposed  
9           to their exposure at Camp Lejeune. They are  
10          supposed to provide a rationale and once they ^ as  
11          to how they weighted this stuff and how they came to  
12          the decision. Is it at least as likely as not that  
13          it was due to the water contamination or to some  
14          other cause. And if they're not providing enough  
15          rationale, my people have been trained that that's  
16          not a sufficient exam. You need to go back and ask  
17          them to either do an addendum to provide the  
18          rationale or redo the exam in total.

19               **MS. FRESHWATER:** I would like to see a poster  
20               of the benefit of the doubt goes to the veteran up  
21               in all of the offices, because none of the veterans  
22               I've talked to feel anywhere near that being  
23               represented. They feel like they have to -- they're  
24               made to feel like they are trying to steal something  
25               that should be given to them because we owe that to

1           them, and they are made to feel like they are trying  
2           to scam the government. And it's hard enough for a  
3           Marine to go forward and ask for help, and then when  
4           they have this kind of attitude that they face, it's  
5           very, very difficult. And none of them feel  
6           anywhere near the benefit of the doubt is on their  
7           side. So I just want to say, it's not just, you  
8           know, one or two. I talk to a lot of them, and  
9           it's -- I'd never hear anyone say -- and I'm not  
10          saying your people don't do good work; I'm not  
11          saying they're not good people or they don't care.  
12          I believe that they -- I -- you have my benefit of  
13          the doubt, I believe that. But the point is that  
14          I've never had a veteran come to me and say, yeah, I  
15          felt like the law changed everything for me and I  
16          was able to get care for what happened to me.  
17          Because as Jerry was saying, we know they were  
18          exposed. We don't know -- the other -- everything  
19          else is a mystery as far as what they did with the  
20          rest of their lives but it's not a mystery as to  
21          what happened at Camp Lejeune. So I just wanted to  
22          say that. And I stole the mic from Chris again so I  
23          have to give it to him now.

24               **MR. ORRIS:** I'd like to know why dependents and  
25          civilians get the benefit of the doubt of the 15

1           onsets that the veterans do not, and why veterans  
2           are eligible for illnesses that civilians and  
3           dependents do not. It's not like there was a  
4           veterans' water or a dependents' water or a  
5           civilians' water. This whole thing is set up in  
6           such a way that it doesn't seem like it's going to  
7           be -- it doesn't make any sense, you know.

8           A civilian can say I got kidney cancer, and now  
9           I'm eligible for benefits. And you say, okay, you  
10          were at Camp Lejeune, therefore under the law you  
11          get it. And then the veteran says I have kidney  
12          cancer and I served at Camp Lejeune, and then you're  
13          talking about all of these co -- you know, all these  
14          other risk factors. You know, if the veteran has  
15          kidney cancer and it's on the 15, they should be  
16          eligible no matter what too.

17          **MR. SAMPSEL:** I think you mischaracterized the  
18          situation because, first of all, veterans don't get  
19          denied when civilians do get it. First of all,  
20          we're talking about treatment versus compensation.  
21          We're the Department of Veteran Affairs to assist  
22          veterans. Civilians are not part of the VA's  
23          mandate by Congress.

24          This is a particular unusual situation with  
25          Camp Lejeune because of the public law that provides



1 free treatment to dependents and family members.  
2 That does not occur in the VA in any other  
3 circumstance. I'd just like to explain that.

4 And every veteran that was at Camp Lejeune that  
5 develops any of the 15, also gets free treatment.  
6 And as Terry Walters explained, they get healthcare.  
7 They get treatment. The issue here is compensation,  
8 monthly paychecks, which are not authorized for  
9 civilians. But for a veteran to get that, we have  
10 to service-connect them, and that's where the  
11 Compensation and Pension Exam comes in.

12 **MR. ORRIS:** So you can be at Camp Lejeune and  
13 be exposed to the water and get treatment as a  
14 veteran but you don't get the same consideration to  
15 get disability benefits.

16 **MR. ENSMINGER:** That's correct.

17 **MR. SAMPSEL:** Absolutely true, because of  
18 Senator Burr -- I know it's public now but Senator  
19 Burr's statute, public law, signed on by all of  
20 Congress, obviously, that is a very special, very  
21 unusual law. There's no equivalent to that and  
22 there's no other law, to my knowledge, where --  
23 well, there's dependent and benefits to spouses,  
24 deceased spouses -- you know, the veteran dies, the  
25 wife will get a benefit called the DIC benefit, but

1           there's nothing for family members under the VA  
2           system; it's for veterans. And this law, this  
3           statute provides for family members.

4           **MR. ENSMINGER:** Title 36 had to be amended to  
5           include family member healthcare.

6           **MR. SAMPSEL:** That would be for Congress.  
7           Congress needs to do that.

8           **MR. ENSMINGER:** They already did that. That's  
9           how they got the family members included in that  
10          bill.

11          **MS. FRESHWATER:** That leads to my next  
12          question. Can we get -- is there any kind of update  
13          on where that stands for family members?

14          **MR. ENSMINGER:** They just announced it.

15          **MS. FRESHWATER:** I think I was in the --

16          **MR. ENSMINGER:** No. Dr. Walters said  
17          October 15<sup>th</sup>.

18          **MS. FRESHWATER:** Well, I came in late, then. I  
19          didn't hear --

20          **MR. ENSMINGER:** It's been approved by OMB.

21          **MS. FRESHWATER:** That's great.

22          **MR. SAMPSEL:** But that's under the statute.  
23          We're talking about under the statute; we're not  
24          talking about, you know, compensation of benefits  
25          here.

1           **MR. ENSMINGER:** No, yeah, I understand that --

2           **MS. FRESHWATER:** But I watched my mother die in  
3 a bed that was broken in a hospital room because she  
4 didn't have insurance, and we had never had any kind  
5 of financial stability. She never had any anyway.  
6 And I watched that happen, and I had to go out into  
7 the hallway and get her a bed when she was ten days  
8 away from being moved into hospice. And that should  
9 not have happened to my mother because she drank  
10 that water. And that shouldn't have happened. And  
11 I'm just very anxious for the family members to be  
12 able to get the dignity in care.

13           **MR. SAMPSEL:** Well, I think Senator Burr  
14 addressed that, and now we're moving forward in a  
15 different direction.

16           **MR. ENSMINGER:** Yeah, but the VA took them over  
17 two years to develop the rules, and OMB's had this  
18 thing since March.

19           **MR. SAMPSEL:** I can tell you that the  
20 government works very slowly.

21           **MR. ENSMINGER:** Oh, tell me about it.

22           **MR. SAMPSEL:** Well, believe me, it frustrates  
23 me too but I don't know what I can do about it.

24           **MR. TEMPLETON:** Well, going back to the C&P  
25 claims, now, it appears at least through some of

1           them that I've seen, that it is limited -- you guys  
2           are limited to 15 conditions, if you don't fall  
3           within those 15 conditions, then game over.

4           **MR. SAMPSEL:** I don't think that's true.

5           **MR. TEMPLETON:** So that's what it appears.  
6           Well, and then maybe this goes back to the language  
7           that we were talking about that I quoted as  
8           boilerplate, that has to be included.

9           **MR. SAMPSEL:** By the court decision, we have to  
10          put it in there.

11          **MR. TEMPLETON:** I got it, so okay. Thank you.

12          **MR. SAMPSEL:** But I will tell you that, you  
13          know, if somebody has -- I think it's feasible that  
14          if somebody can be service-connected outside of  
15          those 15, if they have initially filed their claim,  
16          they had some kind of medical evidence associating  
17          that particular disability or disease with the  
18          water, maybe a private medical opinion, they'll get  
19          an exam. And then it would be up to that examiner  
20          to determine what to do.

21          **MR. TEMPLETON:** All right. Thank you,  
22          appreciate it.

23          **MR. BRUBAKER:** Folks, I want just do a quick  
24          reference to the agenda. We are actually at the end  
25          of our scheduled time. I'd like to let it go on

1           because it's been a rich and robust exchange of  
2           dialogue. There are three remaining agenda items,  
3           all of which can be covered in the next CAP call.  
4           But before we end the meeting, I'd like to make sure  
5           that there are no other CAP updates and concerns  
6           that need to be taken at this time.

7  
8           **CAP UPDATES AND CONCERNS**

9           **MR. ORRIS:** I would like to point out that the  
10          ATSDR website still references fact sheets from 1997  
11          for TCE, and I would like to see the ATSDR updating  
12          their information to -- with not only their own  
13          studies but as well as the EPA.

14          **MS. FRESHWATER:** I would like to formally  
15          request that we have a meeting with Dr. Frieden,  
16          either the entire CAP or some designated  
17          representatives. And I would also like to say that  
18          we are all in favor -- I think I've talked to  
19          everybody -- of this idea of having a meeting in  
20          Raleigh hopefully with some press that we will plan  
21          very vigorously. And it'll give us time to organize  
22          that.

23          **MR. ENSMINGER:** I think Greensboro would  
24          probably be better.

25          **MS. FRESHWATER:** Wherever Jerry wants to have

1           it is where the CAP is for having it.

2           **MR. ENSMINGER:** Well, looking for a central  
3           location. Well, not only airport, but looking for a  
4           central location where it's not weighted one side of  
5           the state or the other. I mean, North Carolina's a  
6           very long state. If you hold the thing in  
7           Wilmington, it's over 400 miles for people in the  
8           western part of the state to get to Wilmington.

9           **MS. FRESHWATER:** And Jerry promises barbecue  
10          wherever we are.

11          **MR. ENSMINGER:** I'll cook a hog.

12          **MR. BRUBAKER:** So hearing that, Sheila, you  
13          want to talk about the next meeting set for January?  
14          Oh, I'm sorry, Melissa.

15          **MS. FORREST:** I'm sorry. It's just Chris, if  
16          you remember earlier today, we were kind of going  
17          back and forth on what exactly -- formulating the  
18          question that he and Gavin both were presenting to  
19          the Navy and Marine Corps, and so Chris just asked  
20          me to, you know, read off for the official record  
21          what the request is. In light of the July 9, 2014  
22          EPA Region 9 memorandum, is the Navy/Marine Corps  
23          planning to personally notify women at Camp Lejeune  
24          who may have been in the past or might now currently  
25          be exposed to TCE and vapor intrusion? The CAP

1 recommends this notification include all buildings  
2 over the TCE plume and especially the 12 buildings  
3 currently being investigated for vapor intrusion.  
4 Immediate communication should occur with current  
5 workers, residents, who are potentially being  
6 exposed now to explain the recent EPA memorandum  
7 recommendations.

8 The CAP also wants the Marine Corps to visit  
9 how to inform women who worked/lived in areas of  
10 potential vapor intrusion between 1985 and now. And  
11 a list of methods the Marine Corps will follow to  
12 identify, locate and communicate with the women.  
13 Note that solely putting the information on the  
14 website is not sufficient because the website  
15 focuses on exposures before 1984 and misses a large  
16 group of potentially exposed women. That capture  
17 it? All right, thanks.

18  
19 **WRAP UP**

20 **MS. FRESHWATER:** I want to get a picture of the  
21 CAP members and if you would join us, I would like  
22 to do that just to have a current picture of the  
23 CAP, for good purposes.

24 **MS. STEVENS:** Okay, I've got a quick couple  
25 updates. So September 15<sup>th</sup>, which is Monday, would

1 be our next CAP call. So I want to know do we need  
2 to have the next CAP call or do we want to go with  
3 October 20<sup>th</sup>? Jerry?

4 **MR. ENSMINGER:** What?

5 **MS. STEVENS:** Do you want to have a CAP call on  
6 September 15<sup>th</sup> or do you want to go October 20<sup>th</sup>,  
7 which would be the next one? Monday, this coming  
8 Monday, would be our next scheduled CAP call.

9 **MR. ENSMINGER:** No, that's too soon.

10 **MS. STEVENS:** Everybody good with October 20<sup>th</sup>?  
11 Okay, I will send out a -- just a reminder to  
12 everybody on that.

13 The next item that I just need to quickly cover  
14 is when our next in-person CAP meeting would be, and  
15 that would be in January of 2015. I have three  
16 proposed dates. I'm going to look for quickly a  
17 raise of hands for the first one, and then I'll send  
18 out again another kind of quick communication to  
19 people to see if this is check, really what we want.  
20 The first date we would have possible would be  
21 January 15<sup>th</sup>. These are all Thursdays, too, that I'm  
22 proposing. January 15<sup>th</sup>, which would be the second  
23 Thursday of the month in 2015.

24 **MR. ENSMINGER:** That's fine.

25 **MS. STEVENS:** Okay. The second one I have is



1 January 23<sup>rd</sup>.

2 **MR. ENSMINGER:** First one, first one.

3 **MS. STEVENS:** Okay. Is everybody good with  
4 January 15<sup>th</sup>? Perri, are you good with that one? I  
5 know you had something through the 14<sup>th</sup>.

6 **MS. RUCKART:** Oh, yeah. That's fine. I was  
7 just saying I don't -- how can January 23<sup>rd</sup> be a --

8 **MS. STEVENS:** What was it?

9 **MS. RUCKART:** If the 15<sup>th</sup> is a Thursday.

10 **MS. STEVENS:** Or maybe I did it wrong. They're  
11 all Thursdays so -- sorry. Fifteenth. We will go  
12 for the 15<sup>th</sup>, and I'll send out an email with those  
13 two dates with our next call, and our next meeting  
14 we'll start looking at -- make sure that we have  
15 times available and hotels and the room space here.

16 And then the last thing is that we'll discuss  
17 during calls coming up is planning our meeting that  
18 will be off-site in North Carolina in the months of  
19 April or May of 2015. So with that, if there are no  
20 questions I will convene the meeting.

21 **MR. BRUBAKER:** Conclude.

22 **MS. STEVENS:** I mean, conclude.

23 **MS. BRIDGES:** This is Sandy Bridges.

24 **MS. STEVENS:** Yes, Sandy.

25 **MS. BRIDGES:** I'd like to say hi. I've kept

1           quiet all this time but I'd like to say something  
2           before the meeting adjourns.

3           **MS. STEVENS:** Yes. Thank you, Sandy, go ahead.

4           **MS. BRIDGES:** Well, as much as I hate to do  
5           this, and I really do, but I'm going to resign from  
6           the CAP. There's been some health issues that I  
7           have to take care of. And y'all don't need me. I'm  
8           an old woman. I've been at this, you know, working  
9           with Jerry since 2005. That was our first meeting  
10          in Atlanta with that -- the scientific advisory  
11          panel, in '04 -- well, that was '05, excuse me. And  
12          I've been on the path since '06. And ^ 67, and we  
13          need those bright minds that we've got there today.  
14          I mean, I am so impressed with all the people, you  
15          know, that we have now on the CAP. And I'm going to  
16          pack and let someone else younger and more in tune  
17          with everything that's going on, that can make a  
18          difference, which is the most important thing. I  
19          never became involved in this to get money, a  
20          lawsuit. I've never talked to an attorney. That  
21          wasn't my main objective. My main objective was the  
22          children that were born, the dependents, and seeing  
23          that not just mine that I nearly lost that are  
24          suffering but others as well. That's my, my thing.  
25          That's why I became involved in this in '05 and

1           that's my same thing now. And I hope that everyone  
2           else would help me in doing that.

3           I've enjoyed working with you all. And I hope  
4           to be at the meeting, you know, just as an observer,  
5           when you are in Greensboro or wherever you have it,  
6           the next meeting.

7           **MS. STEVENS:** Sandy, we'll keep you informed  
8           where that meeting is so that you can attend, and I  
9           appreciate all your time working with the CAP.

10          **MS. BRIDGES:** Perri, I miss seeing you. And  
11          thank you very much.

12          **MS. RUCKART:** You're welcome.

13          **MS. BRIDGES:** We have come a long way. You  
14          were a young girl, a thin young girl, and no  
15          children. You'd just gotten married.

16          **DR. BOVE:** Well, this is Frank Bove, Sandy.  
17          Sandy, this is Frank Bove. I'm glad that you've  
18          done all this work for the CAP. We appreciate it  
19          and I had a few less gray hairs, too.

20          **MS. BRIDGES:** Okay.

21          **MS. FRESHWATER:** And Sandy, this is Lori. We  
22          need you as our cheerleader, okay?

23          **MS. BRIDGES:** I'll be right there. Okay.  
24          Thank you. Goodbye.

25          **MR. BRUBAKER:** Thank you and the meeting is

officially adjourned.

(Whereupon the meeting was adjourned at 2:37 p.m.)

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**CERTIFICATE OF COURT REPORTER****STATE OF GEORGIA****COUNTY OF FULTON**

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of Sept. 11, 2014; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither relation nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 20th day of Oct., 2014.

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**STEVEN RAY GREEN, CCR, CVR-CM, PNSC****CERTIFIED MERIT COURT REPORTER****CERTIFICATE NUMBER: A-2102**