THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

TWENTY-SECOND MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

APRIL 2, 2012

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at the ATSDR, Chamblee Building 106, Conference Room B, Atlanta, Georgia, on April 2, 2012.

STEVEN RAY GREEN AND ASSOCIATES
NATIONALLY CERTIFIED COURT REPORTING
404/733-6070

C O N T E N T S

April 2, 2012

TRANSCRIPT LEGEND

The following transcript contains quoted material. Such material is reproduced as read or spoken.

In the following transcript: a dash (--) indicates an unintentional or purposeful interruption of a sentence. An ellipsis (. . .) indicates halting speech or an unfinished sentence in dialogue or omission(s) of word(s) when reading written material.

-- (sic) denotes an incorrect usage or pronunciation of a word which is transcribed in its original form as reported.

-- (ph) indicates a phonetic spelling of the word if no confirmation of the correct spelling is available.

-- "uh-huh" represents an affirmative response, and "uh-uh" represents a negative response.

-- "*" denotes a spelling based on phonetics, without reference available.

-- "^" 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)

AKERS, PAUL, CAP MEMBER
BLAKELY, MARY, CAP MEMBER
BOVE, DR. FRANK, ATSDR
BRIDGES, SANDRA, CAP, CLNC (via telephone)
BYRON, JEFF, COMMUNITY MEMBER
CLAPP, RICHARD, SCD, MPH, PROFESSOR
DAVIS, DR. DEVRA, CAP MEMBER
DICK, WENDI, VA, OFFICE OF PUBLIC HEALTH
ENSMINGER, JERRY, COMMUNITY MEMBER
FLOHR, BRAD, DEPARTMENT OF VETERANS AFFAIRS, COMPENSATION SERVICE
FORREST, MELISSA, NAVY MARINE CORPS PUBLIC HEALTH CENTER
MASLIA, MORRIS, ATSDR
PARTAIN, MIKE, COMMUNITY MEMBER
PORTIER, DR. CHRISTOPHER, DIRECTOR NCEH/ATSDR
RUCKART, PERRI, ATSDR
STODDARD, LANDER, CDC
TOWNSEND, TOM, CAP MEMBER (via telephone)

1

P R O C E E D I N G S

(9:00 a.m.)

WELCOME, INTRODUCTIONS AND ANNOUNCEMENTS

MS. RUCKART: Good morning. It's actually 9:00 o'clock even though that clock says five after 9:00, but it's 9:00 and we're going to start streaming. So I want to just welcome everyone. Today we have with us, Lander Stoddard. Our regular facilitator, Chris Stallard, had a family emergency, so we were very lucky and very grateful for Lander to come step in. Some of you may recognize him; he has helped us out before, so I just wanted to introduce Lander and then turn it over and we'll start our meeting. Thanks.

MR. STODDARD: Thank you, Perri. A bit of administrivia, there's sign-in sheet circulating around, if everybody would sign in, if you could, please.

Let's start with introductions. I'm Lander Stoddard, I subbed in a couple years ago for Chris; unfortunately he couldn't be here. I work here at CDC and I do meeting group facilitation. Let's go around the -- why don't we start remotely. Who do we have remotely? Who's on the phone?

MS. BRIDGES (telephonically): Sandy Bridges.

MR. STODDARD: Thank you, Sandy. Anybody else on the phone?

MR. ENSMINGER: There was supposed to be three.

MS. RUCKART: Well, one is the court reporter. Yeah, that's probably us, the court reporter and Sandy that's three.

MR. STODDARD: Okay, and the court reporter. All right? And who's on video?

MS. BRIDGES: Tom Townsend won't be on this morning. He, he just won't be on this morning.

MR. STODDARD: Okay, thank you, Sandy.

MS. BRIDGES: May be on later on but not right this -- right now.

MS. RUCKART: It's not an interactive video --

MR. STODDARD: Thank you, Sandy. That's the web stream?

MS. RUCKART: Yes, that's the stream, it's not interactive.

MR. STODDARD: Okay. So just in case everybody knows, this session is being streamed live across the internet.

MS. BRIDGES: I can't get it on mine.

MR. STODDARD: Not yet?

MS. BRIDGES: No.

MR. STODDARD: Would you let us know when you do

get it?

MS. BRIDGES: Okay, I'll do that.

MR. STODDARD: Thank you.

MS. RUCKART: Can you try -- Sandy, try refreshing your screen. It's 9:01, you might need to refresh to have it come up.

MR. ENSMINGER: Better ask her if her computer's on.

MR. STODDARD: All right, well, let's go around the room. Who'd like to start?

MR. ENSMINGER: I'm Jerry Ensminger and I'm a member of the Camp Lejeune, North Carolina CAP.

MR. STODDARD: Okay, thank you.

MR. BYRON: I'm Jeff Byron and I'm also a member of the CAP.

DR. AKERS: Paul Akers, also a member of the CAP.

MR. PARTAIN: Mike Partain, also a member of the CAP.

MS. RUCKART: Perri Ruckart, ATSDR.

MR. FLOHR: Brad Flohr, Department of Veterans Affairs, Compensation Services.

DR. PORTIER: Chris Portier, Director of ATSDR/NCEH.

DR. BOVE: Frank Bove, ATSDR.

MS. FORREST: I'm Melissa Forrest from the Navy

Marine Corps Public Health Center. I'm here for Maryann Simmons, who's retired as of today, so...

MR. ENSMINGER: Oh, good.

MS. FORREST: I'm the transitional representative. You will have a full-time representative at the next meeting.

MS. BLAKELY: Mary Blakely. Mary Blakely, the CAP.

DR. CLAPP: Dick Clapp, the CAP.

DR. DAVIS: Devra Davis, CAP.

DR. DICK: Wendi Dick, VA Office of Public Health.

MR. STODDARD: Okay, thank you. And we have our court reporter, recorder. Thank you.

I've forgotten, it's been awhile since I've been here. Can you remind me of what your ground rules are?

MR. BYRON: Tackle everybody, take no prisoners.

MR. STODDARD: Okay. That's one perspective.

MS. BLAKELY: Say whatever you want.

MR. STODDARD: Whatever you want? I understand you do have some official written-down ground rules. Does anybody remember what those are? Perri?

MS. RUCKART: Well, I'll just remind everybody what we've agreed to in the past. They're basically

just what we consider like kindergarten rules. They're just some basics tenets: everyone treat each other with respect, no personal attacks, one person speak at a time and the audience is here to just witness the proceedings; however, if anyone on the CAP would like to address the audience and have a question for an audience member, then they can be invited to participate.

MR. STODDARD: Okay. Thank you.

DR. DAVIS: It might be helpful to know who's in the audience.

MR. ENSMINGER: Yeah.

MR. STODDARD: You'd like to know who's in the audience? Is that a normal procedure?

MS. RUCKART: No, but we can do that if Devra would like.

DR. DAVIS: I'd just like to get an idea.

MR. STODDARD: Okay, so if, folks in the audience, if you would stand up, give your name and what your affiliation is.

DEBORAH TRESS: Hi, I'm Deborah Tress, I'm with the General Counsel's Office for CDC and ATSDR.

KENYA FORD: I'm Kenya Ford, I'm also with the General Counsel's Office.

VANESSA BERTKA: Vanessa Bertka with Bell Legal

Group.

JACKIE HUNEAULT: Jackie Huneault with Bell Legal Group.

LYNN RIVARD: Lynn Rivard, invited by Mike Partain and Jerry Ensminger.

BARBARA ELLIS: Barbara Ellis, CDC.

REGINA SIDER: Regina Sider, CDC.

SHEILA STEVENS: Sheila Stevens, CDC.

VERONICA KENNEDY: Veronica Kennedy, CDC.

KEVIN WILKINS: Kevin Wilkins, I'm just here to watch.

CAROLYN HARRIS: Carolyn Harris, ATSDR.

EDDIE SHANLEY: Eddie Shanley, CDC.

BILL CIBULAS: I'm Bill Cibulas with ATSDR.

VIK KAPIL: I'm Vik Kapil with NCEH and ATSDR.

ROBIN LEE: Robin Lee with ATSDR.

STEVE DEARWENT: Steve Dearwent, ATSDR.

CAROLINE MCDONALD: Caroline McDonald, ATSDR.

ED MURRAY: Ed Murray, ATSDR.

CAROL ALIOSIO: Carol Aliosio, NCEH and ATSDR.

MR. BYRON: One minute. I really didn't catch what group you all are with?

MR. ENSMINGER: Bell Legal Group.

MR. BYRON: Bell Legal Group, okay, thank you. I didn't hear it, sorry. Allergies.

MR. STODDARD: All right the agenda says -- why don't we go over the agenda? It's going to be shuffled around a bit, so we may have a few more administrivia announcements. Before we get into CAP updates, Dr. Portier has a few words he'd like to say. Jerry, you've also asked that we address breast cancer while Dr. Portier is here?

MR. ENSMINGER: Yeah.

MR. STODDARD: Okay, so we can move that up. Then we get into the CAP updates, the recap of the last meeting, Q and A with the VA. Morris got in late from an international flight last night so he's sleeping in this morning; he will be here later. So we'll, we'll, we'll let him present whenever he gets here. So that means we'll probably move up the health studies updates and the communication plan and the wrap-up.

Any questions about the agenda?

(no response)

MR. STODDARD: Okay. Any other administrivia that I have missed? Okay. Dr. Portier.

DISCUSSION WITH DR. PORTIER

DR. PORTIER: Good morning and thank you all for being here today. I'm here this morning to 11:00 and then I have to go over to Dr. Frieden's office for a

meeting, and I'll be back after lunch.

MR. STODDARD: Could you pull the mike a little closer?

DR. PORTIER: I'll be back after lunch until the very end.

I just wanted to talk to you about two things real quickly this morning. The first is the reorganization of ATSDR. Since ATSDR is doing the Camp Lejeune studies, I thought you would like to know a little bit about how I've restructured the organization.

Currently it's a proposed structure but we're operating under that proposed structure while it goes through formal clearance here at CDC and the Department of Health and Human Services.

ATSDR used to be in four separate divisions. I felt that the four divisions was not exactly the proper structure for where we wanted to take the organization so we've collapsed the organization down into two divisions. The first division, which is Community Health Investigations, is the division that goes out to communities, does our investigations, does the public health assessments and reports those back. That's where Morris and his group are. They're in that particular group. That group is made up of what

was formerly DHAC, the Division of Health Assessment and Consultation, and the division of regional operations. Those are now both in one group, and that's being run now by Tina Forrester.

The other groups were the Health Studies Group and the Toxicology and Environmental Medicine Group. Those have been collapsed into one group, and I can't remember its name at this point, so I won't tell you what that name is. But that division is where Frank and Perri are both located. They're now under Steve Dearwent, who is here, within his branch.

Everything should be the same as it was before. Those studies are still ongoing and there shouldn't be any, hopefully, change in any of those operations. The focus of this reorganization was to strengthen the science of ATSDR by bringing epidemiology, toxicology and environmental medicine all together under one roof; to do the, the science support for ATSDR and to strengthen our ability to work in the communities by taking all of our community operations under one division and making it better coordinated.

The new divisions, the new division of community health investigations is broken into three geographic regions of the United States, southeast, west and central. And then within those regions there are

three or four regional offices that are located out in those regions of the United States and co-located with the EPA's regions. So that covers that issue.

The other issue I wanted to cover was the Chapter B report and the redaction from the Chapter B report. I know you have some concerns about that. You've expressed them to me very clearly.

I wanted to walk you through my thought processes for what we did there and why be did it, and explain to you where we stand with this at this point. Just prior to our release of Chapter B, months ago, the Navy had asked us to avoid putting in the exact locations of active drinking water wells in the Chapter B report. But they'd only done it verbally and we've been after them for months to give us a formal written request for it. The day before we were going to release Chapter B, they sent us the formal written request. When I looked at the request, and we had spent some time looking at what other agencies did, most notably EPA and the U.S. Geological Survey, both of the other two agencies do not report locations of active water wells. The reason they do this is because they feel they are a -- they are a terrorist threat, and they do not want to sort of make it easier. That's a simple way to put that.

But those two requests and the request from the Department of the Navy, we decided that the most prudent approach was to redact the information, release the report rather than wait to release the report while we thought a long time about this issue, and then move on from there.

Now, it was clear at the time that we redacted the information from the report that the Navy had not matched the legal requirement for a FOIA override with what they had told us. That was quite clear to us at the time. The choice, and it was my choice, to redact was based upon several things. The first is that the main purpose of that document was to provide the history of the aquifer on which Camp Lejeune sits, to be able to show where the plume existed, and at one time it existed there.

MR. ENSMINGER: Plume?

DR. PORTIER: The plume, the toxic chemicals in the water. It's called a plume.

MR. ENSMINGER: Plumes. Plural.

DR. PORTIER: Plumes. Yeah, multiple plumes. And it -- knowing the exact location of the wells did not reflect upon that particular purpose of this particular document.

The second was that we had used all the

information in developing the document and in developing the water model so whether I put that information in this report or not, it did not affect the scientific integrity of our work.

Now the downside of that, I've been told, is that no one can reproduce this work without knowledge of those well locations. So to solve that problem, we have put into place a process whereas anyone wanting to reproduce this can have access to those well locations. We will send them to them under a confidentiality agreement and they are welcome to reproduce our work with all of the information that we have. So there's no restriction there.

In the meantime, we have received FOIA requests on the Chapter B redacted version. That FOIA request now triggers a legal issue that is in the hands of our Office of General Counsel between -- of whether or not we can release the unredacted Chapter B report. We are working with the Department of the Navy to get the necessary documentation, if they do not want us to release that information, but we have yet to resolve that issue.

That basically covers the Chapter B. I'll be happy to answer any questions for you but that's where we stand with Chapter B.

Chapter D is currently in review, on its way. There will be no redactions from Chapter D as far as we know and it should be fine. Thank you very much.

MR. ENSMINGER: So you've adopted EPA and USGS's FOIA policies.

DR. PORTIER: It's not a FOIA policy the USGS and EPA have. It's really just an internal policy, and I suspect that if they were FOIA'd on the issue, that would require them to think long and hard about the policy. They're just using that as a guidance at this point and that's what we are doing as well; we are writing a guidance for ourselves on what type of information we do release about vulnerable assets like water wells.

MR. ENSMINGER: Well, there's only one big difference here between the EPA and the USGS. I do believe that ATSDR was mandated by Congress to do human exposures and health effects at NPL sites.

DR. PORTIER: That is correct.

MR. ENSMINGER: And your mission is different. Your mission affects lives and impacts lives. The EPA and the USGS do, to some degree, but not to the extent that your work does here. And when you got a polluter who's dictating to the investigating body what they can and can't use, the only term I got for that is

bullshit, okay? That's what it is. Now what year was 9/11?

DR. PORTIER: 2001.

MR. ENSMINGER: Okay, now all of a sudden in 2012 the Department of the Navy has concerns about the safety of their people? They want to protect these well sites and locations and, oh, my God, how are we going to mask those hundred-and-some-foot-tall towers? Have y'all developed a cloaking device over there at the Department of the Navy for that?

MS. FORREST: I can't speak to that.

MR. ENSMINGER: I mean, they're big red and white checkered tanks stuck in the middle of barracks and the middle of housing areas. This is bull. You got drinking water supply wells right out along Highway 24, and the only protection around them is a chain-link fence and a locked door (unintelligible). This is nothing more than CYA for the Department of the Navy and the Marine Corps. I'm sick of it. And it's about time somebody that's supposed to be looking out for public health gives a little bit of push-back. That's all we expect. You're serving us. We didn't ask to be poisoned but we were.

MR. PARTAIN: Dr. Portier. In regards to all this scurrying that's been going about redacting and

what have you from -- at the request of the Department of the Navy, I'd like to know, and doing all this both on the website, the reports and what have you, has an investment of time. What effect has this work done on the water modeling, the Chapter B reports and anything that is upcoming for Camp Lejeune? Are we adding more delays to what we -- you know, the answers that we're patiently waiting for? And number two, I want to point out, you know, like Jerry said, about the cloaking device with the red and white checkered towers. Please consider that this is an active military base. I for one, if I was to go to the main gate with malicious desires to the base, I would be stopped and I would be turned around. And if I tried to charge past the main gate, I would be shot because there are armed guards. The base is a military installation. It does not have the free public access for people to go in there unless as a terrorist I went and paradropped in the middle of the night, and I'm quite sure the Marine Corps would see that too. So anyways, what about delays?

DR. PORTIER: So let me assure you there are no -- this causes no delays, certainly that I am aware of. The redactions that we have done, and let me repeat about them, the only thing redacted in Chapter

B's report are the exact locations of active drinking water wells. That's all that was redacted; oh, and pumping station and some other parts of the water system.

MR. ENSMINGER: Yeah, the towers.

DR. PORTIER: That's all that was redacted.

MR. PARTAIN: So all the closed wells, like for example, well 602 --

DR. PORTIER: All the closed wells are there exactly where they are with their exact location. It's only the active drinking wells which have been redacted.

MR. PARTAIN: Let me ask you, has the Marine Corps or the Department of the Navy made any other additional requests about redacting information or preventing ATSDR from releasing documents or what have you in regards to this Chapter --

DR. PORTIER: It's Chapter B.

MR. PARTAIN: Yes.

DR. PORTIER: Not that I'm aware of. There is one particular document which they have it marked, I forget the exact wording on the document, that basically said this is for official use only. In fact I think that’s what it was marked as. And I believe my staff followed up with them. I don't know what the

outcome of that is, whether they would allow us to release it or not. But that was their designation.

MR. PARTAIN: Are you referring to the 1977 (unintelligible) report?

DR. PORTIER: I would have to check with my staff.

MR. ENSMINGER: Correct me if I'm wrong but didn't they classify all of the documents as FOUO now?

DR. PORTIER: Not that I'm aware of.

MR. ENSMINGER: Yeah, they did.

MR. BYRON: What's FOUO?

MR. PARTAIN: For official use only.

MR. ENSMINGER: For official use only.

DR. DAVIS: Is your staff here? You can clarify that.

DR. PORTIER: Morris would be one.

MR. PARTAIN: We'll follow up with Morris after lunch.

MR. ENSMINGER: You take the O's out and it's FU.

MR. PARTAIN: Dr. Portier, I'm, with the --

DR. PORTIER: Let me finish.

MR. PARTAIN: Okay, go ahead.

DR. PORTIER: We have security on the Marine base. We've made this clear in multiple statements to the press and other groups, the security of our Marine

Corps base Camp Lejeune is not our concern; it is the Marines' concern, and we will listen to their concerns and act accordingly. There is a legal requirement for a FOIA request that they must respond to, and that is something they have to do at this point. But as far as the security of that base goes, especially the infrastructure on the base, we will follow their request almost certainly.

MR. BYRON: This is Jeff --

MR. PARTAIN: And to follow up --

MR. BYRON: Go ahead.

MR. PARTAIN: On follow-up on the documents and the FOUO. Is it ATSDR's intention that once these chapters are published and the documents are cited in the chapters, that these documents be published in their entirety for, you know, so people in the public and other people can follow up and research? For example, when the 2007 Tarawa Terrace report was released, there were accompanying DVDs with the CERCLA library and documents supporting the research that you all did.

I am concerned that the opening salvo in this latest game of the Department of the Navy and the Marine Corps concerning the terrorist threat and security concerns, that we're going to start to see

heavy redactions in documents to where they're going to be worthless to myself, Jerry and anyone else that wants to go through and research this, and verify what you guys are finding and what you're saying, and also checking on the conclusions. To me access to that information is critical and it's part of your task as ATSDR to make sure that we understand what happened to us.

MS. BLAKELY: I have a concern too. You say that people will be able to access that information if they sign a form saying they won't share it? Isn't that the main problem of this whole thing, no sharing? Was it hard to find people that would agree to do the study with you? People that are affected? If this information is hard to get to, people won't know about it, just like they still don't know about it.

MR. BYRON: Yeah, this is Jeff Byron. I'll be honest with you, I got a call from a North Carolina news agency, wanting my opinion on the redactions. Well, I didn't give an opinion because I have read about it, you know, I wasn't really up on it. To be honest with you, being a former Marine and my son being a Marine, I think, you know, what's best for the society and culture at hand.

I don't have a problem with the redactions. What

I got a problem with is like in 1983 when the Beirut bombing hit, they locked down my base. They had gate guards at all the base housing. Did they test the water? If they're so concerned about a terrorist threat? Okay? And right after that, one of the -- first off, you may get on base, okay, without being shot because a news agency at the same time packed a van full of cardboard and parked it right in front of headquarters right after that. So I'm not real sure, okay?

But as a Marine, former Marine, what, those former Marines -- but as a, you know, as a father to a Marine, I want the Marines safe. But can you tell me that I'm drinking poisonous water now? I doubt that. And I don't know if I believe it, to be honest with you. It sounds like you're kind of giving away the farm a little here and there.

DR. PORTIER: Well, we --

MR. BYRON: Slowly but surely.

MR. ENSMINGER: We just had a congressional -- several congressional staffs had a meeting with the Office of the Secretary of Defense, his counsel and representatives from Headquarters Marine Corps about this issue. And Senator --

MR. BYRON: Can you tell me when Congress is

going to act? They've known for, let's see now, well, I was there in 2000. What're they waiting on? I guarantee it, y'all really already know half the results. You see the documentation and the data, and I've yet to hear anyone say these kids were exposed and their illnesses are caused by what happened at Camp Lejeune. And I'll tell you I want to hear the results in the next meeting, and I'm probably not going to be very, yeah, I'll hold my tongue 'til the end but I'm going to pretty much bash every department of the government because I -- the judicial branch has done nothing. It basically all boils down to everybody gets a check from Uncle. 'Cause like I'm the skeptic still here. I was a skeptic the day you met me; I'm still the skeptic. And there's reasons, because our families are suffering. There's now a cancer in my family for the first time ever that I know of, okay? I'm not going to say which family member but I'm very upset because you guys are taking seven years of my time up. Twelve years since you notified me. And not one result has come out of this?

And I'll tell you right now, I'm pretty much requesting that the Secretary of Health and Human Services be here at the final meeting as far as these results of these studies, which I hope is the next

meeting. And if she can't make it, by God I can go to Washington so that we can arrange our schedule around hers. Because for somebody to sit up in the Supreme Court for three days and listen to healthcare for the whole nation when 12 million of us here aren't even citizens, okay? Where is she in this situation? Why hasn't she been at this meeting? This is the largest toxic water spill in the nation and by God you know what they say in the Marine Corps? What rolls downhill? Well, I'm at the damn bottom as a victim. And I want to look up and see who's rolling it on me. I'm pretty sure it's the administration, just like every previous administration. But I want her at the meeting if that's at all possible. And if she can't make it, then we adjust our schedule to be in Washington to meet her. But I'd like to hear where it's going from, after this, right from her. What recommendations, if any, will be made to Congress for the help of these kids, and for family members and for the veteran Marines who are sick.

MR. ENSMINGER: Like I was saying, Senator Nelson's representative at this meeting asked a very pointed question of the representative from the I and L, Installations and Logistics, from Headquarters Marine Corps, he's a retired colonel. He said, well,

do you have any contractors working on these water systems down in Camp Lejeune? He said, oh, yeah, yeah, we just got done installing a whole bunch of new pipeline and new valves, the whole works. And he said, well, can you provide me a list of the employees that work for that contractor? No. Have you recovered the blueprints from the contractor who installed all that? No. Come on. These, these concerns are bullshit. I'll say it again, okay?

MR. BYRON: I might as well (indiscernible) this. Here's the other thing I'm worried about that is my concern.

What I see in the studies -- this is Jeff. What I see in -- are we on here?

MR. ENSMINGER: They shut you off.

MR. BYRON: Well, I'll speak loud enough so everyone can hear me.

DR. DAVIS: No, it has to be recorded, Jeff.

MR. BYRON: My other concern in these studies is, is we're studying the land and the water just fine. Okay.

DR. DAVIS: We have, we have a problem --

MR. BYRON: Hold on a minute, I'm talking.

MR. ENSMINGER: Wait, your mike.

DR. DAVIS: We have a problem hearing. That's

what I'm trying to tell you. There's a problem.

MR. ENSMINGER: It won't get recorded.

MR. BYRON: I don't care if this gets recorded or not, personally. What I'm more concerned with is how about the children? I'll be honest with you, you're conducting these, this study for the children in utero how long ago? Where's the follow-up? I don't know of any doctors called my house. I don't know of anybody's requested a physical from my daughters or my grandson or me or my wife, being the exposed personnel that were on base. I mean, even rats get checked after they're exposed to see what illnesses they come down with, don't they?

MR. ENSMINGER: And monkeys.

MR. BYRON: Huh? Well, what's up? All your care about's the land? I know that's all the government cares about 'cause they'll just trash it again later anyway.

DR. PORTIER: So there were a lot of questions in there. Let's hope I can remember them all.

MR. BYRON: Let's start with the Secretary.

DR. PORTIER: Duly noted. I've written down that you'd like to meet with the Secretary of Health. I will pass that on.

MR. BYRON: I'd like her to be at the meeting and

explain where it's going from here.

DR. PORTIER: Well, like, I don't do security phases, I don't schedule for the Secretary, I can't guarantee she will be here but we will ask.

MR. BYRON: Can't even get (unintelligible) here.

DR. PORTIER: Mike, I can't give you a blanket promise that every single document we used to develop the report will be released. I can't do that; that's not possible. Certain of those documents do indeed belong to the Department of Defense or the Department of the Navy or the Marine Corps, and we don't release their documents if they tell us not to. It's just not our responsibility to do that nor do we actually have the authority to do that.

If they refuse to release it themselves or won't let us release it, then the only legal action we have is through FOIA, Freedom of Information Act. And they then have to make a case for why they are not releasing the document. Have I got that right, Deb? Yes, okay.

MR. PARTAIN: Well, Dr. Portier on that note, though, I mean, ATSDR is supposed to be doing a health study for the effects, what happened to us. And you're investigating a national priority listed site, Camp Lejeune. The polluter, the Marine Corps and the

Department of the Navy, holds these documents so they control the information and as you know the axiom, who controls the information controls knowledge and truth. If you're using documents to develop a report, those documents need to be out.

Now, if there's something security-wise, like the Navy's brought up the locations of the towers and active water wells, then redact that information. But the other reports, I mean, I can't understand how you can complete your mission and give the public and the, you know, the families and the service personnel at Camp Lejeune a viable report without providing the documentation to support that report. I mean, that, to me that's not possible. And we saw a good example of that is the 1997 Public Health Assessment that your agency produced. It was a POS. And one of the clear indicators at the beginning was where were the references? They evaporated. So the question I have is, you know, there was a reason why it evaporated. You know, we have our suspicions; of course, there's a different, several different versions from ATSDR why that documentation for that public health assessment went away.

MR. ENSMINGER: Fell off a truck.

MR. PARTAIN: Yeah. My question would be, well,

there's a lot of different ways you can construe that. If you're doing your report and you come across something that the Marine Corps and the Navy does not want to release, we'll just -- we just won't sign it. So that information disappears. We don't know about it. That is why, you know, it's imperative that your agency identify the key documents, site them in the report and get those available to the public, otherwise we're not going to know. And this is not right.

MR. ENSMINGER: Well, while we're discussing this, before you respond to that, the Department of the Navy and the Marine Corps came out with a new version of their question and answer booklet on the 16th of March. Melissa, I'm speaking directly to you. They continue to put out obfuscated information in that question and answer booklet and omissions, big ones. Like the regulations pertaining to drinking water back at the time these, this contamination took place.

I discovered one of your own documents two months ago. It's titled P-5010-5, dated August of 1963, which clearly the Department of the Navy adopted the public health service, service's recommendation for carbon chloroform extract method of testing for total

organics in drinking water. They issued the BUMED instruction the month following the issuance of the NAVMED, which set a limit of 200 parts per billion of total organics in the finished drinking water. That was in 1963, September.

Every one of the chemicals that was discovered in Camp Lejeune's drinking water is an organic substance. Had they been doing those tests like they were required to, they would have discovered this contamination decades earlier.

In 1972, they reissued the BUMED, in December of 1972, 6240.3C, and they lowered the standard from 200 parts per billion to 150. Now, the Department of the Navy's latest stance through their lawyers is, well, just because we can't locate the analytical result sheets for those tests doesn't mean we didn't do them. Give me a break.

In 1980, when they were told that they had these contaminants that were interfering with the THM testing, and they didn't take those wells offline; they didn't even bother testing the wells for five years, that's proof. They weren't doing their ^ testing that they were required to be doing for total organics.

So why is the Secretary of the Navy and the

Commandant of the Marine Corps putting their names on a booklet that's full of lies and omissions? Their coin phrase in there is, there weren't any regulations for TCE, PCE and benzene at that time. No, you have a damn standard for all of them. Don't worry about it. Just write it down and take it back to your superiors and say, hey, we're, you know, this is not true.

MS. FORREST: Can you repeat what you said, it was PE50 or?

MR. ENSMINGER: P-5010-5, dated August of 1963. It's a NAVMED-issued document.

DR. DAVIS: Perhaps, Jerry, if you have a copy you could provide it.

MR. ENSMINGER: Oh, yeah, I would.

DR. DAVIS: They may not be able to find it.

MR. ENSMINGER: These microphones are spotty.

MR. PARTAIN: Now they're cutting out on you. Well, the Navy apparently doesn't understand their own documents because they refer to them as --

MR. ENSMINGER: Mike.

MS. BLAKELY: That's been said off the record. It needs to be on the record.

DR. AKERS: I talk loud enough that I think I can be heard. I want to speak to something Jeff --

MR. STODDARD: Hold, hold on, Paul. Just a

second. Let's get this mike issue fixed.

(pause for microphone repair)

MS. RUCKART: Hey Sandra, can you see us? Are we streaming now?

MR. ENSMINGER: She didn't hear you.

Hey Sandy?

MR. PARTAIN: If we don't have the mikes, she can't hear you.

MS. BRIDGES: Yes, I can -- it's streaming, yes.

MS. RUCKART: Thank you.

MS. BRIDGES: You're welcome, and thank you.

(pause for microphone repair)

MR. STODDARD: Okay, while we're trying to get the mikes fixed, we can use the hand-held mike, pass it around.

DR. AKERS: What I was going to say, I'd like to speak to something Jeff had mentioned. As far as I can tell I'm the only person in this room who was exposed to the contaminants as a child.

MS. BLAKELY: No, I was.

DR. AKERS: We were there for nine years. We played under these infamous water towers. The ground was wet. We played baseball at the other end of Tarawa Terrace, Tarawa Terrace one. We all went to school at one site.

There's only, there are only three cases of cancer in my family: my mother and my sister and myself. They're both deceased, okay? When is bench work going to be done to prove that we were victims of contamination? We do water models, and I appreciate statistics but I want to know when somebody's going to sit down at the bench and do some hard science to determine can these agents cause what we're being diagnosed with. I mean, we can do large trends, of course. I want -- I would like for someone to sit down and say yes, PCE can produce non-Hodgkin's lymphoma. Hard science.

MR. BYRON: Like I say, even the rats get checked once in a while.

DR. PORTIER: All right, so to finish up. So Mike, I really agree with you but just because I philosophically agree with you that all of the information should be put in the public domain for all of the, all of what we do on behalf of the U.S. government and behalf of the people of the United States, I don't control all the rules and I don't control all the regulations. I cannot break law just to make something -- just for my own philosophical satisfaction. We must follow the letter of the law and the letter of the law won't allow me to release

documents that don't belong to my agency. So that -- I can't make you a promise other than to say if we own it, it's going to be out there.

MR. PARTAIN: But doesn't the fact that you're, when you cite these documents, it's part of your report?

DR. PORTIER: Go ahead. I'll repeat the question.

MR. PARTAIN: Because your agency is citing and using these documents as part of your report, in essence they do become part of what ATSDR is doing. Now I understand if you want to talk about legal ownership being for the Marine Corps and the Department of the Navy, but there is also a legal requirement that the Department of the Navy and the Marine Corps release these documents under CERCLA, under the 50-year record retention. So in essence they are a part of the public domain, and your work is part of the public domain and the documents therein cited are public domain.

DR. PORTIER: So if you didn't hear, Mike's question was, since we've cited the documents, doesn't that ultimately fall under public domain on our ownership, and because these are CERCLA records, one of their legal mandates that require these CERCLA

records to be released.

I don't know the answer to the second part about CERCLA records all being able to be released, but the answer to the first question is the same one I've given you before: just because we've cite -- just because we've used it does not put it into the public domain. We can do things under, for our eyes only, and allow us to use some documents. We've done it before in other situations and we will certainly end up doing it again at some point. So that's not a precedent.

MR. PARTAIN: And that would be the same for a private polluter like Monsanto, DuPont?

DR. PORTIER: In fact, one of the first cases I had here was the case of a private polluter who had given us some information confidentially before I came here, and we weren't allowed to release the information, which annoys me to no end. But yes, the answer is that there are cases where they have, the agency has accepted confidential information and not let it go.

Finish quickly with the last few questions and then hopefully I'm done. You asked if the water was safe to drink at this point. By law the Marines have to follow the Safe Drinking Water Act which was

enacted, and they are indeed, like every other municipal water supply in the United States, they must test their water on a routine basis and report those tests to the Environmental Protection Agency, so technically they are as safe as anywhere else in the United States. And I think that covers the questions.

MR. BYRON: Environmental Protection Agency didn't tell me for 15 years. The Environmental Protection Agency didn't tell me about this exposure for 15 years, and I'm supposed to trust them? Who am I supposed to trust? You guys? You're getting a check from Uncle too, okay?

MR. ENSMINGER: Jeff.

MR. BYRON: What? I'll give it to you in a minute. But they knew for 15 years. They knew from, maybe not 15 -- no, North Carolina EPA knew in 1982, according to the record. Where were they? The Marine Corps knew in 1980. They talk about security in the Marines and they just let a half a million of them -- I take that back. They probably didn't know 'til '80. After '80 they knew. They let my family be exposed for no reason at all. I lived on base. They had to be off base. They never stopped it. I don't trust them. I wouldn't trust the government now; I wouldn't trust the Marine Corps and the base water now. If it

was me, there should be some regulations, some laws passed through Congress and your buddies that stop this, and say somebody's going to follow up on this that has no connection to the military, no connection to the government, at every single base. That's the only way it's going to stop.

DR. DAVIS: Jeff and Jerry, you're addressing some issues that have not been resolved really since the beginning of this country. It has to do with what is a trade secret and unfortunately, and I would invite counsel here to clarify this, but it can be a trade secret that what you've done has produced a product that has killed somebody. And settlement agreements are signed with the condition of agreement to secrecy. That's the way our legal system works.

Now my question is whether there's a basis for seeking to override that through, for example, saying that anyone who wants to make a query about these data can sign a nondisclosure agreement, which means that you agree to use the information but not disclose information that would be materially relevant to a business.

But this is a very challenging issue in the law, and it's really become a tremendous barrier to research as well. 'Cause we can't get that

information about what's gone on because it's a, quote, protected trade secret.

MR. PARTAIN: But this is not a trade secret. The Marine Corps was not producing anything. They weren't producing ^. This is not a trade secret.

MR. BYRON: They were producing birth defects.

MR. PARTAIN: Yeah, producing death, mayhem and destruction but...

MR. ENSMINGER: Okay. Let me -- I got a question. The Marine Corps and Department of the Navy love to make the statement that first and foremost let us assure everyone that our drinking water meets all drinking water standards of the day. Hell, that's what they were saying when they were poisoning us. Now, let me ask you this: where are the toxological(sic) profiles on munition contaminants? Those things disappeared in the early 1990s and haven't resurfaced. RDX, HMX, TNT, where are they? Where are the risk assessments for them? They had been published on ATSDR's website for the first year or so and then all of a sudden they just disappeared.

DR. PORTIER: Ed? You're better poised to answer this than I am.

MR. STODDARD: Could you introduce yourself, please?

DR. MURRAY: Ed Murray, ATSDR. I'm the Acting Director for the Division of Toxicology and Human Health Sciences.

We have a toxicological profile that's in the final stages for release on RDX. We also have a toxicological profile on TNT and other things like that, so those documents are out there. And they still are on our website.

DR. PORTIER: And we're just finalizing the (inaudible) which is also used (inaudible).

MR. ENSMINGER: Yeah, I know. And unfortunately we used it first. They did the risk assessments after.

MR. STODDARD: Are there any other questions for clarification or reactions to the redaction issue?

MR. PARTAIN: One other thing. Dr. Portier. Dr. Portier, on, you know, I understand what you're saying with the redactions issue. I'd just like to bring up that one of the researchers working on the reports for Camp Lejeune did put in writing their concerns and their obje -- I would say contradictions to what you were saying as far as the validity of the report, and that brings concern to the community that the very people working on the research are, and one of them has at least put in writing that the

redactions requested by the Marine Corps and the Department of the Navy will affect the validity of the report. Can I have your thoughts on that, please?

DR. PORTIER: Difficult issue to easily explain. That particular writer and I just plain disagree. Scientific integrity of a work has to do with a lot of different issues related to scientific integrity, but one of the key issues is reproducibility. It's not the only issue; it is one of the key issues, however, in the scientific integrity of the report.

There is concern that if you do not have access to the exact location of all the wells at Camp Lejeune, then you cannot reproduce this report. I'm still exploring this a little bit. I'm not actually certain that that's the case. Modeling is my area of expertise, and I'm still having a little bit of trouble trying to understand why that's the case here.

Briefly the idea is that the wells, go down into the water and they have this plume of poison running through the water, and when it hits the well, that's when the well starts pumping parts per billion of bad stuff. So you do have to know the exact location of all the wells that are in the poison -- or in the included area, which is in the report. But the wells that are pumping only clean water, it's still not

clear to me why we have to know the exact location of those wells because I could easily pump clean water from anywhere and that would still satisfy the modeling. So we're still debating the question.

But let's say they're even right. If they're right, that's why we put into place the ability for someone to come in and get all the information so they can reproduce what we do, which keeps the scientific integrity of the report there.

MR. ENSMINGER: Well, I have a question about that policy there that you just spoke of, about people that want access to this thing, you know, they can come in and request this stuff and you will provide them with the -- what was it?

DR. PORTIER: It's basically, oh, sorry. It's basically the same agreement that you signed when you read the report, confidentiality --

MR. ENSMINGER: Well, you know, that doesn't make any damn sense because if I'm a terrorist, I don't give a shit about confidentiality, okay? I'm going to get the information and I'm going to go kill millions of people and then run up to the main gate and let them kill me. I'll blow myself up. Okay? So that doesn't -- that -- holy shit, I mean, I feel like I'm in the *Twilight Zone* here.

DR. PORTIER: The key here is that you have to have a reason for working a report and you have to be qualified to use it to do what you want to do. Those would be checked before you would be given the information in there.

MS. BLAKELY: I have a question. So the only reason people would want this report is to do research? Is that what the ATSDR is supposed to do?

MR. ENSMINGER: That's the peer review.

DR. PORTIER: No, the report is still there. It's the location of the active drinking water wells. That's the only question being addressed. And the active drinking water well locations are something that we will be, we would be willing to share with a researcher who wants to reproduce our results. But they have to be a researcher and they have to have the ability to reproduce the results, so they'd have to have Morris's modeling capabilities. If they don't have those two things, we wouldn't release the report to them because they don't have a need to see the information.

MS. BLAKELY: Well, at the end of all of this, are you going to notify the affected community exactly what they could possibly face or have faced?

DR. PORTIER: Yes, that's what our report's on.

MS. BLAKELY: And it'll be open?

DR. PORTIER: Yes.

MR. ENSMINGER: You know, I really have a hard time understanding the Department of the Navy and Marine Corps' recent concerns about the drinking water all of a sudden. I mean, back in the 1980s when they were told that they were poisoning us, they didn't give a rat's ass. They didn't even test the wells.

So now they don't want anybody else to know where the locations are of their wells and water treatment plants and their hundred-and-some-foot tall red-and-white-checkered water tank. What, they want to reserve the right to poison their own people? They don't want anybody else to do it? They want to keep that right?

MR. STODDARD: Okay, any other questions or reactions to the redaction issue?

(no response)

MR. STODDARD: Okay, we'll close that section of the meeting and move on to the CAP updates.

CAP UPDATES/COMMUNITY CONCERNS

MR. STODDARD: Does anybody from CAP have an update they want to share?

MR. ENSMINGER: I've been traveling all over the United States and even all over the world, really,

with the film, the documentary, *Semper Fi - Always Faithful*.

I've been to Capitol Hill quite a bit. A lot of initiatives taking place on that side of the issue that I can't discuss openly right now but we'll have some information here shortly about an issue up there.

We were at Athens last weekend for a film festival. There was an interview on C-SPAN last night that was done the same week that I testified to the Senate Judiciary Committee. There's recently been a letter put out by the Civil Congressional Offices to the Secretary of Defense, which was signed by both the chairman and ranking member of the Senate Judiciary Committee. Next week I go to North Carolina State University for a screening of the film there. Their university bought, their library bought the film for inclusion into the film li -- or the university library, and I'm going to go up and speak after they screen it. Then that next weekend, the 13th, I got to go to the RiverRun International Film Festival in Winston-Salem for four days, two screenings.

And then the week following -- the weekend after that I go to Bermuda for Bermuda Fest. And they're going to do a screening at the film festival, and then they are going to show the film to all five high

schools that are located on the Bermuda island chain, and they've asked that I -- they twisted my arm and asked me to stay additional days over there to go speak after each screening at the schools. I understand that they cut the F bombs out of the film for the kids so... Kids, they're not going to like the kiddie version but you know.

And then I fly back, straight back to Washington, D.C., from there the film has won a very prestigious award. I can't announce the name of it right now because they haven't made their announcement so, but I get to go give a speech to the National Press Club. And then it just continues on from there.

MR. BYRON: This is Jeff.

DR. DAVIS: What was the letter about? You said the Senate, they signed a letter, what was -- to whom, about what?

MR. ENSMINGER: It was about the FOIA.

DR. DAVIS: And specifically what is -- all right. Can you tell us what the letter says? Do we have a copy of it? Just, I'd be interested to see.

MR. ENSMINGER: Yeah, yeah.

DR. DAVIS: Okay. It's basically asking --

MR. ENSMINGER: It's on our website.

DR. DAVIS: Okay. I haven't seen it, Jerry;

otherwise I wouldn't be asking. Thank you.

MR. BYRON: Yeah, this is Jeff again, so I haven't really been too active lately because I'm getting ready to step back from this thing. And once they give us the results of the mortality study and the in utero study, the small for gestation. I started a business recently and I won't have time to put my efforts towards this as well as the medical issues my family's facing.

But I'd like to see, I might make one last effort, I'd like to see Jerry and Mike possibly go to the International Council on Human Rights and show them the documentary and explain what's going on. Maybe you already have. I'll be honest with you, it doesn't look like we're going to anywhere with this government. Maybe we need somebody else to push on them a little bit. Because I'll be honest, I think I've stressed my disappointment and how this has gone, and I suspect that they're pretty much going to tell you guys that are all still be here (sic) that we're going to do more studies, and that we can't make a determination of why your children are sick or why they're deformed or learning disabled, losing all their teeth, they have cancer, or pass away even.

MR. ENSMINGER: Thank you for your service.

Shit.

MR. BYRON: Probably got a point there. So I'd like to see Congress enact some laws where they can't just say we did the testing and get away with it. So that my son as a Marine or your son as being in the Army, officer, enlisted man, whatever, you know, they can go home at night or go off to combat and know that their family isn't being poisoned while they're left on base waiting for their loved one to come home from combat. So that's my concerns; it's still going on. Thank you.

DR. AKERS: I really haven't been particularly active at this point; I hope to increase my level of activity in the near future. But I have a question to ask Dr. Portier. These documents belong to the Department of the Navy, the U.S. Marine Corps and the Department of Defense, correct?

DR. PORTIER: Some of them.

DR. AKERS: Some of them. I just, philosophically it bothers me that the fox, who was supposed to be guarding the hen house, is doing exactly that. I mean, they're only going to give you what they're willing to let you have; am I incorrect? Or do you have free access to everything?

DR. PORTIER: As I understand the legal issues

involved here, they'd better have given us everything at this point. We have maintained all copies of everything we've gotten from them and we intend to maintain those copies. So we're going to be guarding the henhouse as well. It's just we can't release it to everybody. We can only release it under certain conditions to certain groups, but we will retain every single document that we have.

DR. AKERS: Please correct me if I'm wrong but I'm under the impression that, at least previously, that some documents have been withheld, either intentionally or inadvertently?

DR. PORTIER: I am under that impression as well.

DR. AKERS: I guess it's the fox in the henhouse.

MR. ENSMINGER: Well, you know what? The first thing that's ever said about a community -- the first thing that's ever said about a community that's been poisoned or been exposed at anywhere, the first thing that the investigators and the people doing the studies, the first thing out of their mouth is, well, to gain the trust of the people that were actually affected, we've got to have full transparency. Give me a break. I mean, that was the fist thing that was written on that chart, the first meeting we had. Trust. Confidence. Transparency.

You know, here we are, representatives of the affected community, the CAP, and we are cut out of all of the discussions between ATSDR and Department of the Navy and Marine Corps. We've never been allowed a seat at the table. And we're the ones that have the most to lose.

MR. BYRON: We're at the bottom of the hill, dude. What's wrong with that?

MR. ENSMINGER: I mean, come on. Transparency?

MR. STODDARD: Mike?

MR. PARTAIN: And this is Mike Partain. As an update we're at 77 men with male breast cancer from the base, either as dependents, employees or Marines.

We have two more gentlemen that I am trying to get a hold of. Their sister contacted me after seeing the film, *Semper Fi*. She has breast cancer and her two brothers have breast cancer as well, so they would be 78 and 79 once I've talked to them. They were on the base, their father was a chef, and they resided at the base for about nine, ten years, I want to believe. But I find it very interesting, this'll be the first time I've run across two brothers with male breast cancer exposed as children. So as soon as I find that out, I will update the next CAP meeting on that.

Also as an update with the film, Jerry was

talking about traveling, one thing I want to -- like to point out, and this is, you know, the cancers and the things, the illnesses that we're seeing aren't just in the past. They're ongoing. And a good example is the lady in the film who was speaking in front of the NRC in 2009 and holding up a blue jumper of her dead son --

MR. ENSMINGER: No, sons.

MR. PARTAIN: Dead sons, well it was one son, and then talking about her other son who died shortly after, was recently diagnosed with not one but two different forms of leukemia. And she's in the fight for her life now. So Camp Lejeune in many ways is the gift that just keeps on giving.

Finally touching on, and it just occurred to me when Dr. Akers and Jerry were speaking about the redaction issues and what you said about retaining a library here of it, I'm assuming that ATSDR's been retaining a document library of all unredacted documents from the Marine Corps and the Navy.

One of the things here I'm just rolling around the top of my head, you know, we do have a purpose. We do have a reason. We are representatives of the community, and I think we should be given access under the confidence of that agreement to the complete

unredacted documents if we need them. Like Jerry said, we have never had a seat at the table. I think it's time that we get that seat and we become an active party and participant in this issue, and nothing else is satisfactory.

DR. PORTIER: I'll just, to your last point, Mike, I'll check into it and I'll see if we can do that.

MR. ENSMINGER: Yeah, they won't come to the meetings if we're there.

MR. PARTAIN: Well, they don't come anyway, so.

MS. BLAKELY: Mary Blakely. I've been dealing with my father's death. He died -- he was diagnosed with Agent Orange-related lung cancer in April of last year, and he died on January 5th of this year. And so I've been dealing with that, and I actually brought a couple of my files of the infant deaths and infant death certificates that I scanned from the Jacksonville's Register of Deeds and I wanted to give them to Frank. I have all the years from 1950 through part of 1966, and then I have '78 and '79. I tried to look on the computer but I have a learning disability and memory deficit, and doing those types of things is a great challenge to me, and so I decided just to print them out and so that's what I've done. And if

you would like to have them.

DR. BOVE: Sure.

MS. BLAKELY: And I would, I would really like to hear your opinion.

And I also wanted to state that now my father is buried with my mother on Lejeune, and they both died for this country, and they lie in a graveyard across the street from another graveyard where hundreds of babies lie. When is justice gonna come for us?

DR. CLAPP: I'm Dick Clapp. Hard to follow that. The only things I worked on in the last -- since the last meeting are I attended a class at Princeton University that was organized by the editor of the film, *Semper Fi - Always Faithful*, and in the audience it was a typical powerful showing to his class as well as staff that attended. One of the people that attended was somebody who works at Princeton University but was the mother of a small for gestational age child and one that we know at Camp Lejeune. So it just, again, it sort of brought home the fact that the legacy is still with us.

There's another showing of the film in Boston, in Needham, Massachusetts on Wednesday. I think that Pete Devereaux was one of the male breast cancer patients who actually has been compensated, who was at

Camp Lejeune, is one of the speakers, and I will be answering questions with him on the panel.

And then I'm looking forward to the updates on the health studies, actually. That's perhaps where I can have the most useful input and we're still waiting for that. I'm looking forward to seeing where we're at. I looked at Mary's field deaths and mortality birth (indiscernible) last night and (indiscernible).

DR. DAVIS: And I would just add having looked at Mary's, that one of the things that one should do is that the local funeral home and the registrar of the death certificates should be contacted because -- yes.

MS. BLAKELY: I've spoken with the funeral -- I've actually gone to two graveyards. There's another graveyard where some babies are. And I spoke with the director of the one graveyard, it's Onslow Memorial, I believe. And she's really willing to work with me. I can -- I have access to all of the, all of her records, but the way that they have them set up is they don't have them, the babies, listed as individuals. They have them under their parents. And they have a wall of bios, a room really. And she said you can go through it but I don't know how long it'll take you.

DR. DAVIS: The point is, this could be a natural

project for the interns you're about to bring in 'cause it takes, as you know, a lot of time, a lot of labor to do this, and it's obviously, Mary's put her heart and soul into this, and I'm very impressed, particularly given the disabilities that you have, that you were able to put it together. But it just, as you know, it takes a lot of just shoe leather time. And I know you're about to get a number of really bright -- the best and the brightest of interns coming in here. This might be an appropriate series of projects, including the enumeration of the male breast cancer cases. I know that there's -- we'll talk about that later on today, but there's a tremendous amount of work that has to be done here, and it can't be done just by one person. So it might be a good thing to do, since Jacksonville isn't that far away, one could figure out a way, particularly with electronics, to take advantage of the horsepower that you're going to have.

MR. STODDARD: Devra, did you have any other comments?

DR. DAVIS: I'm sorry?

MR. STODDARD: Do you have any other updates?

DR. DAVIS: No, not really.

MR. STODDARD: Okay.

DR. DAVIS: Nothing that I can talk about right now. Some plans for some ready projects that we're developing.

MR. STODDARD: Okay. Thank you. Sandra, do you have anything?

MS. BRIDGES: Well, I, yeah, I'd like to say I concur with Jeff. I believe that the children are, that were conceived, carried and born at Lejeune, they were naturally, everyone should agree, I think, that they were susceptible and they were affected. Why aren't there studies on those children? If they were conceived at Lejeune, carried and delivered at Lejeune, they were, they got it in every direction. Why aren't there studies on those, the ones that we know have had, that have it? That have the -- received the toxins. And there's no doubt. And especially if they've gone through the hospital and been an inpatient, and they didn't know why at the time. Why aren't those being studied?

MR. BYRON: This is Jeff.

MS. BRIDGES: It results in them.

MR. BYRON: This is Jeff. I'd like to kind of know the same thing. Why isn't there more follow-ups? I mean, there's no way this is over. This won't be over for my family, ever. My grandson can't have

children. Or they're telling him not to 'cause he has a chance of passing on his chromosome deletion. I know there's people in here that probably disagree that that came from the water. You can disagree all you like. I know my family history. I know there's not one single cancer in my family 'til just now. Okay?

MS. BRIDGES: Yeah.

MR. BYRON: I know that nobody has lost all of their teeth in my family until this issue, okay?

MS. BRIDGES: Right.

MR. BYRON: So if you really want to know what's going on, you ask guys like Mike, how's your health?

MS. BRIDGES: Right.

MR. BYRON: You ask Mary how's your health? All these kids who were born under it, and especially the ones you've identified for the study. So that's all I have to say on that.

MR. STODDARD: Thank you. Any other CAP updates?

MS. BRIDGES: Yeah, can we hear a response from anyone on that? Do they think it's a good idea or not?

MR. STODDARD: Frank?

DR. BOVE: We included all the births as well as the parents that were in that earlier survey that were

part of the birth defects of childhood cancer study.

MS. BRIDGES: I never heard of anything, Frank.

DR. BOVE: We included them in the survey, the health survey.

MS. BRIDGES: Yes, but initially. That was ten years ago when they first notified us.

DR. BOVE: No, the current --

MS. BRIDGES: I haven't heard anything else about my particular son.

DR. BOVE: The current health survey went out, was mailed to all the --

MS. BRIDGES: Yeah.

DR. BOVE: -- the people who were part of that earlier survey.

MS. BRIDGES: Right. Not one, not a study has been done.

DR. BOVE: Well, everyone --

MS. BRIDGES: -- of children that were conceived, carried and delivered out there at the base.

MR. ENSMINGER: The study's not done yet.

MS. BRIDGES: Not one has been done on them, and we know they were --

MR. PARTAIN: As Jerry just said the studies are --

MS. BRIDGES: -- contaminated. We know that they

know that it's been contaminated.

MR. PARTAIN: Sandra. What Frank's trying to say is that that's -- the recent health survey is including children, that is not complete. We don't have an answer on it yet.

MR. ENSMINGER: No. The in utero study's still underway too.

MR. PARTAIN: And also the in utero study, which I'm a part of, is not complete as well. But one thing I do want to segue into Sandy's point in question here --

MS. BRIDGES: We're not the only ones. How many more have we heard of, the same thing?

MR. PARTAIN: I'm getting questions and feedback, especially after the showing of *Semper Fi* on national TV.

MS. BRIDGES: Yeah?

MR. PARTAIN: People who have received their health study and health survey were skeptical about it, had reservations because of the natures of the questions and what have you, and they have not turned them in. And that's what this is directed towards, Frank, Sandy.

MS. BRIDGES: Okay.

MR. PARTAIN: Can those people still turn their

surveys in? Can those people still, you know, respond to it? And I mean, it just -- that was a concern that I was getting from several people in emails and phone calls.

MS. BRIDGES: Right.

MS. RUCKART: Well, all of these things that you're talking about are things that we can talk about in depth later when we go into the studies because I do think that we need to move on now.

Let's talk about the male breast cancer. Jerry requested that we do that while we have Dr. Portier here. Eddie Shanley, who's working on male breast cancer, is also present, but all of these issues that you're bringing up, we have some updates later on on our studies, and we can get into that and anything else that comes out of those discussions. We can provide you some information.

MS. BRIDGES: Okay. Thank you.

MR. STODDARD: Okay, we're going to be adjusting the agenda a little bit again. We've moved up the breast cancer study report. First we'll have a presentation on it from Eddie Shanley.

MR. ENSMINGER: Why don't we take our break before he gets into this because we're only five minutes off from that?

DR. DAVIS: Yeah.

MR. SHANLEY: Hello, my name is Eddie Shanley, and I had started work on the male breast cancer --

MR. STODDARD: Hold on a second, Eddie. Dr. Portier, what time do you have to leave?

DR. PORTIER: 11:00.

MR. STODDARD: You have to leave at 11:00?

DR. PORTIER: Yep.

DR. DAVIS: Well, maybe we should return.

MR. STODDARD: Okay, we have a request that we go ahead and take our break.

DR. PORTIER: I'll be back at 1:00 if you want to shift this section to the afternoon.

DR. DAVIS: I think it might -- why don't we start it now? I think we should start it now. If you want to take a five-minute break, ten-minute break, we can start it now. I'm just...

MS. RUCKART: Earlier when we were having the issue with the microphones, I mean, we're still having it, but when we were becoming aware of it, we were told that they could try to fix that during the break but I think we would need more than five minutes, so if we want them to fix the microphones during the break, we should take maybe 15 minutes or we can --

MR. ENSMINGER: Ten. We'll go from right now

'til 25 of, and then --

DR. DAVIS: On that clock.

MR. ENSMINGER: Yeah. And kick off again.

DR. DAVIS: All right, let's give it a try.

MR. STODDARD: Ten minutes?

MR. PARTAIN: Yeah, ten minutes.

MR. STODDARD: Okay, ten-minute break.

MR. ENSMINGER: Okay, techies, let's go.

(Break taken from 10:25 a.m. to 10:38 a.m.)

MR. STODDARD: All right, if everybody can move their chairs, we'll go ahead and get started again. We will continue while the technicians are trying to get these table mikes working again.

(pause)

MR. STODDARD: All right, we'll go ahead and get started now. As I was saying before, we'll have a presentation by Ed Shanley, and then we'll do -- I'd like to do it in a sort of organized format so if we could address questions in three ways: First, ask questions for clarification, so let's keep everybody clear about the facts first; then we'll get your reactions; and then we'll get your suggestions for improvement. Does that make sense to you all? Okay? So Eddie, you have the floor.

MALE BREAST CANCER STUDY

MR. SHANLEY: Thank you. So just to get started, to give you guys a brief overview of where we've been. I know it's been previously mentioned in past meetings about the male breast cancer study. We have been working on utilizing a case control study which --

MR. ENSMINGER: Speak up, Eddie.

MR. SHANLEY: All right.

MR. ENSMINGER: You're a big guy. Come on.

MR. SHANLEY: We've been working on a case control study to identify the association between male -- high risk male breast cancer and exposure to (unintelligible). In order to do that we had to try to identify cases of male breast cancer and in doing so we were looking at using the VA Cancer Registry, it's VACCR for short.

From those numbers, we are going to also pull the controls and being -- cases being those individuals that are identified with male breast cancer. Controls are those individuals that are identified with a cancer that's not related to the VOC exposure, and we have a list of, I have a list here, of the number of those cancers.

We will then look at your exposures based on residence and the water modeling data. And based on that information, then we should be able to determine

if there is an association there. That's in general, the general overview.

We currently have 186 cases of male breast cancer from VACCR. That number is being verified as we speak.

MR. ENSMINGER: 186, what kind of cases?

MR. SHANLEY: Again, unfortunately I don't have access to the data yet. As soon as we --

MR. STODDARD: Are they Marine?

MR. SHANLEY: Yes, sir.

MR. ENSMINGER: A hundred and -- that's what I was getting at. It was 186 Marines, right?

MR. SHANLEY: Yes, sir.

MR. ENSMINGER: Okay.

MR. SHANLEY: So those individuals were identified between 1995, when the VACCR registry began, and December 1st of 2011, when we did our data inquiry. We are trying right now to get an update on those numbers and asking for the clarification shortly.

Based on those numbers, we've been able to do some power calculations to determine that this type of study is actually (inaudible). We've also been working with individuals from within the center to develop the methodology moving forward, to make sure

that we are looking at all the variables and making sure that the study that's being done is a feasible study.

MR. ENSMINGER: It looks like you can use your table mike now. You don't have to hold that thing. Just pull it back to you.

MR. SHANLEY: Sure. So there are some limitations to the cases that we'll be looking at. We will be limiting the cases to those that were born prior to 1969. Given that you were born after that date, you would be 17 years old by 1985 and therefore would most likely not have been exposed if you were an enlisted service member.

Some of the other criteria that we're looking to, or data we're looking to gather is also from the patient treatment files.

The VACCR records, they hold medical information regarding cancer and cancer-related information. There are some different types of diagnoses that are associated with male breast cancer, and we want to make sure that we include those as possible cofounders in the study, and so we're also pulling information from the VA's patient treatment file. And so we're going to be combining multiple sources of data in order to conduct the study.

MR. STODDARD: Are you -- hold on.

MR. ENSMINGER: So you -- you found a hundred -- well, they got 186 Marines identified on their cancer registry for breast cancer?

MR. SHANLEY: Yes. Unfortunately at this time we do not have a clear picture of those cases because we have not been able to access that data but we hope to have that by the end of the month.

MR. ENSMINGER: Well, how long ago were these identified?

MR. SHANLEY: This would have been December of 2011.

MR. ENSMINGER: December.

DR. BOVE: Up to December.

MR. SHANLEY: Up to.

DR. BOVE: Starting in '95 up to 2011.

MR. ENSMINGER: So then what I'm getting at, how long have you had this information? How long did ATSDR have that?

MR. SHANLEY: Well, in December, when we arranged for conference calls with members from the VACCR group and the VA to talk about moving forward, from that point forward.

MR. ENSMINGER: So that was what, four months ago?

MR. SHANLEY: This would have been in -- we had those conference calls in December and in January of this year. We've been moving forward since then.

MS. RUCKART: Eddie, why don't you tell them about the plans to go to NPRC, where other work is needed, why there are some additional steps that we're looking to do.

MR. SHANLEY: Sure, sure.

DR. DAVIS: I have a question, I have a question just to clarify methodology. So the plan is to compare your cancer cases of male breast cancer with other cancer cases. Could you give us your case definition of these other cancer cases as excluding all potential solvent-related cancers and what that category of potential solvent-related cancers will be that you will be excluding in your controls?

DR. BOVE: Yeah, we have a preliminary list of cancers, at least cancers that --

MR. STODDARD: Frank, could you pull the mike to you?

MS. RUCKART: Well, I have the --

DR. BOVE: You have the list?

MS. RUCKART: The list is right here. These are the cancers that we talked about previously. This is not set in stone. We have not actually written the

protocol. Eddie is going to be talking about some work that he needs to do to gather some information so we can make sure this is feasible, this is going to work. So this is what we have identified right now. Like I said, it still needs to be reviewed by our CDC Institutional Review Board. But the cancers that we are targeting at this point that are not related to solvents are mesothelioma, buccal cavity, larynx, pharynx, stomach cancer, melanoma and bone cancer. These are the ones that we have discussed.

DR. DAVIS: I'm very concerned to see you include bone cancer given the data on benzene and multiple myeloma. And leukemias --

MR. BYRON: Yeah, really. My daughter got aplastic anemia.

DR. DAVIS: I think that that should be reconsidered.

DR. BOVE: It's a preliminary list.

DR. DAVIS: Oh, no, that's fine. I'm giving you the feedback that I think you should take it off.

DR. BOVE: Right.

MS. RUCKART: Yeah, like I said, this is just our initial thoughts. We haven't gone through any review process so feedback is welcome.

MR. PARTAIN: Going back to what Jerry was

talking about a few seconds ago, at the last CAP meeting, Frank, you told us that there were 185 men, Marines, with male breast cancer from the base, and that there was another -- no number. Not from the base but Marines, I'm sorry, correct. And then there was another group out there that you were still trying to track down to get a number of what they were and what have you. And correct me if I'm wrong, Jerry, but that was December and you're -- now you're sitting here telling us in April that you still have 185, 186 Marines but you don't know whether they're from Camp Lejeune or not? I'm a little lost. I thought that was being addressed in December, and at the CAP meeting in December you were supposed to be going out to Louisville to get the answer to where these Marines were from. And here we are four months later and nothing's happened. Is that what I'm hearing?

MR. SHANLEY: We've had -- so in regards to the additional cases that were mentioned at the previous meeting in trying to identify, at the time we were told where these unknown cases -- we asked the individuals that are managing the VACCR registry to look into that. They have -- those individuals that are -- that were then classified as unlinked were actually non-veterans that utilized the VA medical

facilities, and so when they were treated at the VA medical facility, they were then captured by the VA Cancer Registry.

MR. ENSMINGER: Non-veterans at VA medical facility? What, what, what's the deal with that?

DR. DICK: I'm by no means an expert on the medical side of VA but I do know from the VA Central Cancer Registry, which Eddie refers to as VACCR, the acronym, the woman who's in charge of that, apparently there are some non-veterans who get cancer care at VA facilities because they're located in areas where, I guess the VA facility has a cancer center or cancer care, but there may not be a non-VA facility, and so apparently, you know, there are a lot of VA medical facilities, you know, over 100, and apparently some of them have agreements to provide some treatment or care for non-veterans. Now I believe some of these may be spouses of veterans but I can't speak to any more specifics than that. But, but that's what we understand there are some actual non-veterans who, by special local agreements, get care at a VA medical facility, and I believe it's a small number but it's still important, as Eddie explained, to exclude those from this, this case study.

MR. ENSMINGER: Well, I understand that this was

not a small number. This was like 30 percent of the breast cancers listed.

MS. RUCKART: Not the breast cancers, overall. We asked the VACCR to give us information on cancers and then to get very specific for the male breast cancer, and then there were about 38, 37 percent of all the cancers in the VACCR that were not linked to branch of service. And initially we thought maybe it was because they just hadn't gotten to linking those yet. There was maybe -- there were newer cases, but in further discussions we found out about this issue of them seeing non-veterans. So it's not 30 percent of the breast cancers.

MR. ENSMINGER: Okay. Okay. But getting back to Mike's point and what I was initially just starting to drill down into, where -- how are you going to verify these cases, that have been identified, the 186 Marines? How are you going to verify that yea, they were at Lejeune or nay, they were never at Lejeune? When's that process going to start, Eddie?

MR. SHANLEY: Well, it has. We are looking right now at using the DMDC data.

MR. ENSMINGER: Uh-huh.

MR. SHANLEY: That's available electronically for individuals from 1975 to current. Our concern is that

for the individuals prior to 1975, in order to access that information we would have to go back and look at the hard copy.

MR. ENSMINGER: Manually.

MR. SHANLEY: Manually. In order to access that information we want to make sure that we have all the other pieces lined up. So that way when we go down and start doing these manual searches, we make sure that we gather all the information that we're needing to gather and we're looking at the data that we requested. So these hard copy data, there's, the way I'm told, is that there is a number of different shoeboxes of paperwork that you can request, and so the, if you're requesting the medical files or the personnel files and so forth, those all need to be cleared. And so that's the process we are working in now and hope to have that done -- or will have that done by the, probably the middle of this month.

MR. ENSMINGER: Who's helping you with this? Perri.

MR. SHANLEY: Frank and Perri are assisting me. But they both are really busy.

MR. ENSMINGER: I mean, are you working directly under them?

MR. SHANLEY: Yes. And for Steve Dearwent as

well.

DR. DAVIS: Again, what about the interns? You need -- you could use a lot of help here. This is a big, big job, really. And so I hope you're planning to capture some of those interns.

DR. BOVE: Yeah, I mean, we're talking about interns, we're talking possibly about students from the University of Georgia. We're also discussing whether to get -- if the records in St. Louis are good, to get it for everyone, not just for those who started before '75, as a check on the DMDC data that we have. 'Cause we're basing the mortality study, even the health survey was based on the DMDC data, and the notification was based on the DMDC data. And it would be good to see how good that data is with some independent objective records.

MR. ENSMINGER: So when are we going to start seeing some movement, Eddie? Some numbers?

MR. STODDARD: Could you be more specific, moving on?

MR. ENSMINGER: Well, these 186 breast cancer cases that have been identified as Marines. I want to start seeing some numbers. How many of them were at Camp Lejeune? What years were they there? What units did they serve with? You know, I mean, I can sit here

and somebody can spout me off a unit that they served with, their company and their battalion and their regiment, and I can tell you where they were at at Camp Lejeune. I mean, but, you know, I want to know when we're going to start seeing some of these numbers. Have you run this stuff through the DMDC, these 186 names?

MR. SHANLEY: We don't --

MR. ENSMINGER: Huh?

MR. SHANLEY: No, sir. We don't have that data yet.

MR. ENSMINGER: What data?

MR. SHANLEY: The 186 from the cancer registry.

MR. ENSMINGER: Where in the hell is it?

MR. SHANLEY: We are, in order for, in order for us to access that data requires our protocols to all be in place, and that's currently what I'm working on. And right now they are ready to go, they simply (unintelligible). That's what I've been working on.

DR. BOVE: What we have to do is find out how good this data is in St. Louis. Once we find out how good that data is in St. Louis, which means taking a field trip there and spending a day or two going through the records and seeing how good they are, then we write the protocol immediately and submit it to our

IRB and to the VA's IRB, and go from there. We have to go through certain hoops with any cancer registry and that's the hoop that they have for us.

MR. ENSMINGER: So now you're just waiting to make a trip?

DR. BOVE: We need to make the trip to see if, just what kind of data we have in St. Louis, yes.

MS. RUCKART: The one thing Frank said that we would start the protocol, we have the protocol well underway just pending this missing piece, when we find out how good the data are in hard copy. So we are well far along in that process.

MR. ENSMINGER: What do you need, money for bus fare or what?

MR. PARTAIN: This is what was told to us in December and my point. You guys said you were going, and here we are in April and no one's gone, and we're being told someone's going to go. Now we're going to hear at the next CAP meeting, oh, well, yeah, we didn’t have money for bus fare, like Jerry pointed out?

And also, going back to your protocols and stuff, are we looking at just male breast cancer or are we also including breast tumors, 'cause there are a lot of reports of, you know, men with breast tumors, and

growing tumors.

DR. BOVE: What's in the VA Cancer Registry.

MR. PARTAIN: Okay, I mean, would that capture breast tumors as well, as far as the cancer, like a precancerous tumor? And then second --

DR. BOVE: No, this is the only, no, we also have a survey. We were trying a number of approaches to get at this issue. One was using the VA data 'cause it's there. And the other is using the health survey.

MS. RUCKART: And the mortality study.

DR. BOVE: The mortality study, unfortunately, there are so few male breast cancer deaths. This is a young --

MR. PARTAIN: You don't need breasts to survive.

DR. BOVE: Right. So --

MR. PARTAIN: It's typically not fatal.

DR. BOVE: Right. That's right. And so the mortality study's not as useful for this purpose. The only things that are useful are the VA data right now and the health survey. If we wanted to explore, and we discussed this in the past and maybe we'll discuss it in the future, some other approach that may involve other state cancer registries, then we can explore that. But let's see if we can use the VA data first and see if it can answer this question.

MR. PARTAIN: Also another thing, a number of the men on the list that I've accumulated over the past five years now have VA claims and at least four of them that I know have been awarded VA benefits for male breast cancer, and there have been -- several have been denied, which we'll talk about when we get to the VA. But as a check on what you're doing and the numbers you're getting, I would like to get those things to you so you can make sure that what you're capturing from the VA, that they're represented as well.

MS. RUCKART: Were they treated at VA?

MR. PARTAIN: Yes, they were treated at -- some of them were treated at VA facilities.

MR. ENSMINGER: Only about seven out of the 70-something that Mike and them had found. Only about seven would be on the VA roll.

DR. BOVE: We're limiting it to the VA Cancer Registry, so they wouldn't be in there if they weren't --

MR. PARTAIN: But if they're actively treating, I know some of them were treating through a VA facility; I want to make sure they're captured, and it's a way to check and make sure you're getting your data too.

MR. STODDARD: Okay. Devra?

DR. DAVIS: I want to make sure I just understand what you're saying, so forgive me. Seven of the cases, Mike, that are in your database are going to be in the VA database, only seven out of 70 --

MR. ENSMINGER: That's what they should be.

MR. PARTAIN: Well, we think so. I mean, like I said --

DR. DAVIS: Okay.

MR. PARTAIN: -- a lot of the veterans have reported, you know, that they've turned in VA claims. But from what I understand from what Frank's saying, that they would only be captured in the VA Cancer Registry if they were actively treating at a VA facility.

DR. DAVIS: So that means --

MR. PARTAIN: So not all the guys on the list are actively treating on -- at VA facilities.

MR. ENSMINGER: And you got dependents in there too.

DR. DAVIS: Okay, so that means that we are talking potentially, --

MR. STODDARD: Would you turn your mike on?

DR. DAVIS: I'm sorry. That means we are potentially talking about your 75-plus --

MR. ENSMINGER: Seventy-eight.

DR. DAVIS: Seventy-eight plus the one, the 170 --

MR. ENSMINGER: 186.

DR. DAVIS: 186 that you've identified and there's only overlapping of 70? So that's a lot of male breast cancer.

DR. BOVE: Right. Yeah, and this is the problem we had -- this is the problem with using VA data. I mean, it's good data but VA doesn't serve that many of the veteran population.

MS. RUCKART: But it's not, plus we're not overlapping very completely with Mike's data because Mike's data is among people who were not eligible to be served by the VA, the dependents and also civilian employees so it's kind of like two different groups. The VACCR's just the former active duty and then Mike has --

MR. ENSMINGER: But it still doesn't matter. There's still individual cases of male breast cancer. The only thing is, only seven of those cases that Mike has found will show up on the VA's records, on their cancer registry, and out of the 186 that the VA has identified on their cancer registry, not all of those people would have been at Camp Lejeune now. I mean, we gotta -- we've got to verify whether or not they've

been at Lejeune and what units they would have served in and what, what their exposures would have been and when, okay? I mean, to go along with the water model. Okay? So you're looking at -- I can guarantee you out of the 186 people on the VA's records, these Marines, I'll bet you 75 percent or more of them served at Camp Lejeune.

DR. DAVIS: Well, you know, that's the good thing about data you can actually -- you don't have to vet, we need to get the data so the next and final question is, who is the VA epidemiologist with whom you're collaborating 'cause they do have epidemiologists there, and I think that, again, as someone who used to direct research programs at the National Academy of Sciences and the universities, you need more horses. I mean, I don't need to tell you that. I'm just saying my advice to ATSDR is that you get more horses here and get them assigned to you through FTEs assigned from DOD, DOE, VA, et cetera; that there ought to be an interagency team of epidemiologists all of whom are working on this, not just that we sit here and point at you guys. Because the more people you can assign to this, the faster you can get this done. I would guess it's -- you're going to be lucky to do four cases a day once you get ready to go. And if

it's only one person doing it and you guys presumably, I know you have other work to do. So is this your full-time and the only thing you're working on?

MR. SHANLEY: No.

DR. DAVIS: It's not. Okay. So you don't even -- so what's your FTE assigned to this task?

MR. SHANLEY: It is my priority.

DR. DAVIS: I understand that but I mean how -- what's the total number, I'm asking. What's the total FTE in the budget, perhaps this is an appropriations issue and you need more money appropriated to this, and maybe that's something the friends up on the Hill could address.

MR. ENSMINGER: Well, I --

DR. DAVIS: You know, you can't, you can't do this if you don't --

MR. ENSMINGER: How did you get appointed this? This is your Ph.D., right?

MR. SHANLEY: Correct. Correct.

MR. ENSMINGER: Okay, so who assigned you this?

MR. SHANLEY: This was a collaborative decision that we made -- that I made with ATSDR leadership, with Frank and Perri, with Tom Sinks.

MR. ENSMINGER: Sinks.

DR. DAVIS: And I'm just saying you need more

resources. Okay? And you need them committed because it really, you know, it takes time and money and people. And so I don't want to -- I'm not trying to be -- I'm trying to create a situation where you get more resources, and my advice, which I hope the CAP would share, Jerry, is that they don't have -- they need more resources and people whose responsibility it is so that the next CAP meeting we say well, where's the results.

MR. ENSMINGER: I don't know anything about the funding of this. I don't even know how the hell this came about. I mean, it's a mystery to me, I mean, I know Eddie's working on his Ph.D.

DR. DAVIS: With all due respect, one Ph.D. dissertation, that's important for you, but the reality is this is a lot of work. This is a tremendous quantity of work.

MR. ENSMINGER: Where's the funding coming from?

DR. DAVIS: And you might need more funding and more resources committed, and it might be the role of the CAP to advise you to get that. So can you please clarify what the funding is for this?

DR. BOVE: Well, first of all, let me backtrack a little bit, the amount of work that it would entail. The major part of the work is going to St. Louis and

going through --

MR. ENSMINGER: Sounds like he's getting there.

DR. BOVE: 180-some or maybe more male breast cancer victims and we're using four times as many controls. So that's another 800 in that set. So we're talking close to a thousand people that we need to get hard copy records from St. Louis on. So that's the key piece and also the labor intensive piece. Okay?

So as I said, we were exploring using students and interns and whatever else we can do to do that. If it turns out that we need to have more resources than that, then that's something that we can pursue within the Navy, like any other project, okay.

And so the good news is that the cancers are verified, so that's not a big issue. The other data's electronic, the cancer registry data's electronic, the patient treatment file's electronic, the DMDC data is electronic, the housing records at Lejeune are electronic, with some difficulty and some problems, but that's electronic too. So that part is a lot easier, okay. We're, Perri and I are committed to help Eddie as much as possible on this project given the fact that we have the other studies we're analyzing as well. But we will help Eddie and we'll

have to see just how much additional resources we'll need. Okay.

MS. RUCKART: Well, every year around this time, we begin to think about budgeting for the next fiscal year, and that process is about to start and once we hear more about what Eddie finds when he looks at the hard copy records, that'll inform us as to what kind of resources we need and then we can put it in our, it's called the Annual Plan of Work, the APOW, and then we can present that to the DOD and request funds. So we just need this information to decide what we need to have to ask for.

DR. BOVE: Okay, if the hard copy records turn out not to be useful, then we'll have to rethink what we're going to do.

DR. AKERS: From a personal standpoint, I just received a letter from a lady at the Bureau of Personnel, the records in St. Louis?

DR. BOVE: Mm-hmm.

DR. AKERS: She proceeded to tell me she couldn't find the records of my father at the Portsmouth Naval Hospital. He passed away at Portsmouth Naval Hospital; I know he was there. So the records are not complete.

DR. BOVE: We know that. That's exactly why we

have to go down there and see what we have. Even for the people who have records, we want to see exactly what's in that shoebox.

DR. AKERS: I mean, she was supposed to be onsite and couldn't find any record of him having been in Portsmouth.

DR. BOVE: Right, but studies have been done using these records. Gulf War studies have been done, Agent Orange studies have been done using these records, okay. We just have to see what we have here.

MR. STODDARD: Can we take a brief minute and let Dr. Portier speak before he has to leave.

DR. PORTIER: Yes, I do have to run. You got my attention. We don't have to wait for the Navy to add resources. If this needs more resources, I'll make sure it gets it. Thanks.

MR. ENSMINGER: If you're going for a lunch meeting with Dr. Frieden, why don’t you take me along? I'd like to meet him.

DR. PORTIER: It's not one of those, Jerry.

MR. ENSMINGER: Oh.

DR. PORTIER: This one you don't want to be at.

MR. ENSMINGER: Oh, yeah I would.

MR. PARTAIN: Going back to your work here and your study, one of the early methods of looking at NPL

sites was identification of -- or the identification and realization that there were people, groups of people, reporting similar cancers, and, you know, one thing I do want to point out with the male breast cancer issue, it's not the only cancer and we all recognize that. I know it's getting a lot of attention because it's so unusual. At one point female breast cancer was unusual. At one point, you know, leukemia was unusual, and as you hear about it in the media, you come to be desensitized to it and oh, well, it's increasing now. Well, male breast cancer is in that opening phases where it is extremely unusual, and especially in younger men, and we're seeing it in Lejeune in young, you know, as young as 18 years old.

And I was one -- you know, the term that was generated to describe these unusual cancer incidences was a cluster. Now that has become a boogeyman word and no one wants to talk, oh, this cluster here, and we've heard it and, you know, the media (unintelligible) it had been recognized as a cluster. My question to you, Frank, is, at what point does the occurrence and the -- I mean, as far as I'm aware of, this is the largest single collection of male breast cancer that has ever been identified. But no one has

used the word cluster to term and define that. What is the ATSDR calling us?

DR. BOVE: Well, in an interview with CNN, I called it a potential cluster that needed to be investigated, and that's exactly what we're doing. So we're taking it seriously as a potential cluster. And if the state health departments see a potential cluster or even identify a cluster, we would hope the next step they would take is to actually take it seriously and investigate it, so we're trying to do that.

We had several different ideas about how we would approach it, so we've been taking it seriously all along. We really recognize the work you did and have been trying to come up with something that makes sense here. And we pursued a couple of ideas, and we presented them to you at a couple of CAP meetings before.

And I mean, the best way to investigate this issue would be to use all 50 state cancer registries, and I brought that up several times. It's never been done. It would be useful, not only for male breast cancer but for all the other cancers that we're interested in as well. Okay. So that's something, you know, again, never been done, a lot of

difficulties, maybe someday we can discuss that more seriously once we get the rest of our work done.

Other approaches were to try to figure out what the denominator is. In order to figure out what a cluster is, you have to know what the denominator is. What was thrown out to the media was that there was a lifetime male breast cancer risk and someone, I won't say who, said well, there are about 400,000 men or whatever number they came up with, and therefore you would expect, I don't know how many, male breast cancers were expected. And of course that's inappropriate, and we said so.

MR. ENSMINGER: That was the Marine Corps trying to cover their ass.

DR. BOVE: Right.

MR. PARTAIN: Yeah, and that's the thing here --

DR. BOVE: So, so so, so --

MR. PARTAIN: Okay.

DR. BOVE: Okay, the proper way to do this, this is what the cancer registries do, they have a denominator. The denominator is the population in a town, a county, census track, with an age and sex distribution, a race distribution, to actually calculate what you'd expect, based on that, and they calculate whether there is a cluster.

We don't have a denominator. I don't know but we can come up with assumptions about what the age, race, sex distribution is among the males, veterans or males, any or any male who walked on that base during a certain time period. We have to make various assumptions 'cause we have no data, okay? And I don't want to play that game because I can make assumptions either way and make that cluster disappear or appear. So I don't want to go there.

All I wanted to say and what I said to the media was, that it’s a potential cluster that needs to be investigated. We're going to try to investigate it with whatever data we have available. So that's what we're doing with the VA. We used to -- we saw the VA data as an opportunity to pursue it, and we saw two articles, which we gave to you when the VA had looked at male breast cancer and we were tearing our hair out that they hadn't looked at service in either study, and we wanted to follow that up with trying to look at service, and then beyond that, using the information we have on exposure again.

So that's, I don't know if that answers your question, but that's -- so I consider it like any other cluster, something that needs to be investigate -- or even a potential cluster, that

something that needs to be investigated with any data you have at your hand, at hand to answer your question.

MR. PARTAIN: And going back to the email you mentioned, the email was sent after I testified to the Senate Veterans' Affairs Committee in October 2009, and it was sent to CNN by Major Eric Dent from Marine Corps Public Affairs. And in that email he said that, you know, according to the occurrence rate they have, there should be 400 cases of male breast cancer at Camp Lejeune based on our number of 400,000 men. Okay, and I understand and respect your point that you don't have a denominator. I -- and just like Representative Stupak in the hearing, I have a hard time believing the Marine Corps can't tell you and us how many men went through the gates at Camp Lejeune.

DR. BOVE: They can't.

MR. PARTAIN: Okay, I mean, they may have a hard time doing that with the dependents but here, we're doing with service men. And you got muster rolls, I mean if you go back and you look at history, and my degree's in history, you go back and when you're doing research on battles and you're doing research on engagements and everything, they can go back and look at the muster rolls, find the pay, you know, that's

usually how you track people, how they're paid, you keep records of that, and you can establish head counts and how many people participated in battles that occurred 150 years ago or 200 years ago. But yet we can't pull a number out of our, you know, out of the records of the Marine Corps that give a denominator of how many men were exposed? You know, in Jerry's illustrious words this morning, that's bullshit.

And an email from Major Dent? That is a violation of the public trust. The Marine Corps took it upon themselves to do your job and try to diffuse an issue that's coming up because one of the things they keep saying over and over in the media is oh, there is no scientific link to anything that may have affected our Marine family, but yet when issues come up, such as this male breast cancer issue, which is an unusual cancer, and it is in my opinion a cluster, they do everything to diffuse it including pulling numbers out of their butt and saying this is what happened.

DR. BOVE: All right. Well, first of all, we did challenge that number, okay, that they put out. The number, that 400,000, is a seat of the pants number. I know it is because I did a similar exercise several

years ago and stated that anywhere from 500,000 to a million might have been exposed to Camp Lejeune, and that got picked up by the media and it said that it was up to a million. And I basically just looked at the DMDC data from '75 to '85 that we had, and projected back. As simple as that. That's what I did, okay. A couple of years later the Marine Corps tried their own exercise on this, they had one or two other different sources but really they didn't have any hard data either, and they came up with the same figures again. Okay, so that's, that's where that 400,000 men come from.

MS. RUCKART: Those numbers include women? The total number?

DR. BOVE: The final number, to me, includes anybody.

MR. PARTAIN: Yeah, dependents and Marine.

DR. BOVE: The 400,000 males is another estimate, again, based on what I just told you, DMDC data and maybe some other information they had on school records, just a general number of people going through the schools and stuff, okay?

MR. PARTAIN: But we can agree that was irresponsible of the Marine Corps to do that?

DR. BOVE: We said that it was an inappropriate

number because just what I said, it's a lifetime risk and we're nowhere near the lifetime of these people. This is a very young cohort -- and that's why we're, you know, the mortality study, for example, would have to be revisited because it's a young cohort; they're younger than me. Okay.

MR. PARTAIN: Well, the occurrence rate is actually, I mean, what they're quoting is a (unintelligible) percent chance of risk of --

MR. STODDARD: Mike, Mike, your mike's not on.

DR. BOVE: But let me continue.

MR. PARTAIN: But I mean, going back to the point that was -- it's one in 100,000, not one in one thousand. They're two different risk factors.

DR. BOVE: Let me address that, too. Okay? I think I've said to you before, the one in 100,000 is an average, okay, over all age groups. Okay? All right? And it's similar to taking an average of people who are seven feet tall and people who are four feet tall and coming up with this is the average. I mean it's meaningless because there's a big group and a small group and an average doesn't really capture what's going on there.

Similarly here, you have, for people under 35, okay, the rate is one per million, not one per

100,000, okay. So it's ten times less -- no, ten times more -- yeah, ten times less. And it slowly goes up in each age group until you get to one per 100,000, which is in the 45 to 54 age group, roughly, okay.

So if you're going to do this right, you have to know the age distribution of the people you're talking about. You need to be able to figure out how much person time, we call it, they spend in each in these age groups to figure out what the expected is. And we don't have that information. That's how you do it right. That's what cancer registries do, okay?

DR. DAVIS: Just a point of clarification, 'cause I think this is an important point, Frank, and I just want to say I appreciate that it's difficult for one agency to comment critically about another, and the fact that you called out the Marine Corps when they issued the statement was a good thing.

The reality is that we don't have the information that we need about how much life years each different group's spent. But my recollection is that the average age of diagnosis for male breast cancer is in the 50s so that, you know, your average case is supposed to be in their 50s, and there's many young cases, another way to look at this cohort. And I

think it may be a cohort, by the way, would be to ask what's the average age of diagnosis, and that might be a very simple thing for you to determine very quickly. That would, you know, once you start your spreadsheet, just what's the average age. If you're average age of your diagnosis of these Marines that are all in the VA system happens to be even 45, that's going to give you a big clue 'cause I think --

DR. BOVE: But by the time we do that --

DR. DAVIS: Yeah?

DR. BOVE: We're already way beyond just determining whether there is a cluster, and we're on the road to determining whether the water contamination can explain the cluster, and that's really where we want to get. The idea that we want to say there's a cluster doesn't tell you much. You still don't know why, right?

MR. ENSMINGER: Hell, I know why.

DR. BOVE: It could be chance, there could be other reasons. You don't know why. The -- what we want to --

MR. ENSMINGER: We do.

DR. BOVE: What we want to get to, what we want to get to though, is why. We want to try to answer that question, and that's what we are going to try to

do with using the VA data. There are limitations to the VA data. They don't serve most of the veterans, that's one limitation. Although there are enough cancer cases here to have pretty good --

MR. ENSMINGER: Cohort.

DR. BOVE: -- statistical power, okay. So it's not that bad. The only question we have in our minds right now, and again we won't know 'til we have the data, is how many of these male breast cancers occurred to people who would have been at Lejeune or some other Marine base after the contamination occurred for example. So they wouldn't be exposed. We don't know the answer to that question. We'll find out when we get the data, okay?

So that -- my guess is that most of these cancers will be of people who were of the proper age, so that they would have been at Camp Lejeune, if they were at Camp Lejeune, during the time the water was contaminated so that's -- but until we see the data we won't know. But I do think that -- we can go through this exercise of trying to determine whether it's a cluster or not, but I think at the end of the day we really should move quickly beyond that to determine what the answer is, at least what the VA data tells us the answer is. That's what we're trying to do.

MR. STODDARD: Any other questions for clarification on this study?

MR. PARTAIN: So next CAP meeting we'll have some numbers?

DR. BOVE: It's a priority to this agency.

MR. PARTAIN: Once again, I can't stress enough that I mean, we do hear a lot of women with breast cancer and other cancers and, correct me if I'm wrong but my, you know, yes, we are focusing with that study with male breast cancer, being the importance of it is that it's unusual and if there is a link and there is acknowledgment of that link, then the other questioning goes what about these other cancers we're seeing: the leukemias, the non-Hodgkin's lymphomas, liver cancers, the kidney cancers, the bladder cancers, the Parkinson's disease, all these other diseases we're seeing. 'Cause that is -- seems to be the critical link, and the Marine Corps likes to dance on that and say, well, science hasn't given us an answer yet.

DR. BOVE: Yeah, well, some of these we can answer with the mortality study actually, okay? We're hoping with the survey we can answer some of these questions, too.

Female breast cancer, the problem here is that

there are a large number in the VA Cancer Registry, and even if we did a one-to-one comparison between cases and controls, instead of four to one we're talking with male breast cancer, that increases the work load enormously.

MS. RUCKART: Well, Frank, there's another piece there with a lot of those women, they probably were there after '85. We don't know how many women would be there for --

DR. BOVE: My guess would be that there -- even if you cut those out, the workload would be immense. Right now, as Devra's pointed out, that there are -- there is a huge workload just to get the male breast cancer thing answered. My own feeling is that I'd like to look at female breast cancer the same way. But let's do the male breast cancer study first and see if we -- see what kinds of resources it needed because there's going to be more for female breast cancer if we use the same data. And also see if we can answer that question as well with the survey because there will be more female breast cancers than male breast cancers, a lot more, in the survey, we think. We haven't had a chance to look at the data yet on that.

We have to, you know, there's no -- I mean, for

scientific reasons it makes sense for the female breast cancer. There's a Cape Cod study that found an association. There are some -- a lot of similarities between male and female breast cancer in terms of epidemiology. It does come down to some extent to resources in being able to look at female breast cancer the same we were looking at male breast cancers in the VA data. I'm being honest with you.

So but I do think -- let us try to finish looking at the male breast cancer and answer that question, and then we may want to pursue not only female breast cancers but other cancers, you know, using the VA data or some other approach. Based on what we see in the mortality study and also the survey.

MS. RUCKART: But looking at the DMDC data weren't there only about 8,000 women?

MR. ENSMINGER: Oh, yeah.

DR. BOVE: Seventy-five to 85.

MS. RUCKART: Right.

MR. ENSMINGER: Well, I mean, back in those years there were much, there were much fewer women in the service, especially in the Marine Corps.

DR. BOVE: Sure. So we don't, so for scientific reasons I would like to look at female breast cancer right now but our focus is on working on the male

breast cancer.

MR. STODDARD: Devra?

DR. DAVIS: When will we be able to see your protocol?

DR. BOVE: Well, we, before -- we have to have everything, peer reviewed, including our protocols.

DR. DAVIS: Well, are we part of that process?

DR. BOVE: Well, we have a process, we have a process that our office of science --

DR. DAVIS: An internal, an internal review? You have an internal review and then I assume you have external reviewers?

DR. BOVE: Yeah, actually I'm not sure about the internal review because I'm not sure we do that with protocols, in terms of -- we have this new thing now that was set up where a lot of our reports are reviewed in a complicated internal process. I don't think we do that with our protocol. We have the usual internal process, and then we have -- sit down for an independent external review for protocols. All our protocols in the health studies are done that way. And so after -- after that, I think --

MS. RUCKART: Previously the protocols that go out for peer review before it even started the clearance process here it would go to three to five

peer reviewers, you know, selected by the office of science, then we address their concerns, and we have to provide a written response, and then we submit it for the internal clearance here with the peer reviewers' comments and our responses.

DR. DAVIS: Well, I'm going to volunteer Dick Clapp and me to be part of your external peer review on behalf of the CAP to maybe speed it along so we don't have -- 'cause I think the CAP's going to want to see it and if we function as external peer reviewers and as epidemiologists, that might help.

DR. BOVE: Sure. And we're telling you quite a bit about what's in the protocol already.

DR. DAVIS: Yes.

DR. BOVE: And I have no problem with sharing that with you. So, yeah, and we can work that out so that you can be part of the peer review process. It won't speed it along because we still have other -- we have to have other peer reviewers as well but it'll be -- it won't be impeded by your volunteering and there's no reason --

DR. DAVIS: It might help the CAP.

DR. BOVE: Yeah, so we'll, we'll make that suggestion to our office of science, all right, and again, we have to go through IRB approval as well and

the VA will have some input as well, I'm sure.

MS. RUCKART: Right, the IRB approval comes, you know, after.

DR. BOVE: We'll work it out. We'll try to do this as quickly as possible, try to do things as parallel as possible.

MR. BYRON: Okay, this is Jeff. Are we -- 1:00 update? 'Cause that's where male breast cancer --

DR. BOVE: Yeah, we moved it up.

MR. STODDARD: We moved it up.

MR. BYRON: Okay. Well, --

DR. BOVE: We moved it up because Morris's plane got in.

MR. STODDARD: Just the breast cancer.

MR. BYRON: So I got a question for you, okay? Mike found the male breast cancer. What have you found other than male breast cancer? I mean, information's coming in. Let's hear an update on that. Are you seeing an increase in kidney cancers? Are you seeing an increase in people that are losing their teeth? Are you seeing an increase in aplastic anemias? What, I want to hear the data.

MR. STODDARD: Can we hold that off 'til we get to the health studies?

MS. RUCKART: Yeah, I was going to say one thing. First of all, I don't think we need to do the recap because I think we're past that point and so we can take that out. I handed out the sheet about what we discussed last time. We're building upon that now; I don't think we should revisit it, but do we want to go to the VA? I don't know if -- do you guys have flights you need to catch?

MR. BYRON: I don't want to go to the VA. I want to know what you're finding in the health survey.

MS. RUCKART: Well, I would -- we can discuss this in a minute. I would like to find out if our VA representatives need to leave, if we need to work them in before they have a flight.

MR. STODDARD: Okay, so we're done with the breast cancer study questions and suggestions?

MS. RUCKART: They're telling me that they're indicating that they will be here, we can go into the updates now, if that's what everyone was wanting.

MR. STODDARD: Okay. Thank you, Eddie. All right, so we're moving to the -- we're skipping the update of the last meeting -- the recap of the last meeting and we're moving to the VA commentary. No?

MS. RUCKART: No. No, no. We're going to just continue on with updating on our health studies and

then we can go to the VA after lunch because they don't need to leave right away, so.

MR. STODDARD: Okay. Okay.

MR. ENSMINGER: Yeah, they want to stay down here and play golf.

MR. STODDARD: So given the order we've got, we're moving on with the health studies, the mortality study first.

UPDATES ON HEALTH STUDIES

MORTALITY STUDY

MS. RUCKART: Okay, so I want to let everybody know, I think we discussed this before but I just want to remind you all of our work needs to be peer reviewed. Once we actually have results and we write reports, that needs to go through a peer review process and approval process. We cannot share any very specific results until those processes are complete so everything that I'm going to, and Frank will discuss with you today is more general and in the aggregate, so unfortunately a lot of the answers that you want, we cannot give you today. We can just let you know where we are in the process and some more initial data.

So as we have discussed with you in our mortality study, we had, we're looking at the Marines and

sailors who were at Lejeune between the second quarter of 1975 and the end of 1985, that was based on the available data that we had electronically, and for the active duty cohorts for the Camp Lejeune and Camp Pendleton, there were 18,818 deaths. That's among 323,222 Marines and sailors from both bases. And it's approximately similar numbers between each base so you can basically say 50 percent of the 323,000 were at Lejeune or at Pendleton.

Now of these deaths, there were 2,180 people with the cancer that was the underlying cause of death, and when you include underlying or contributing cause of death, that turned out to be 2,317. And there were 16,638 deaths where they had other diseases besides cancer as the underlying cause. These deaths are coded based on the National Center for Health Statistics, 113 codes for diseases.

So for the civilian employees, we're looking at those separately, and there were 1,412 deaths among the civilians at both Camp Lejeune and Pendleton from the second quarter of 1974 to the end of 1985, again, based on the availability of our DMDC data. That's among 9,241 civilian employees, again, about equally distributed between Camp Lejeune and Camp Pendleton; not the deaths but just that total number that we were

looking at.

So of those 1,412 deaths, 457 people had a cancer that was the underlying cause of death, and when you include underlying or contributing, that becomes 494. And there were 956 deaths where other diseases were the underlying cause, again, based on that National Center for Health statistics coding scheme.

Now previously we have reported to you that there were a larger number of deaths identified in our searches, and that is because the numbers I just gave to you were the people who had to start active duty in those years that I mentioned, so that we would have a good idea of their exposure history. The DMDC data unfortunately, the data that we have, doesn't really tell you when somebody was exactly at Camp Lejeune before 1975, when they began, second quarter of '75, when they began tracking the Marines more closely.

So if we look at our whole larger group, people that were there as of April 1975, started at any time for the active duty, and as of October 1972 for the civilians were there at the base, there were about 41,000 deaths. So as you can see we're focusing more, our initial analyses on the 18,000 or so for the active duty and the 1,400 or so for the civilians because we know more about their exposure history, but

we will be looking at a secondary analysis including all of these deaths.

And the reason why there's so many more deaths in those who were there as of 1975 and 1972 is 'cause those people are older. They didn't have to start as recently as '75 or '72, they could have started much earlier and they would be much older. So we're currently beginning the analyses very specifically to look at the cause of death. What I just gave to you were the general aggregate numbers. But when we do our analysis we'll be looking at each cause of death separately because you can't really say much when you're looking at everything together, so we'll be doing our analyses to look at each cause separately, determining if the contaminated water at Camp Lejeune is associated with those deaths.

MR. BYRON: So there is an increase?

MS. RUCKART: I cannot say at this point --

MR. BYRON: Based on population?

MS. RUCKART: I would not say that -- we're at that point yet.

DR. DAVIS: What you can say, look, one out of every two men will hear the words, you have cancer, in their lifetime because if by the time you die, that's how common cancer's become. So we have to be really

careful to look at the age distribution of the people you're talking about, that's number one.

Number two, although of course you're going to do your analysis for each cancer separately, have you thought about grouping the cancers so that you would have a classification? Just as you're going to make your classification for non-solvent-related cancers, having a group of solvent-related cancers. So that would also -- you would group together, which might give you more power in your analysis.

DR. BOVE: Well, actually we have pretty good power for a lot of the cancers, looking at them individually. We can group, for example, hematopoietic cancers together.

MR. BYRON: Speak English.

DR. BOVE: Without saying -- without giving away anything, there are problems with doing that. And I think that you have to be careful because, you know, if you lump together cancers together based, you know, based on a hypothesis, you may be lumping together cancers that -- you may actually dilute the effect by doing that, okay, as much as making clear. So you have to be careful about that.

So what, we'll, right, right. Our priority is to look at each individual cancer and do that, and then

we'll go beyond -- go, you know, if it makes sense, if it looks like it makes sense -- I don't know how to phrase this without saying anything. So I'll just say we're going to look at each individual cancer first. And then we'll do sensitivity analyses after that. How's that? And we can't answer any question about whether there's an excess at Camp Lejeune or at Camp Pendleton or whether there's any connection with the water until we go through this peer review process. We just can't do that. And also for the scientific credibility of the work, we have to do this. Otherwise we would be attacked for lack of objectivity and everything else, so we can't give you to that detail results until we go through this peer review process.

MR. STODDARD: Okay, any questions for clarification on what was presented?

MS. BLAKELY: I have question for Frank. You're doing the health studies and they include the neurological effects of the water, correct?

DR. BOVE: For mortality we're looking at Parkinson's, MS, Alzheimer's, we have a bunch of non-cancers for the mortality study that we're looking at, okay. In fact I just got some rates for those particular ones I just mentioned, Parkinson's, ALS,

MS, that we can look and see if there's --

MS. BLAKELY: Comparisons.

DR. BOVE: Comparisons with the general population as well as we'll do all our comparisons between Lejeune and Pendleton, and then internally with Lejeune, so there's a whole lot of analyses here that we're talking about doing for the mortality study. And so there's, again, one more time, we compare them with the general population, we compare both Pendleton and Lejeune with the general population, we compare Pendleton with Lejeune because of something we've talked about before called the healthy veteran effect, and then we do an internal analysis of Camp Lejeune as well, looking at, specifically with the contamination data that Morris is doing (unintelligible) on a monthly basis, so there's a whole lot of analyses here. Okay?

MS. BLAKELY: So are the subjects that you're using, are they all just Marines or are they civilians, independents, also?

DR. BOVE: Okay, the mortality study is just of Marines and civilian workers. That's the only data that the DMDC has. There are no data on dependents other than what we have from the case control study that the earlier survey, and there are school records

on microfiche that we found, but it was disintegrated so we can't even look at that so, other than that, I'm not aware of any other data that the Marine Corps has, at least that they've told us about, that could identify dependents, so we're left with the -- our survey that we did way back when, to identify and survey dependents.

MS. BLAKELY: Well, the reason I ask about it, and I'm concerned is I mentioned that I have learning disability and memory deficit, and I was a child on Lejeune, a young child, preschool, and there are thousands of me out there who have struggled their lives with learning disabilities gone undiagnosed and I'm just concerned that we are being left out, and I know you can't study everything, but when you do write up your report, are you going to include anything about us?

MS. RUCKART: I'd like to say something about it, Mary. As you mentioned, you know, it's just not possible to study everybody, and Frank mentioned some difficulties we have. We have wanted to get some more data on dependents and we had searched at several sources and it just wasn't possible. So unfortunately we couldn't do that, but we are looking at large numbers of people, especially in the health survey,

and we can talk in a minute about how many responses we're going to be including, and our feeling is, as you say, we cannot sample everybody, we cannot survey everybody, but if we're looking at a large enough group of people, whatever results we find, we could apply to those people who were not studied but still have the same exposures, so I hope that that comforts people to realize that even if you weren't studied, if you have the same exposures as the people we study, which there's no reason to believe you wouldn't, then the results would also apply to you.

DR. BOVE: But what Mary's talking about is learning disabilities, and there's not a very good way of, of dealing with that even in a survey. And it's difficult actually to deal with severe learning disorders or developmental disorders, like (unintelligible) for example, without a surveillance system, and surveillance systems are in place now in a number of states but it’s still -- there hasn't been much work done even on autism, which is a severe developmental disorder, let alone other learning disabilities. So we can't study it effectively. That's the bottom line.

MR. BYRON: So we get no answers on that.

DR. BOVE: If we can't study it effectively, how

can we get an answer?

MR. BYRON: I don't understand it, what the health survey is for if you can't ask what's your IQ level, or what are your children's IQ level, or does your child -- are they able to get a driver's license at the age of 27, okay? Or -- you get what I'm saying?

DR. BOVE: Yeah.

MR. BYRON: I mean, that's why I was asking earlier this question of what're you going to -- what information are you going to give us, unless there is none, okay, that's fine by me too, but if there's an increase in kidney cancers, just come out and say, yeah, looks like there's an increase and we'll find out and the study will be done and peer reviewed and everything else, but it's like pulling teeth here. Okay, and I've just had one done so I know what I'm talking about right now.

DR. BOVE: Jeff, we've been through this.

MR. BYRON: The only reason I think we're at the male breast cancer is that it's been identified is because Mike took the effort and found 77 guys, or would we even be talking about male breast cancer right now?

DR. BOVE: Probably not. Probably not.

MR. BYRON: Would you have found them?

DR. BOVE: Would I have found them?

MR. BYRON: Would the ATSDR have found the 77 cases with the health survey or any other --

DR. BOVE: No, not the -- no, not through the mortality study. We would not have (unintelligible). Okay? Only through the survey. That's why we're looking at the VA data.

MR. BYRON: Well, let me ask you this then.

DR. BOVE: But let me, let me say something, Jeff. We've told you over and over again that we need to get the water modeling results done before we can actually make the link between these diseases, okay, and drinking water contamination.

MR. BYRON: You have the water modeling done at TT.

DR. BOVE: We don't have the --

MR. BYRON: It's been done for years but you won't give us the results until you haven't heard the whole point.

DR. BOVE: We don't have the water modeling done for Hadnot Point, okay. And it's important to do that.

MR. BYRON: How long will it take?

DR. BOVE: We're almost done. We're at --

MR. BYRON: Are we going to get results the next meeting we're at?

DR. BOVE: Yes.

MS. RUCKART: Well, not.

MR. BYRON: I don't know.

MS. RUCKART: On that -- let me say something.

MR. BYRON: We're going to back it up again?

MS. RUCKART: Later on, we need to discuss when the next meeting will be. I don't think we can say we'll give it the next meeting. It depends when we decide to have the next meeting --

DR. BOVE: Right, right.

MS. RUCKART: So --

DR. BOVE: I mean, that would be --

MR. BYRON: When, when you have the results is when we should have the next meeting and hopefully it won't be eight months from now.

DR. BOVE: All right, well, this is (unintelligible).

MR. BYRON: And I would like the Secretary of Health and Human Services to be there.

DR. BOVE: It may make sense to have the next meeting to discuss the water modeling results and then the next meeting after that to talk about the actual results from the studies, that may be -- or we may

want to combine the two at the next meeting. That's another discussion. But just let me say this, that we needed to finish the water modeling, and we're analyzing the data now, okay, so we're not trying to delay anything.

MR. BYRON: I don't mean you.

DR. BOVE: No, all right, --

MR. BYRON: (Unintelligible).

DR. BOVE: The agency's not trying to delay anything. We need to finish pieces of the study in order to finish the study. We can't do part of the study and then, you know, you just can't do that.

MR. BYRON: Okay. Well, let me ask you this, are all the health surveys out now?

MS. RUCKART: Okay, you want to talk about the health surveys?

MR. BYRON: I just want to know if they're all out.

MS. RUCKART: Let me tell you about the health survey.

MR. BYRON: 'Cause my daughter didn't receive one.

MS. RUCKART: Okay.

MR. STODDARD: Let's wrap up the mortality. Does anybody else have anything on the mortality study?

(no response)

MR. STODDARD: Okay. So we're ready to move to the health study.

DR. AKERS: Let me ask you a question about -- Frank, you mentioned the schools and the microfiche and disintegration, are there no other hard copies of the records on children that attended the base schools?

DR. BOVE: Not that we know of. That's it. They stored them in a place that the community got to.

DR. AKERS: And how about something simple like going back and tracking through yearbooks?

MR. BYRON: They tried that.

MS. RUCKART: We explored that also. That was something we thought about a long time ago and it's just not really possible. There's no, you know, complete collection.

DR. AKERS: I've got some from '63-'64.

MS. RUCKART: But it's not the complete collection.

DR. AKERS: No, I agree but it would be a starting point once you find it. It has to be found.

MR. PARTAIN: Frank, you mentioned that there were a handful of cases in the mortality study with male breast cancers, if I heard you correct. Any way

of, you know, I know between what you're doing with the VA, my list and everything, I know you can't release the names and everything, but for record purposes, to get a count and keep the count going, can we cross-check my list, VA list and the mortality names and make sure -- and have you guys have a compiled list of names of male breast cancer and a number?

DR. BOVE: I don't see why not. But we need to get the VA data and then we need to see your data.

MR. PARTAIN: Yes, I'll get that to you.

DR. BOVE: But that was done at a later date.

MR. PARTAIN: I want to keep, 'cause I understand I can't see the names in the VA list 'cause I'm a private citizen, I'm not working for ATSDR and so forth, but I think it's important that ATSDR take what I've done and add to it and keep an accurate number 'cause as I said at the beginning, it's an unusual cancer, and when you have a large number of unusual cancers, especially with exposure, an established exposure, that's indicative of a problem. And in my opinion further establishes that there is a cluster of at least one unusual cancer at Camp Lejeune.

MR. STODDARD: Back to the health study?

MS. RUCKART: The health survey, yes.

MR. STODDARD: Or survey.

HEALTH SURVEY

MS. RUCKART: The health survey, okay, we sent out health surveys from June to December. We sent out 283,967, and I'll talk about your daughter in a second here.

MR. BYRON: You don't have to talk about my daughter.

MS. RUCKART: I mean, the situation of why she hasn't received it. I will talk about a separate group in a minute. Let me just focus on this for a second here.

So that's about seven months of mailings and even though the last surveys were sent out in December, we still kept the data collection period open 'til February 16th. That's about -- and when I say the last surveys, that's the last contact. You know we had a series of repeated contacts. The last first survey was sent out in October. So we left the data collection period open for quite a bit of time after that to get in as many surveys as possible.

And we're kind of in this rock and a hard place now because we want to move forward, we need to move forward, we have to have a completion date for closing out receipt of surveys to go to the next phase.

However, some people may still want to send them in but if we want to move forward with being able to confirm what's reported, we have to pick an end date. So your question, can we still take surveys? I'm sorry, if surveys were not received by February 16th, we can't include that because we need to move on with the next phase.

However, we have about 77,000 surveys that were turned in. So we have a lot of material to work with here. And the response rate overall -- I'm sorry it's 76,026, so I said 77,000, 76,000; and the overall response rate was 27 percent. Now that just includes the very basic response rate: we sent out this many, we got this many back. It doesn't factor in some situations where maybe it never got to the right person or maybe it couldn't be delivered, and so there are some different ways to calculate a cooperation rate that takes in some of these factors. And when you look at that, reasons why it possibly didn't reach the intended party, there's some different estimates you can use. For those that aren't returned, you can estimate, maybe 25 percent didn't really get it, maybe 10 percent didn't really get it. When you look at that, the cooperation rate is about -- it could be as high as 37 percent. But regardless we have 76,000

surveys to work with.

And we had similar response rates from the former active duty at Lejeune and Pendleton. Twenty-six percent at Lejeune, 24 percent from Pendleton, active duty. I think that is very encouraging. Of course, it doesn't say whether things are biased or not but that is still very encouraging. It's not like 50 percent Lejeune, 5 percent Pendleton. I think that's good news that they were reporting similarly from Lejeune and Pendleton.

Then among the civilian employees from Lejeune and Pendleton, those rates were slightly higher than the former active duty: 42 percent from Lejeune and 34 percent from Pendleton. And we talked a lot about the dependents, how are we going to get at those. As Frank mentioned, we have the people who were in our case control study of the birth defects and childhood cancers and the larger group from which they came, the survey to identify those people. And we had a response rate of 32 percent, so higher than the former active duty, lower than the civilian employees. Put all that together, you get 27 percent.

And about 75 percent were completed in hard copy and 25 percent online. The overall refusal rate is about 3 percent. That is an active refusal. That

means somebody actually took the time to say I don't want to participate, either by calling in to the help desk or filling out the non-response postcard that came with the last mailing. As mentioned, you know, all these surveys that didn't get returned, what is the reason, did it not get delivered or whatever, probably a lot of those are more what we call passive refusals, people who did not want to participate but didn't want to actually say they didn't want to participate. That is something we'll never really know.

But as of the people who let us know by filling out the postcard why they didn't want to participate, I have some information from the first 901 refusal postcards received. Thirty-six percent, they said they don't have health problems; 33 percent don't want to provide personal information; 21 percent, waste of government money; 10 percent, it would take too much time and effort; 9 percent, don't remember the details, it's been so long I've forgotten where I lived; and 7 percent did not feel it was important. And so take that for what it's worth.

Now, Jeff's question about, you know, his daughter registered, why did she not receive her survey. If you recall the surveys went out in waves.

We were sending out, trying to send out approximately 300,000 surveys so we sent them out in batches every three weeks or so, just to, for some logistical reasons, and waves one through six were the people who were in our study group, the morbidity study, not the registrants, and they went out from east coast to west coast. That was deemed to be the most efficient way to send them out, and the registrants were going to be wave seven. Some registrants have received surveys, they did receive them in 2011.

The way the contract was awarded, the contractor ran out of money to send surveys to all of the people who had registered by the end of June 2011. Recall we had to set a cut-off for when people registered to send the survey so that the contractor had enough time to get their mailing ready.

MR. BYRON: And I shouldn't be upset?

MS. RUCKART: We are planning to send surveys to the rest of the people who registered by June 30th, 2011.

MR. BYRON: Okay.

MS. RUCKART: As the contactor did with waves one through six, they sent it out geographically east coast onward, so in Ohio they were not able to get the surveys; the money ran out halfway through Florida.

So starting with the lowest ZIP codes, that would be somewhere up in, you know, New England, going all the way down to central Florida, surveys were sent out.

This other wave we're calling it wave eight, it's the additional registrants, we are planning to send those out. We're having some internal details we need to work out. Unfortunately the contractor has shut down their help desk because their, you know, official study portion of the survey is over, and we need to work out some internal details about how these phone calls that are going to come in are going to be handled, and this is taking up some time and once we resolve these issues, we are going to be sending out the wave eight.

So if you look at our website, you'll see we say something about all the surveys being sent out; however, for the morbidity study, we know that some registrants have not received it, and it will continue in 2012. As everyone has heard us say before, the people who are registrants only will be analyzed separately and handled separately in the morbidity study, so we're still moving forward with the morbidity study. We had to cut it off in February so that we can move forward with the confirmation of the cases. The contractor has an 18-month period,

starting in March, goes until September 2013, so it's just necessary to do that.

It's a trade-off. You know, getting it done sooner versus keeping the, you know, receipt process for getting surveys in longer. So this is what we decided was the best way to go.

We still have 76,000 surveys. That's a lot to work with there. We're in the phase now of beginning to confirm the cases that requires developing a lot of materials that will be sent out to the survey participants to get information about what doctors treated them or what hospitals they were seen at or what state they lived in when they were diagnosed with the cancer. All our materials need to be approved. So we're in the process right now of developing final materials to send for approval and then everyone who reported diseases of interest in the confirmation process will be receiving some further contacts from us.

MR. BYRON: Okay, but like I said, can you see why I'm frustrated? I mean, I think the people out here can. I can kind of tell that, but I mean I understand you guys are moving along. I'm not mad at you guys. I'm mad at how long it's taking the Marine Corps to give the information. This has taken seven

years of my life, and actually 12. And when you go back to when I served in the Marine Corps, I've been dealing with this since the day I went into the Marine Corps, or since the day my children were born. And you know, we're looking at 30 years now. And we're experiencing more health effects. I'm trying to give you the victim's perspective. I don't know that that's really all I can give you, okay, and that's why the next meeting's going to be my last so that you can get somebody in this seat who can give you more or try to give you more ideas. I'm done with ideas. Now it's criticism time. Sorry.

MS. RUCKART: I understand that you're very frustrated. We certainly can recognize that and understand that it has taken a long time. As Frank mentioned, we were waiting on the water modeling, there was not much we could do. And now we have received that and we are working on analyzing the studies and as you know we have a lot of levels of review, like approval process, we're working within the confines of the organization but we are -- I hope you know we are doing our best. We're working on this; this is our full-time job. Eddie says this is a priority but this is --

MR. BYRON: I do know that. I know you guys are

working hard but I want you to realize I'm a businessman, and when there's a problem I don't go to any underlings. I'm going to the top dog and that's why I am requesting the Secretary of Health and Human Services to be here and I don't want this brushed off. In other words when I leave here today, I kind of want an answer. Is she interested in attending our meeting? Because if she's not, she shouldn't be Secretary of Health and Human Services. I can't think of a more critical issue in America today than the largest toxic water spill in the nation. Okay? If she's not interested in that but she's interested in giving healthcare to 12 million non-Americans? I got a problem with that, a major problem. And not that I'm willing to lead the revolution but if one occurs, you bet I'm participating. Sorry.

MR. STODDARD: Are there any question -- thank you, Jeff. Any other questions for clarification on the health survey?

(no response)

MR. STODDARD: Okay. Let's take -- let's break for lunch.

MS. RUCKART: Well, should we just update on our other studies? That won't take that long and then we'll be finished with our --

MR. STODDARD: Let's break for lunch.

DR. DAVIS: I've got a lot of questions about the birth defects.

MS. RUCKART: That's fine.

MR. STODDARD: Let's let everybody catch their breath. Okay, we'll reconvene at 1:00.

(Lunch break, 11:55 a.m. until 1:05 p.m.)

MR. STODDARD: All right. You all ready to get started? So we've finished with the health survey and we're ready to move onto birth defects, childhood cancer's up then. Perri?

MS. RUCKART: Well, Devra said she had some questions about that. Is she on her way to the meeting room?

MS. BLAKELY: Yeah, she's finishing lunch.

MS. RUCKART: Okay. Because my update will be about two minutes and then if she has questions. But I don't know if we should just wait for her?

MR. STODDARD: You want to go to --

MS. BLAKELY: You want me to go get her?

MR. STODDARD: Or do you want to go to the VA and then we can come back?

MR. ENSMINGER: That's fine.

MR. STODDARD: Go to the VA? Okay. All right, Q&A, who's got questions? Do you have anything to

report, Brad?

Q&A SESSION WITH THE VA

MR. FLOHR: Well, I can report on things we've been doing, that we've been doing for quite some time now. First of all I want to say that Jerry and Mike, the documentary was really well done. It was really excellent. And it was interesting last night I walked into the Marriott and who's there on the TV but Jerry. You know, they got the big TV in the lobby. So that was good too.

We have -- there's a lot of interest in Camp Lejeune everywhere right now. A lot of that is because of your efforts. People have seen the documentary. A lot coming from Capitol Hill. Wendi and I are going to be briefing the acting director of one of the subcommittees in the H-VAC this coming week, who's new, Disability of Memorial Affairs Subcommittee. So it's really an informational briefing. She just doesn't know about the issue. I keep frequently writing updates to Senator Burr's staff as well as the S-VAC and the H-VAC, and our leadership.

Louisville's been consistent in the last 14, 15 months now that they've been working claims. Results are consistently there are approximately 25 percent of

individual veterans' claims have at least one condition that is being granted -- that has been granted. Continue to work those. We, for budget and other type of concerns, (unintelligible) concerned with all the environmental exposures and the level of input and support we get from DOD. So Dr. Dick's office actually prepared a spreadsheet tracking all of the exposures that we are working on, not just Camp Lejeune but also burn pits in Iraq and Afghanistan, exposure to hexavalent chromium and (unintelligible) in Iraq, the incinerator fire, Atsugi in Japan. All these issues -- particulate matter, which is a big issue also when we're (unintelligible). And we created a spreadsheet for the Secretary, and he's really concerned about what level of support we're getting from DOD as we work through these issues. That's something we may hear about more in the future. We don't know at this time.

MR. BYRON: Is that with all of the, sorry Brad, is that with all of the situations you just spoke about or are you talking about Camp Lejeune on that?

MR. FLOHR: All the situations.

MR. BYRON: All the situations.

MR. FLOHR: Yeah. Including also I worked with the DOD last fall, three-day conference on radiation

exposure at Fukushima, the nuclear power plant there following the earthquake last year. The DOD is actually developing a registry of everyone who was there, every service member, every civilian, DOD employee or contractor. They're going to have all the information. They had streaming. On a daily basis they streamed information about levels of radiation for people who were badged and people who were near people who were badged. All that will help the VA in the future 'cause we'll get claims. At some point in time somebody will file a claim saying I've got X, Y or Z and I was in Japan when the radiation exposure, and we'll be able to get the information we need very quickly as opposed to now.

So a lot of things we're tracking. There's a lot of still Agent Orange going on. Residue in C-123 some 50 years later that's been raised of Agent Orange, in the planes that we used to spray it. A lot of assumptions. But we're also trying to update, and Dr. Dick's office is really working to provide information in a source on Camp Lejeune and on other exposures so that when someone walks into a VA medical center and says I was at Camp Lejeune and I have this and I have that, they won't get a blank stare, as sometimes happens unfortunately, so maybe Wendi, you

want to talk a little bit about that?

MR. BYRON: Could I ask you a question, please?

MR. FLOHR: Sure.

MR. BYRON: Well, because all of us here, well, we're not all veterans but we're all connected to veterans. Me and Jerry are veterans. Just as a for instance this tooth issue, should I just stop in the VA and then just, you know, tell them the situation and have them take a look and then, because if I start losing teeth like crazy, I'm going to be making a claim for sure. I want them to see before, if I suspect it. I don't -- is there any advice you can give us there versus -- I mean, I don't know. It just seems kind of -- they call it thinking ahead but I mean, I don't want to fight you. I don't want to have to fight with the VA six years from now saying my teeth fell out and they say well, you know, prove it or whatever. Obviously you can open your mouth and prove it. But you know that my teeth were good five years ago and I suspect Camp Lejeune had something to do with it. And I'm not saying that because I lost a tooth, that's it, but if I start losing more, I'm going to be very suspicious.

MR. FLOHR: Right. Right. I don't know. Wendi, what do you think?

MR. BYRON: And not just teeth.

MR. FLOHR: Any disability, at a VAMC, will they know that he's a Camp Lejeune veteran?

DR. DICK: You should identify yourself, definitely. Definitely tell them what you're concerned about and, you know, if they're not aware of Camp Lejeune, you -- you know -- I'm sure you will --

MR. BYRON: They know about it.

DR. DICK: Let them know and they should be aware of...

MR. BYRON: Sorry.

DR. DICK: And we always, I'm sure -- VBA's the Veterans Benefits Administration is the same, that if somebody is concerned about an environmental exposure that they had while they were in the military, and they think that they have a health problem that's related to that, they, you know, should discuss that when they're seen, what, where they were, how long they were there, what they think they were exposed to, what health problems that they're having, and they can, you know, make, make a claim. They can submit a claim.

MR. BYRON: I guess what I'm saying is even in lieu of submitting claims, say, you know, well first off, I do suspect that my tooth loss was from it,

okay, 'cause I've never heard of internal absorption. They did explain to me how it can happen in instances but I guess what I'm saying is it's kind of a precursor, you know. I kind of want to head off a battle. Okay? If I had to go to the VA ten years from now because I come down with male breast cancer and I'm losing my teeth, I kind of want to walk in there and say here's my health today at 55 years old, you know? Pretty physically fit and I should not be losing teeth that way.

DR. DICK: Well, you definitely want to get attention before, you know, it gets worse, and whether you're getting your first opinion or whether you're getting your -- you know, just a second opinion, your health is always important and you don't to let it get --

MR. BYRON: Right, right.

DR. DICK: -- deteriorate too much if there is something they can do to, you know, to help you or slow it down even.

MR. BYRON: Yeah, as far as I'm aware the rest of the teeth are fine but if now all of a sudden they take x-rays again and one's bad, then I'm going to be very, you know, like suspecting that it came from Lejeune. So what I'm asking is if I was to go to the

VA today, would they give my a physical based on the fact I was at Camp Lejeune? And check an overall health or would you just take your medical records into them and let them have that?

DR. DICK: Well, I think it'd be based on what, you know, what symptoms you're --

MR. BYRON: You're dealing with?

DR. DICK: **--** you're complaining about, and I don't know if the health survey, is that looking at even dental? Is it querying that? Or is it --

MS. RUCKART: We have specific conditions that we're asking about but we do have a general question where people can report anything that wasn't specifically asked about.

DR. DICK: Okay. And we're also always doing outreach and education efforts with VA providers so that they stay aware of environmental exposures because there are new ones that arise or there's new information about old exposures, and we know that about 25 percent of veterans who come to the VA for care, they have a concern about an environmental exposure from their, you know, military service. So some of the things we're doing right now involve pocket cards that doctors can keep in their white coat that many of them, you know, wear in the office,

keeping our public website updated and also having regular ongoing phone calls where we talk about hot issues, ongoing issues and allow time for questions.

We have a pocket card that's specifically on environmental exposures, so it clues providers in to hey, there's certain, you know, chemicals of concern or, you know, smoke from burn pits, those sorts of things, so ask, you know, prompting the veteran to tell them what their concern is and where they were and what they think they were exposed to and what health problems they're having.

And this pocket card is being tested right now just to get feedback from doctors, how it could be more useful. It'll be finalized in the next few months. It'll be posted on our public website so anybody can download it.

They've also incorporated information into a pocket card that they give to doctor trainees and medical students who rotate through the VA. And it's hard to get a medical degree these days without spending time at a VA, which is really, really good, but most of those medical students and residents, they don't end up working for the VA so it's nice, you can educate them about the military and military exposures even if they go into private practice and never, you

know, take care of a veteran again.

And we have a website that we keep updated, and we try to keep it at a level that isn't overly scientific or, you know, that's just easy to read and easy to find and people can sign up so that, I've done it too, so that sometimes I don't know when there's an update that, oh, yep, that was posted. So that there's no information and you will get an email so that you don't have to constantly be checking.

And then we've had ongoing calls quarterly, so four times a year every VA medical facility has an environmental health clinician so oftentimes it might be a family doctor or someone in primary care, and they've been given extra, you know, education about environmental health exposures so that when other doctors in the VA have somebody, they see somebody with an exposure and they don't really know what they're dealing with, they can call this environmental health clinician and consult with them or send the patient to them. And we have nearly a hundred providers who participate in these calls.

And we talk about Camp Lejeune, it's always on the agenda. And, you know, sometimes we answer the same questions every single call, and that's okay because it takes people time to really, you know,

understand some of the issues, and once they start seeing patients from a certain area, then it prompts more questions, and so we'll be addressing this for as long as, as long as we need to.

MR. FLOHR: But Jeff, to answer your specific question, if you walk into a VAMC today and say I was at Camp Lejeune and I'm having these problems, can you get examined? I don't know.

MR. BYRON: Okay.

MR. FLOHR: I will go back and I will talk --

MR. BYRON: I appreciate it.

MR. FLOHR: -- with the people involved with the examinations and see what the possibilities are.

DR. AKERS: I have some input in that regard. A number of my colleagues work at the VA in Columbia, South Carolina, and I queried two of them, and they responded. I said, suppose I walked in, I said I was at Camp Lejeune. He said their immediate response was, they'd send me to the regional office, which is on the back of their VA campus. That was through the ER so they're being referred, at least the two guys I talked to, to a regional evaluation site, and what goes on there I don't know but I mean --

MR. FLOHR: You mean, for filing a claim?

DR. AKERS: Well, for being examined. For having

a problem and being seen by a provider.

MR. FLOHR: Oh.

DR. AKERS: Along that same line I have a question about the training letter?

MR. FLOHR: Yes.

DR. AKERS: Chemical abstracts? That was what a reference that was supposed to be readily available to any provider who had a patient present who they suspected was having a -- had been chemically exposed, and their reference was to the chemical abstracts, from the American Chemical Society, I believe.

MR. FLOHR: I'm not aware -- I'm not familiar with what you're --

DR. AKERS: Well, my point being, again, I queried the same number of individuals, which included three VA ER physicians. One VA -- and some of these people overlapped. One fellow who was -- who had worked the clinics at the VA, four urgent care physicians and one former army green shirt -- in other words she'd been in the Army and was an internist, every one of them said if they had to come up with some answers for a patient, they would much rather have the MSDS than the chemical abstracts. And I was just curious why the VA selected chemical abstracts as their reference source.

MR. FLOHR: I would have to look at that. I don't -- it's not familiar to me in terms of our training letter. I don't know chemical abstracts as something --

DR. AKERS: Chemical abstracts from the American Chemical Society.

MR. FLOHR: As a link maybe?

DR. AKERS: Well, that was supposed to be the reference source. If you had a question you were to go to the chemical abstracts to obtain your answer. What symptoms they would present with, what your treatment should be, the particulars regarding this.

MR. FLOHR: I'll have to look at that. That's unfamiliar to me.

DR. AKERS: Dr. Dick --

MR. FLOHR: And I wrote the letter. So I would know.

DR. AKERS: I have a question about the nonveterans that utilize the VA, how could that happen? How does that happen because I was under the impression one of the big objections to Senator Burr's bill was that there was some opposition from veterans' groups who didn't want nonveterans to use the VA system.

DR. DICK: I don't know. I can look into that

and talk about at the next meeting.

DR. AKERS: Well, how does one access I guess the VA if you're a non-veteran? Is it on a humanitarian basis that you -- the example you used was those individuals who needed an oncologist or --

DR. DICK: Just anecdotally from the cancer registry, the woman who's in charge of that, she mentioned that oftentimes the nonveteran who's getting care at a veteran -- at a VA facility may be the spouse of a veteran. And I will need to verify that.

MR. BYRON: More of that was based on -- from what I got that you said, it was more based on the availability of the care in the region so like if your hospital can't take care of a certain illness and the VA does, then that might -- it's probably --

DR. DICK: That might be --

MR. BYRON: -- farmed out to them basically.

DR. DICK: Yeah, it might be a special service for spouses but I do not know. I'm not the authority on that at all. I will have to check with the people who can tell me exactly more about that because, you know, --

MR. FLOHR: I think the VA would see people who have been injured severely and they're in critical condition, and that's the closest place to take them.

But also spouses and dependent children, those who have children, are entitled to any healthcare if the veteran himself is rated totally disabled.

DR. DICK: So it depends on, you know, different --

MR. BYRON: That's my understanding, even with the other healthcare (unintelligible) as a veteran I can walk into the VA and get services. I don't have to -- I mean, I know guys that do and I don't personally because, you know, I don't want to tax the system that's needed for wounded warriors. And I'm not a wounded warrior. So but my understanding is is if I was injured and couldn't pay for healthcare, I can walk into any VA facility 'cause I'm a veteran and get care. Is that correct? I imagine it is. I don't see why not. That's what it's for.

MR. FLOHR: Yeah.

MR. PARTAIN: Brad, you mentioned that Louisville's kind of getting, I guess in colloquial term, their act together as far as their reviews and stuff. Do you have a date of when we should stop seeing --

MR. FLOHR: Did I say they were getting their act together?

MR. PARTAIN: Well, I thought you -- you

mentioned something earlier about that, you know, the consistency from Louisville. I mean, is that as of now, last month, December, November? I mean, when is -- I know there was some inconsistency when we talked at the last CAP meeting, you weren't here but we were bringing up some issues.

MR. FLOHR: You know, inconsistency is a word that's used a lot; I think it's misused. There may be for example a veteran who was at Camp Lejeune who developed kidney cancer, and there may be another veteran who was at Camp Lejeune who developed kidney cancer. That doesn't mean that both of them could be granted service connection, and that doesn't make them inconsistent, because one veteran may have had exposure to a lot of other chemicals, may have had exposure to benzene in another job outside the Marine Corps, which would have been more perhaps, may have had family history. So the decision's consistent based on facts in the individual case. It doesn't mean that one granted, one denied makes it inconsistent.

MR. PARTAIN: Now what degree -- to what degree is the NRC report in 2009 still being used in VA decisions?

MR. FLOHR: As far as I know it's never been

used.

MR. PARTAIN: Okay.

MR. FLOHR: Except we reference it in our training letter just for the 14 diseases that they found limited or suggested evidence of the association to TCE and PCE. All that does, all that we use that for is we told our Louisville office, if a veteran presents with one of those 14 conditions, you don't need any other medical evidence. You can request a medical opinion at that time. Okay? That's a good thing.

MR. PARTAIN: Let me ask something of Dr. Davis, Dr. Clapp, Dr. Bove something. Relations between TC -- scientific knowledge between the relation of TCE, PCE, benzene and bladder cancer, can you all want to -- ever one of you comment or one of you all comment about the scientific knowledge between the links of that chemical and that disease?

DR. CLAPP: Yeah, it's strong.

MR. PARTAIN: Was it -- when you say strong, what's it based? What, how do you think --

DR. CLAPP: Studies of dry cleaners for example, workers within the dry cleaning industry have gotten excess bladder cancer. Studies of solvent manufacturing workers.

MR. PARTAIN: So there is a scientific knowledge out there that there is a link between exposure to TCE -- PCE, TCE, benzene, whatever, the chemicals we have at Camp Lejeune and --

DR. DAVIS: Not necessarily for all of them. You don't have to have all of them combined.

MR. PARTAIN: I understand.

DR. DAVIS: What Dr. Clapp's referring to is that there are actual surveys of highly exposed workers. Workers who work in dry cleaning are known to have had very high exposures to PCE and then, and TCE. Now in addition to that, though, and I want to stress this, I don't think we should get too hung up on the epidemiologic data, as an epidemiologist. I think we often are chasing statistical significance in human studies where we don't need to do that at all. The National Toxicology Program has a very impressive program of assays where they've tested now over 400 -- how many? What's the number?

DR. PORTIER: Oh, about 700.

DR. DAVIS: Seven hundred, thank you -- chemicals in animal assays, which involve short-term, long-term, chronic studies, and a number of these solvents have been shown to be very toxic to a number of different organ systems, including but not limited to cancer,

but including neurodegenerative things, and necrosis and degeneration of, in particular, the bladder and the kidney. So, and the male rat kidney is a whole subject, one that's written books about how to study it.

My point in mentioning all this here is simply to say that when you ask about evidence and causation of bladder and other types of cancer for these exposures, don't get into the trap of asking whether you have enough human data. You really have had data on these particular compounds now for more than 40 years that I know of, showing in animal studies under controlled conditions a whole spate of damage that's associated with these exposures. So don't get snookered by the notion that we may not have robust human studies. In fact, I agree with Dr. Clapp.

MR. PARTAIN: Well, according to the Marine Corps, Navy, and NRC, you know, the links between animal studies and human, well that doesn't really show anything, so.

DR. DAVIS: Well, that's the whole --

MR. PARTAIN: Well, going back -- I want to get back to my point here 'cause I mean this is the crux of the issue. I mean, we have a 12 or a list of diseases from the NRC report, if I -- correct me if

I'm wrong, Brad, 'cause I don't want to put words in your mouth, that those diseases are looked at as -- that the NRC report is not the final say-so in the decisions, and that according to the -- what was the word you used about the list, the 12 conditions?

MR. ENSMINGER: Fourteen.

MR. PARTAIN: Fourteen?

MR. FLOHR: Fourteen. The NRC found that there was limited or suggested evidence of an association from TCE, PCE and those conditions.

MR. PARTAIN: Okay. I want to take a second to -- I want to come back on this, and I'll come back, Devra. I want to read an excerpt. I like to deal with specifics and that's something that I have, you know, you cannot deal in generalities or hypotheticals. I'm going to read an excerpt from a veteran's denial out of the Department of Veterans Affairs, VA Louisville's regional office. I'm not going to read his name or anything like that. This was sent to me, his brother, they were brothers. They both served at Camp Lejeune, one has male breast cancer, the other one has bladder cancer. And pay attention to the error, I kind of chuckled when I read it the first time, but (reading) On VA examination of January 3rd, 2012, the examiner reviewed your claim

file. The examiner opined that bladder cancer is less likely than not caused by result of the exposure to contaminated water at Camp Lejeune. The rationale, from a review of the recent findings of a national regulatory commission in 2011.

MR. ENSMINGER: That's --

MR. PARTAIN: Let me repeat that, from the review --

MR. ENSMINGER: That's supposed to be nuclear regulatory --

DR. DAVIS: Yeah.

MR. PARTAIN: Yeah, the national regulatory commission in 2011 --

DR. DAVIS: That's a mistake. It's --

MR. PARTAIN: Well, obviously, I mean, it's repeated throughout the letter though. But here's the concerning part. (reading) There has been some associations with certain latencies by the contaminated water, the 14. However, this is a conditional statement, this is not the same thing as causation which is defined as resulting in a particular issue. Currently there is no causation that is proven -- that has been proven between the contaminated water at Camp Lejeune and malignancies.

The veteran's private sector's physician notes,

who was an urologist, which I would call an expert, were knowledge regarding the malignancies at Camp Lejeune. However, their comments are observational and not based on scientific studies. So, I mean it's a fancy way of -- I mean this guy has bladder cancer -- he's got prostate, bladder and colon cancer. The bladder cancer is, I think, a stronger argument, it's on the 14 list. And here they are citing incorrectly, a report that didn't happen, but then I know what they're referring to is the NRC report in 2009. And they're saying that that report is the basis for his denial. I mean that -- something's wrong. And his doctor, I mean, it doesn't -- his doctor wrote: In my opinion there is a strong possibility that the exposure to these chemicals did contribute to his developing both bladder and prostate cancer. And the fact that this man has had three different malignancies would seem to indicate that there was some source of underlying, underlying causative effect for his condition, since it is quite unusual to have multiple malignancies in the same patient.

I mean, this guy's an expert but his, you know, his conclusions, which, you know, are to a degree backed by the 14 list from the NRC report are

dismissed as opinion. And then they come back, and the concerning thing to me is this reviewer, you know, granted he's citing a report that didn't happen, to an agency or commission that didn't exist, is saying that that report, which is the NRC report in 2009, is the basis for this man's denial. That science hasn't proven anything. But yet I just heard from Dr. Clapp and Dr. Davis, science has a pretty good clear understanding where, you know, I wouldn't -- I don't want to say clear understanding, but I would say science has a pretty good idea that there is a causation and effect between bladder cancer and these chemicals. But yet this reviewer, based on a commission that didn't exist in a year that didn't happen, and he's citing stuff that's totally incorrect. That's inconsistent and that's what I mean when I ask the question.

DR. DAVIS: Just want to add a point of clarification, Mike. As I think you know, and just for the record I want to make it clear, that it is the position of the World Health Organization International Agency for Research on Cancer, which appears in every one of the prefaces to their monographs, that where there's evidence on controlled studies of carcinogenicity in animals, this is

considered as evidence per se of risk to humans, and therefore anything that is known to cause cancer in animals is assumed to cause it in humans. That's the basis of the whole World Health Organization approach. And that is an expert agency.

Now, urologists treat disease. They are not experts in cancer, and that's one of the dilemmas that we're facing here. You are over and over again showing us that doctors are humans and they make mistakes just like other people do; maybe perhaps even more so because they come to expect that they aren't going to be making mistakes, and that's part of the problem in our training in physicians today. But the reality is that animal evidence has to regard it; otherwise, we are conducting experiments on people and treating all of us like lab rats.

MS. BLAKELY: We can volunteer, can't we, guys?

MR. ENSMINGER: We already did.

MR. PARTAIN: We already did.

MS. BLAKELY: Yeah, I know. That's what I mean.

MR. PARTAIN: We didn't know about it.

MR. ENSMINGER: I didn't volunteer that.

MR. FLOHR: And Mike, each case is different, you know, in that case you read, I don't know if how long the individual was at Camp Lejeune, I don't know what

his family history other than two brothers and things like that, how long he was there, where he lived when he did. Physicians who provide opinions, this one, at least he gave a pretty good explanation, reasoning. They're not always going to be favorable but that's the main reason the claims were denied is because we don't get a favorable opinion. But we are working to address that with people in charge of the examinations in the Veterans Health Administration. They are actually going to be developing a really good training program for people who provide opinions, to really make sure that they're on top with the latest information and the latest that we know about Camp Lejeune and these contaminants, and that's where we'll be getting very soon.

MR. PARTAIN: But the problem is the foundations for his denial are completely wrong and they go contrary to what you said earlier.

MR. FLOHR: No, they don't go contrary to what I said --

MR. PARTAIN: It's contrary --

MR. FLOHR: What I said was those 14 conditions, they don't mean anything other than it provides us a basis to request a medical opinion because there's been some suggestion of an association by the NRC.

Didn't say that there was any causation, that it caused it, just that there's some association.

MR. PARTAIN: I understand that but they, you know, he's saying there's -- the reviewer there is speaking on the knowledge of science in referring to the NRC report and talking there is no scientific evidence. That is fundamentally wrong. There is scientific evidence linking it. I understand everyone's individual, I understand that we gotta go through and look at everything, and, you know, that's, I passed over to you the gentleman's denial and you can do with it what you want there and follow up with the family, but the fact of the matter is, I mean, the guy didn't even get the right name for the commission (unintelligible) commission, couldn't get the right year. I mean, the fundamental basis for what he was saying was wrong, is screwed up. And then also -- well, they are, but and also not only that, to make a statement that there is no scientific evidence to support a causation is wrong.

MR. FLOHR: I'm not going to try and put --

MR. PARTAIN: I understand.

MR. FLOHR: What's in the examiner's review because I don't -- I'm neither a scientist nor a physician. Well, as Devra said, the possible

conditions that can result from exposure to benzene and TCE has been known for a long time. But what is missing, and what the water modeling result will show, is how much in the individual is exposed to because that plays a good part in it too.

MR. PARTAIN: I don't know how do you see exposure (unintelligible) I mean, it could be one-time exposure, it could be a lot more. If it's a carcinogen, it's a carcinogen.

MR. FLOHR: Well, I don't know that. I don't think --

MR. PARTAIN: Yeah, it's kind of like being dead. You're dead once and you don't -- you're not mostly dead or partly dead, you're dead. All right? The same thing when you're exposed to a carcinogen.

DR. DAVIS: Just a point of clarification, and the IARC system has different classifications for level of evidence, and in the case of vinyl chloride and benzene, they are confirmed human carcinogens. In the case of TCE and PCE, they are probable human carcinogens, and there's a ferocious fight about whether it should be probable or definitive. But that classification that I just mentioned is based in the case of the Class I definitive human carcinogen of definitive human evidence, but in the case of PCE and

TCE, it's based on a number of experimental studies and some human epidemiologic studies. So there's a lot of --

MR. FLOHR: Well, actually there was -- I'm sorry there was, the EPA issued a report on TCE recently, just in the last several months which elevated TCE to a known human carcinogen.

DR. DAVIS: Thank you for that clarification, but the point is there's been evidence around for a long time, and you've pointed out an error that this person made, and so the question I have to the VA is what process will you have in place to correct this kind of error? What is the routine appeal that can be set up now so that they can get this right?

MR. FLOHR: Well, I can follow this and participate with the decision.

DR. DAVIS: And I assume -- Mike --

MR. PARTAIN: (Unintelligible). I know.

DR. DAVIS: Right. And maybe there's some way we can be encouraged that the process here because, you know, it is, you know, you've got a lot of different claims here.

MR. PARTAIN: But the lay person doesn't understand what we do. I mean, it's taken me five years to build my database and my knowledge on it. If

I'm a veteran who served four years and went home to work at my job and live my life, I'm not going to know this stuff. I mean it sounds correct unless you know what you're talking about, and then the errors start jumping out at you.

And I mean these -- how many people walk away with legitimate cases for the VA because of errors like this? And I mean, we recently -- Jerry told me a couple weeks ago that one of the veterans he knows did receive an award but the award was associated to his exposures in the Gulf War, not Camp Lejeune.

MR. FLOHR: It actually was not. It was just a typo error.

MR. PARTAIN: Typo error?

MR. FLOHR: It was a clerical error.

MR. PARTAIN: Okay, but they get classified in the VA that way or -- I mean, typo -- I'll take your word for that.

MR. FLOHR: No, they're going to fix it actually.

MR. PARTAIN: Good, 'cause I mean, that would, you know, I hate to drop that data out of anything in the future and scientific worth.

MR. FLOHR: I don't know that it would be, even if it wasn't corrected because Louisville keeps its spreadsheet on every claim that they grant and

petition which is granted. That's all of it. It's available.

MR. BYRON: Okay, this is Jeff. I'll play nice now. I guess the real question is all these guys are going there for, you know, making a claim to the VA and this information isn't even out yet, and they could be being, you know, denied. And we really don't even know the results. I mean, I imagine that list will either get larger or smaller once the study's out as far as the --

MR. FLOHR: Are you referring to the results of the water modeling study?

MR. BYRON: -- the diseases and the cancers. Yeah, once those results are out I mean anybody that goes in there that's hurting now gets denied, and then the information comes out that maybe they shouldn't have been denied later --

MR. FLOHR: Well, then they can reopen their claim.

MR. BYRON: They can reopen their claim?

MR. FLOHR: Absolutely.

MR. BYRON: Oh, okay. Okay, so even if they appealed and lost the appeal, then after the information comes out --

MR. FLOHR: Based on new studies would be new

evidence.

MR. BYRON: Okay. And then as you guys see the studies' results, who adjusts that list? Is it you all or is the NRC going to, I mean, what's that process? I mean, obviously they didn't cover every disease or they covered too many, it's one or the other. But they didn't hit it dead on at 14, you know that and I know that. So what -- how does that get adjusted?

DR. PORTIER: So for -- let me touch on a couple of things first to make some points clear and make sure our expectations are clear.

I think the decision as to whether or not veterans get healthcare from exposures at Camp Lejeune should not rest solely upon our health studies. There is a tremendous amount of evidence out there, as Devra pointed out. Benzene is a known human carcinogen, methylene chloride is a known human carcinogen. We know something about the magnitudes of those chemicals that cause cancer. We are estimating exposures to this population, we will compare the two and make some opinion as to whether we think this is affecting the population.

The positive or negative aspects from the epidemiologic study are driven by a lot of different

aspects. The magnitude of the response in the population, other exposures the population has seen can all make it very difficult to interpret clearly the one study. We're going to try our hardest to make an opinion that says something about the whole body of evidence.

But to answer your question now, in the United States for cancers, the definitive answer comes from the National Toxicology Program in their report on carcinogens. And both of these two, benzene and methylene chloride are known human carcinogens. TCE and PCE are reasonably anticipated to be human carcinogens.

MR. ENSMINGER: TCE is.

DR. PORTIER: And TCE is -- might have been just made a known human carcinogen within two -- I was trying to find that.

MR. ENSMINGER: And vinyl chloride.

DR. DAVIS: Vinyl chloride is definitely a known.

DR. PORTIER: Known human carcinogen. In fact when I was there, I tried to make all of the chlorides, vinyl chloride, vinyl fluoride and vinyl bromide, all of the human carcinogen 'cause the evidence is pretty clear on all of them but I couldn't get that through.

Now, so that's cancer only. ATSDR maintains our tox profiles and in the tox profiles we do everything else besides cancer, and so that is a summarization of the other evidence that is out there. Even when the ROC report on carcinogens does cancer, they also summarize the other evidence, although they don't categorize it, they don't classify it. IARC does also summarize all the evidence it doesn't classify.

Everybody lives off all these lists. EPA has lists as well. So when you're looking at something like this, we look at all of it. But usually the real definitive answer on these things comes from the NRC. When it comes through VA and other groups, they like to bring in the NRC to look at all of this evidence and provide an opinion of association.

Sometimes the problem is that this is, this is subtle language differences, but sometimes this is the problem you see when looking at this. When you get a group of scientists together and you tell them you must reach a consensus, and you're looking at something like causation for a chemical, even when those scientists generally agree on things, if you force consensus, if there's one person who feels like it's not causative, then they can't say that. That blocks consensus. So, but most of the groups do, like

IARC and the RT -- NTP and those groups, is they sort of get to debate, then they do a vote and they go for majority rule. But the NRC doesn't do that so sometimes it's very difficult in the NRC to interpret causality. But the VA usually uses association, strong association as a good reason to act on something so they know how to interpret this.

MR. BYRON: Okay, so real quick, once the studies are done, say, some other cancer, brain cancer, needs to be put on the list, or should be on the list or suspected to be on the list, is it the NRC that decides who -- if it goes on the list or will it be the CDC?

DR. PORTIER: Well, in our papers, if we see a significant increase in brain cancer, we will make that clear in our publications.

MR. BYRON: Okay.

DR. PORTIER: Once we make it clear in our publication, then that's going to signal a lot of groups to look at this evidence and think about it carefully. If it's strong enough, then the entity will revisit their finding and see if that contributes to their overall findings, and they might redo their finding, and so would other groups.

MR. PARTAIN: Okay, 'cause we do see a lot of

brain cancers from Camp Lejeune including --

MR. ENSMINGER: Well, I wasn't bringing that out.

MR. PARTAIN: Yeah, just so -- I just want to throw in a little historical point, one of the more infamous brain cancers that was at Camp Lejeune was a gentleman named Charles Whitman from south Florida.

DR. DAVIS: Oh, yes.

MR. PARTAIN: And who in the 1960s climbed a bell tower with his rifle and snipered a bunch of people at Texas University shortly after he was discharged from two and a half years at Camp Lejeune.

DR. DAVIS: And actually he left a suicide note that said please autopsy my brain; something's wrong. And he, for months before he did this, he knew something was wrong and he did not get medical attention. I'm not sure that he sought it either but I think that he did. He's been written up in a number of books. His, Charles Whitman had a glioblastoma multiforme and it was only diagnosed at autopsy after he'd been on that rage and shot all those people.

MR. PARTAIN: And prior to Camp Lejeune he was an Eagle Scout with an IQ of 139, I think.

DR. DAVIS: Right.

MR. PARTAIN: Kind of interesting but just throw that in as a tidbit.

MR. ENSMINGER: Damn good shot too.

MR. BYRON: I used to beat those guys up.

MR. PARTAIN: There was a gentleman in the audience that came up and asked me, he's had some recent dealings with the VA and I'd like to give him a couple minutes to just to address that. Would that be all right?

MR. ENSMINGER: Our marksmanship training works.

DR. DAVIS: Please.

MR. PARTAIN: Anyway, would that be okay? All right. Just give him like two minutes. That's all I'm asking.

MR. STODDARD: Are you asking the whole panel?

MR. PARTAIN: No, I'm asking -- There's a gentleman in the audience who wants to recognize the -- talk about the VA, just wanted to state some of his recent experiences in dealing with a VA hospital.

MR. STODDARD: So, are you asking him to come and speak?

MR. PARTAIN: I'm asking if we could recognize him to speak for a few minutes.

MR. STODDARD: So this is a question to the group. Devra? We have a question to the group. Would the group be willing to hear from this gentleman in the audience regarding his experience with the VA?

MR. BYRON: Yeah, I'm okay with it.

MS. BRIDGES: Yeah, I'm okay with it also.

MR. PARTAIN: As long as we keep it to, you know, two minutes or so.

MR. STODDARD: Two minutes? Two minutes? Okay, and the person's name is?

MR. PARTAIN: Kevin.

MR. WILKINS: Kevin Wilkins.

MR. STODDARD: Could you come to, come to use the mike, please?

MR. ENSMINGER: Go over there so we can throw stuff at you.

MR. STODDARD: Okay, Kevin, you have two minutes.

MR. WILKINS: I won't even take that. I'm not going to muddy what Mike's done. But as far as Jeff and his experience with the VA, I'm from Louisville, and if you walk into the Louisville Medical Center and ask for the environmental person, she has no idea what's going on with Camp Lejeune.

If you go to the regional office, tell them you want to put in a claim about Camp Lejeune, they have no idea what you're talking about. Now they may have eight people down there assigned but they're not spreading the information among the service officers, you know, the DAV, the AMVETS, they're not spreading

out the information. So even when you go to see the representative, they have no idea what your, what your symptoms should be.

Now the VA put me on a non-service connected pension in 1989. When I found out about Lejeune, I was able to link my symptoms to the water, ask for service connection and I got an answer just about like Mike, and I felt like they just off the wall evaded, just said well, it's not connected. And that's, like I say, if you went to the VA expecting anything, you'll get nothing.

MR. BYRON: I understand where you're coming from. I've actually heard good news in the Cincinnati area about the VA.

MR. WILKINS: Well, what was their flagship?

MR. BYRON: And I think part of that is is because some of the newscasts that I've been in and some of the people that I know, you know, one gentleman, his wife works at the VA so they've had their eye on us for years. So --

MR. FLOHR: Anyone who's represented by the service organization, when a rating decision's done on a claim, it goes to the VSO to review. So I can't imagine that they don't know about it, and the fact that there's, as of two weeks ago, there was 1,212

cases pending to be worked in Louisville. I can't imagine the people in Louisville, outside of the group that's just working those claims, don't know about it.

MR. ENSMINGER: Well, I got the same type of report from my mentor in the Marine Corps who was one of my former commanders. He's an officer. And he gave me basically the same report about the Las Vegas VA. Now when his stuff got transferred from Vegas up to Reno, then he got a phone call from some guy in Reno that actually knew about the Lejeune situation, but down in Vegas, it's crickets. I mean they, they don't even want to talk about Camp Lejeune.

MR. FLOHR: I don't know about that but, you know, last year, last fiscal year, VA received 1.3 million claims, and that wasn't just -- that was claims that require a rating decision based on medical evidence and scientific evidence. That's not to mention the millions of claims we get just to add dependents, hospitalization, things that have to be done, so 1,200 claims that we got last year from Camp Lejeune compared to 1.3 million claims, sometimes they won't be recognized right away.

MR. BYRON: Well, that's why we're here, right? I mean, we're trying to make process so people know about it, and the VA is -- are you continuing --

you're continuing the training?

MR. FLOHR: Absolutely.

MR. BYRON: I mean, I don't know what to tell you back there as far as your experience. I don't know, check again.

MR. WILKINS: I've been down front.

MR. BYRON: You been down front?

MR. WILKINS: I can tell you just what happens.

MR. BYRON: I might take a trip to Louisville soon then because I'm close to there in Cincinnati.

MR. WILKINS: Come on down.

MR. BYRON: I will.

DR. DAVIS: When did this happen?

MR. WILKINS: I just got the, whenever that meeting was in Pittsburgh, Jerry told me to ask for a mammogram, ask for a radiation test, that's when I had the experience with the environmental person, and then they did the examines on me, and I just got the decision about three weeks ago that said yeah, you've got all this stuff but it's not service-connected.

MR. PARTAIN: That's November 2010 that he's referring to.

DR. DAVIS: Yes.

MR. FLOHR: The Columbus meeting?

MR. BYRON: 2010 is when --

MR. PARTAIN: Well, Pittsburgh -- if it was the meeting in Pittsburgh, that was November 2010.

MR. BYRON: When did you get -- I'm sorry, this is Jeff. When did you get here, Brad? It was 2010, wasn't it?

MR. FLOHR: Yeah.

MR. BYRON: I mean so this is -- to be honest with you, the VA's just really gotten involved. I mean I hate to say that. It's a shame. It should have been involved for a decade now. But this man doesn't -- I don't think he knew about it ten years ago.

MR. FLOHR: Well, it sounds like Mr. Wilkins also is referring, not having gone to the regional office and people in the regional office not knowing about it, he went to the VA medical center.

MR. WILKINS: I've been to both.

MR. BYRON: So but I mean is it, was that pre -- not your fault that it would be premature that you went there before they knew about it, would they more than likely be more informed now, do you believe?

MR. FLOHR: I would hope so, Jeff.

MR. ENSMINGER: I would hope that they're reading your training letters.

MR. BYRON: Yeah.

MR. ENSMINGER: You know that, that's a big question. What do they do with your training letters once they get them?

MR. WILKINS: Well, they didn't have the one for 11/03, the revised, they didn't have it posted on the website, and I called a veteran service officer about it. He said it's not on here so I faxed him a copy of it. I picked it up off the internet.

DR. DAVIS: I know there's been a lot of discussion about traumatic brain injury and training for things like that. I would hope that the VA has additional resources now to handle the additional demand that the brain injuries are creating, and I wonder, again, what the question I asked before: what's the FTEs that you have for this? Is it a question of giving you more resources for training?

MR. FLOHR: I'm sorry, training for what?

DR. DAVIS: For your intake people to understand the science behind this issue.

MR. FLOHR: I think I mentioned earlier that the head of our examination group in the Veterans Health Administration is planning on doing training very soon, to bring people up to date, people (unintelligible).

MR. STODDARD: Okay. Can, can we wrap up the VA

questions now? We've got a little over an hour and we've got three studies to review as well.

MR. ENSMINGER: We've got Morris. We've got more.

MR. STODDARD: Is Morris -- Morris is here? Is Morris ready?

MR. MASLIA: Yes, I'm -- I need a couple minutes just to boot up the computer.

MS. RUCKART: So we can just briefly go over the other studies.

MR. STODDARD: Okay, birth defects and childhood cancers.

BIRTH DEFECTS AND CHILDHOOD CANCERS

ADVERSE PREGNANCY OUTCOMES

MS. RUCKART: Yeah, okay. With that, there's really not too much to say other than we have the water modeling data. It's not been finalized but as we've been mentioning, we're using these results and doing our analysis so that when we get the confirmation that the water modeling has been approved by the agency ^, that we will be ready to go.

If for some reason there's some tweaking that needs to be done on that side, then we will incorporate that into our analyses. So we have the 52 cases, 15 neural tube defects, 24 oral cleft defects

and 13 hematopoietic cancers, which is non-Hodgkin's lymphoma and leukemia. And I'm well underway in analyzing that, just finishing up some different analyses.

I looked at the average exposure during the critical exposure period, the first trimester for birth defects and various time periods for the cancers. I also looked at maximum exposure and for cancer, the cumulative exposure. And for each of the chemicals separately, looking at different ways to distribute that, looking at the distribution of the chemicals in the controls and as we stated earlier, we're not able to share the results until things have been peer reviewed, but Devra said she had some questions about that study?

DR. DAVIS: No, this is the cancer study?

MS. RUCKART: The birth defects and childhood cancers.

DR. DAVIS: No, you're talking about birth defects and childhood cancer combined. So you looked -- at the types of birth defects that you looked at --

MR. STODDARD: Could you turn your mike on, Devra?

DR. DAVIS: I'm sorry. The types of birth defects that you looked at would have been major

congenital anomalies, particularly cardiac or -- how did you -- what was your database to get the birth defects data?

MS. RUCKART: Well, we've talked about this extensively in the past. I'll just briefly summarize. There were no birth defects registries at the time period that we're looking at, so we couldn't just go and query them all. So we had to do a survey of those who were at Camp Lejeune from 1968 to 1985. We selected '68 because that's when the birth certificates began to be computerized. We contacted as many people as we could; we ended up with 12,598 people that we surveyed to find out if they had birth defects. We cast a wide net, we were trying to look at heart defects and some other birth defects, but when all was said and done we were only able to move forward with the study of the neural tube defects, oral clefts and the cancers that I mentioned because of the numbers that were self-reported to us.

DR. DAVIS: Okay, so, so that's my question 'cause as you know, things like cardiac defects sometimes don't even show up for a while depending on if they're major or minor. And is this the same cohort that Sonnenfeld did in 2001?

MS. RUCKART: No, we used the birth -- hers was

based on the birth certificates of on-base births. We used that as a starting point. There were also a number of pregnancies where they were delivered off-base, and there was a media and outreach campaign to try and identify those, so about 80 percent or so did come from that study and the rest came from the outreach.

MR. ENSMINGER: The Sonnenfeld study was flawed because they had incorrect water system data. They were -- the ATSDR was provided water system data by the United States Marine Corps that showed that the Holcomb Boulevard water system had been online for the entire study period, which was 1968 through 1985, when in fact the Holcomb Boulevard water plant was never constructed until 1972. So you had four years of some of the biggest housing areas on Camp Lejeune that were thought to have been on clean water.

DR. DAVIS: Even so they had a positive result with it.

MS. RUCKART: Yes, so that's why we're going back and re-analyzing that study. The priority was to first analyze the birth defects study; we started that in 2005. I have almost finished that. Frank is analyzing the mortality data. We are both going to work on analyzing the small for gestational age, the

Sonnenfeld study that you're referring to. And our expected timeline is to finish those three studies this summer. When I say finish those, I mean finish them through our center's clearance. Then, as we discussed, we have many other levels of review. We are still hopeful that we can get those cleared in a timely matter. There's obviously there are a lot of eyes looking at this but -- do you want to say more about that, Dr. Portier, what happens once we finish?

DR. PORTIER: Just to say that it's going to get a priority. There's absolutely no doubt we want these studies out the door, you know, because I'm pushing my staff to clear it from my center. I'm also fairly certain that the rest of the CDC would like to see these studies out the door so they will probably clear it quickly. If it has to go to the Department for clearance, that could take longer. We just don't know.

MR. ENSMINGER: Go where?

DR. PORTIER: The Department of Health and Human -- to the Secretary’s office.

DR. DAVIS: The Secretary's office.

MR. ENSMINGER: (Unintelligible.)

MR. PARTAIN: Dr. Portier, you're talking about the studies --

MR. ENSMINGER: If there's any findings, they will.

MR. PARTAIN: When you talk about studies and the registering the community and everything, and this has been brought up before and it's come up again here, as of December 2011, the Marine Corps is the steward of the Camp Lejeune registry, of all the people that have come in contact, and granted with the film and the premier on national TV, there's been a lot of attention. We've received a considerable amount of emails, phone calls from people who were just still finding out about Camp Lejeune. Matter of fact I added three male breast cancers to the list from Missouri, of all places, and I'd never heard from there.

But anyways, as of December 2011, the Marine Corps did bring us the problem with the registry, and did not update and could not update their computer sites up until recently. And there's a huge question, especially with the community, is did the Marine Corps actually capture all these people who called in? 'Cause according -- correct me if I'm wrong, Jerry, we had around 170,000 registrants --

MR. ENSMINGER: 178.

MR. PARTAIN: In December -- huh?

MR. ENSMINGER: 178,000.

MR. PARTAIN: Well, now we have 178,000 --

MR. ENSMINGER: Well now it's only 179.

MR. PARTAIN: Okay, so we had 178,000 as of December and in a four-month period only a thousand more people have been added on.

And it goes back to what I brought up before with the letter that you had in October 2010. The Marine Corps is steward of the registry, and they have clearly shown -- have abused their responsibility as steward by not disseminating information and using it to disseminate their propaganda. Once again now we've got a problem where there's a huge hole of four months when there was national exposure to Camp Lejeune on national TV, when people conceivably would have been pounding the phones to call and register or at least get on there, and the Marine Corps, their server was down. And they knew it was down in December, and it took them four months to fix it.

Now the premier broadcast was February 24th, 2012, on MSNBC of *Semper Fi*, right in the heart of this time period. What else has to happen for ATSDR to, you know, realize and take ownership away from -- of this registry from the Marine Corps and put it where it needs to be with you guys? They paid for it. You

guys, it's your responsibility to inform the community and keep the community informed, to keep this registry, that's part of what ATSDR was created for.

MR. ENSMINGER: That's what the R is.

MR. PARTAIN: Yeah, as Jerry pointed out the other day, it's what the R in your name is. But yet the Marine Corps has custody, stewardship and responsibility of it, and evidently when they feel like it, oh, they can turn it off, blaming it on a technical glitch, and then turn it back on when the danger's past.

MR. ENSMINGER: Well, Dr. Ozonoff made the statement in our initial meeting, well, it was the expert panel meeting, which subsequently created the CAP from their recommendations, but Dr. Ozonoff was on that panel, and he said, we'll just call you guys ATSD.

MR. PARTAIN: And I would like, you know, if possible, I would like some type of written response from you on that, for the record. It just concerns me, you know, I brought it up in 2010, Jerry's brought it up and here we are dealing with the same problem again, and it just, it casts a huge shadow on what you guys are doing.

DR. AKERS: Perri, let me ask you a question

about --

MR. STODDARD: Hold on. Hold on a second. There's somebody on the phone.

MR. BYRON: It's Tom.

MR. STODDARD: Tom? Are you on the phone?

MR. TOWNSEND: Yeah. Yes, this is Tom on the phone.

MR. STODDARD: Do you have a question or comment?

MR. TOWNSEND: No, I just -- the comment I had, I just saw the -- Jerry and, and the thing on CNBC last night. I'm very pleased at the work that the ATSDR is doing and that Jerry and crowd are doing. I'm wearing out but I'm kind of still following it, and I hope you guys keep whacking away at it.

MR. STODDARD: Thank you, Tom. Paul?

DR. AKERS: So my question was going to be your source of information. You said those infants that were born on the base and those who were born else where, correct?

MR. BYRON: Onslow.

DR. AKERS: Was it just Onslow or were these people that might have been part of their prenatal care and then were transferred to Quantico or Pendleton or wherever?

MR. ENSMINGER: Yeah, my daughter's one of them,

Janey.

DR. AKERS: Yeah, but I mean, that's what I'm trying to find out.

MS. RUCKART: Yeah, it was just the eligibility is the pregnancy was carried, conceived or delivered on base, so anyone who we can identify as having met those conditions was eligible if the pregnancy occurred even overseas. I mean if the, you know, part -- if the delivery occurred overseas, it didn't matter as long as one of those three conditions were met.

DR. AKERS: What prenatal visit qualified you to -- are any prenatal visits?

MS. RUCKART: Not, not necessarily a prenatal visit because some people might have conceived and were transferred off the base before they even knew they were pregnant and had a prenatal visit. That's not a condition.

DR. AKERS: Well, I mean, it's my example.

MS. RUCKART: It's just --

DR. AKERS: I guess in my mind is if the person was transferred in from say Pendleton.

MS. RUCKART: Yes.

DR. AKERS: And somebody shows up at the naval hospital at Lejeune saying I'm in active labor, my

water's broken, et cetera, et cetera, would they be included in your study?

MS. RUCKART: Anyone who was carried or conceived or delivered on base who we could locate. So as long as they met those conditions and we could find them, then they were part of it.

DR. BOVE: But keep in mind how we had to identify those who were born off base. There's no records.

DR. AKERS: I know.

DR. BOVE: Okay? So the only way we -- the only way that we can identify them is through word of mouth, through the advertising and media campaign. Other than that there's no -- we have no idea who they are, okay. So that's how that's resolved.

DR. AKERS: Well, you have a partial idea because if they were referred from the base in, if I mean I don't know if it existed at the time but if there was a higher risk pregnancy, would Lejeune take care of it or would they ship it into Onslow?

DR. BOVE: If it's a high-risk pregnancy?

DR. AKERS: Yeah.

DR. BOVE: Well, we wouldn't have been aware of it because --

DR. AKERS: That they would exist.

DR. BOVE: They wouldn't have been born yet.

MR. PARTAIN: If they lived on base, their birth certificate would be --

MR. ENSMINGER: A high-risk pregnancy would have been sent to Greenville.

DR. BOVE: Yeah. If they were born in the county, because that's how we, we got all the data from the county itself, okay. And then identified those (unintelligible) so that's how Nancy's study was done.

MR. BYRON: Both my daughters were born -- I'm sorry, this is Jeff. Both my daughters were born at Onslow Memorial. And the year that I was contacted about the in utero study in 2000, I went to Camp Lejeune, went down to Onslow Memorial, and they had destroyed the records after seven years.

DR. BOVE: Yeah, that's not how we did it.

MR. BYRON: I mean, I know that. I was just trying to inform him. I know you had some referred record.

DR. PORTIER: We have one hour left so we'd better be watching the time. Mike, yes, I'll get this to you, Mike.

MR. PARTAIN: Thank you.

MR. ENSMINGER: All right, Morris.

MR. STODDARD: Okay, we're ready for Morris.

MR. FLOHR: Before Morris starts, Dr. Dick and I are going to have to run off to the airport. Appreciate being here again. Appreciate all of you and good to see you.

MR. ENSMINGER: Thank you.

WATER MODELING UPDATE

MR. MASLIA: I appreciate everyone's indulgence for allowing me -- yeah, to move my discussion to the afternoon. I got in last night at 2:00 a.m., and it's about almost bedtime, body time. So we'll do that.

But just while I was overseas -- and I'll go over the reports right now. But just to show you where I was, the desert's in bloom. I was in Israel. That's the southern part of the country, the desert. They had a record rainfall year in the northern part of the country and so it's all in bloom.

And as a juxtaposition of all nations historically in the Middle East, that's the top photo there, right there is Gaza, about two miles there. But everything is as white as --

MR. BYRON: The base is there.

MR. MASLIA: What?

MR. BYRON: That's why --

MR. MASLIA: No, the (indiscernible) Reservoir

actually is a fresh-water reservoir that -- what I found interesting and I'll just -- in terms of water resources which is why I brought these photos up, they actually use – and it's color coded, the whole country, that's first year-in treated water. By law they're not allowed to use any processed water even no matter how treated it is -- for potable water. Potable water has to be original source of sea water, surface water.

But tertiary treated water is used to irrigate and they color code the pipes purple. The other ones are brown. And so that's how they irrigate the desert and all the farms over there, by reclaim -- they reclaim about 90 to 95 percent of their water. That's just a major pipeline, so I just found that interesting from a professional standpoint.

That's the big canyon of the southern district, and last year there was -- of course in the desert you have flash floods, and they go kayaking in there. There were people going kayaking for the day, and the water main ran through there, so -- and sunset over the mid craters.

That was my off-the-record trip, annual leave, and now we'll get back to official business here.

We are working on finalizing the Chapter A

report, and rather than summary *of* findings, it's summary *and* findings because it will now contain both a summary of all the technical water modeling analyses and findings, and as part, there's the title with the authors, and as part of that, we will have on a DVD supplemental information. It will be presented in laid-out format like we do the other printed reports that you have seen, and contain all the various subject matters that would have been summarized and would have been published separately. And that is data in terms of water supply, well capacities and histories that we needed obviously for the historical reconstruction. The water level data and ground water flow, the information that you need before you can do a model. We developed, or our cooperators developed a methodology to fill in the gaps where we did not have operational data from the water supply wells to in fact allow us to synthesize on a monthly basis how those wells were operated. We had daily operations from 1998 through 2008, and so they developed a method to use that information and then reconstruct the historical.

We'll discuss and present detail -- and all these will present the detailed technical information. Groundwater flow. We will also -- we also developed a

method to allow us to reconstruct concentrations in selected water supply wells. This is at the HP-651, without going through the very difficult and arduous task of using a groundwater flow model that comes from linear control theory.

And it matches quite well. In fact if we had information for the industrial area, which we did not, 'cause we checked over and over again, we could have not gone to the full-blown Rolls Royce fate and transport model because what we're interested in is not really the movement of the contaminants in the aquifers but rather what the concentrations are at the wells. But we were --

MR. PARTAIN: Morris, what data are you missing between 651 and the industrial area that prevents you from doing that?

MR. MASLIA: Everything.

MR. PARTAIN: Everything like?

MR. MASLIA: You have to have -- this method calls for concentrations in the well in question, plus observation wells around that, okay, with specific measurements.

MR. PARTAIN: And the concentrations for 651 have been (unintelligible).

MR. MASLIA: Yes, yes. We have -- and in fact in

our interim report, which we made a comparison between what I would call the Rolls Royce approach, which is a true full-blown fate and transport model and a linear control theory, and it matches incredibly, okay. And that is the approach we used for the Landfill model for all the subsequent degradation products.

MR. ENSMINGER: Do you -- you didn't have any of that stuff for Hadnot Point?

MR. MASLIA: No. No. No. You have to have -- you have to have monitor well information before remediation starts, okay. Okay? We just happen to have that at Landfill, okay? And so that's how they developed it.

MR. ENSMINGER: Oh. So they started, they started remediating, what, in '92 at the Hadnot Point fuel farm?

MR. MASLIA: Right, right. Something like that, yeah. But they had -- we had sufficient monitor well information and historical concentration data in HP-651 to demonstrate that the method works. Okay?

MR. PARTAIN: Well, what about the monitoring data on industrial area between '86 and --

MR. MASLIA: We have a look at -- believe me, we have looked at every single way of trying to do that. Again, what you're doing is you're replacing a

mathematically correct, of the physics, with a simplified method, okay? So it's a trade-off. But so that's all I'm telling you is where we could, we tried to use some simpler methods and still develop with that. We're able to do that at the Landfill, okay.

MR. PARTAIN: I'm just trying to understand and just see if, you know, understand what data was missing for that.

MR. MASLIA: Well, I'm telling you everything is missing at the industrial area.

MR. ENSMINGER: Wasn't that convenient.

MR. MASLIA: What? Well, no, I mean it's, it's, you know, the method is based on, on, you know, one other assumption is we're not -- it's a black box, the simplified method is a black box. That's the linear control. You have a certain input; you don't care how it gets to the outside, and then you have the output, okay?

MR. PARTAIN: Well, I'm just trying to understand why you got the data in one place and not the other.

MR. MASLIA: Well, as you know at Camp Lejeune, and I'm saying this not to be critical but to say the facts are, is that in the early years, there was not necessarily a comprehensive program to collect monitor well data or any type of data.

In recent years there have been but in recent years they're also pumping for remediation, for pump and treat, and one of the criteria of the simplified method is that you have the supply well pumping historically, and then when that supply well shuts down, it is just the monitor well with no remediation pumping taking place. Okay, so we can't go in the industrial area where they're pumping for pump and treat, they're doing pump and treat and use that kind of information 'cause it violates the method. Okay? So anyway that's -- that'll be -- I can assure you we've looked at every -- believe me, if I could have used this in the industrial area, I would have.

Anyway, then we've got the fate and transport using the full-blown, you know, modflow MT3DMS, the numerical like we did with Tarawa Terrace models to do epi, both at the industrial area and the landfill. We have to do it at the landfill to see if the simplified method worked, you know, was verified.

And then we've got the LNAPL analysis, this, for the benzene or the fuel (unintelligible). That does both calculation of the volumes, varying numerous properties, and it does the migration of the floating product as a source to the various supply wells in the industrial area.

And finally we've got the field tests of the water distribution system with the emphasis on the intermittent transfers between Hadnot Point and Holcomb Boulevard. And so each section will be, you know, contained on the DVD, the figures will be done according to cartographic standards, the data will be presented. They will just not be hard published like the other reports; it'll all be part of Chapter A. The front part of Chapter A, the summary findings where I may say, you know, for details refer to supplement such and such, will be hard-printed like the Tarawa Terrace chapter, Chapter A report. So that's Chapter A. And let me just finish -- I got a couple more and then I'll open up to questions.

The Chapter D report, which is basically the above-ground and underground storage tank report, has all reviewer comments have been addressed, and it is now in the ATSDR clearance system, and going up through the, you know, clearance protocol. And that report will be the one that contains the DVD with the releasable underground storage tank files from the underground storage tank portal. And that'll be in the Chapter D report. Our plans are to publish it because it's a companion to the Chapter C report, which Chapter C is the CERCLA sites and Chapter D is

the selective micro sites. And that's my report. I'll be happy to take any questions anyone may have.

MR. ENSMINGER: Explain the application of FOUO on the documents. The way we're understanding this, that everything that was on the disk that you've distributed for the Tarawa Terrace report, the CERCLA and CLW documents are now being declared FOUO?

MR. MASLIA: I have no knowledge of that. That's again a policy issue. All I know is we asked permission when we did Tarawa Terrace, okay, and told the Marine Corps -- at that time we dealt only with Marine Corps, what documents we wanted to release, they said okay, and we released it, and they did not -- the documents that they told us were releasable, like the CLW documents, they did review, okay, and review whatever they wanted to review, and gave us a list of what was releasable and what was redacted, according to the (indiscernible) and their final list but there was no, to my recollection, no for official use only statement provided to us for Tarawa Terrace. I want to make that clear, that was for Tarawa Terrace.

MR. ENSMINGER: So now they're trying to claim that those same CLW documents and CERCLA documents are now FOUO?

MR. MASLIA: They have not communicated that to me, okay. They've, on documents we have requested for, say, Chapter D.

MR. ENSMINGER: Yeah.

MR. MASLIA: Or a chapter which underground storage they call it, they do place and the Camp Lejeune historic drinking water --

MR. ENSMINGER: Consolidated document report.

MR. MASLIA: Data repository, repository documents, they do send that to us, even with a cover statement that says for official use only, and we produced Chapter D. We reference that statement in the cite -- reference citation part as that's what they have provided us.

DR. DAVIS: Well, is there someone else here that can answer that question?

MR. MASLIA: I can't answer to the legal policy. I'm just telling you what we're doing.

MR. PARTAIN: Morris, have you come across documents that were, like for example you're talking about Tarawa Terrace, which by the way, you know, you mentioned Tarawa Terrace was approved by the Marine Corps and Navy and released and the information was up on ATSDR's website for a very long period of time. I understand now they've gone back and redacted

information off that, the Tarawa Terrace --

MR. MASLIA: I have no knowledge of that.

MR. PARTAIN: When they -- the well locations and stuff, and the same issue before, but my question was have you come across any documents that were previously held or maybe even used in the Tarawa Terrace model that are now being FOUO?

MR. MASLIA: Yes. But only because we were not told where those documents came from. There were about 70 files, specifically that now we know are part of the underground storage tank portal, that are published, on the Tarawa Terrace DVD. At the time we asked to publish those documents --

MR. PARTAIN: But those were given permission to publish those.

MR. MASLIA: Yeah, right, right, right.

MR. PARTAIN: But now they re --

MR. MASLIA: But they -- they were not provided to us as, quote, as part of an underground storage tank (unintelligible). They were just, we requested documents. We did not know where they were housed in other words. All we know is that they were provided by the Marine Corps to us and that they're on the DVD in Chapter A of Tarawa Terrace, okay. And so to answer your question, they acknowledge that we were

going to release them as part of the Tarawa Terrace and they are in the public domain now.

MR. PARTAIN: But they're saying -- the question was --

MR. MASLIA: They have not said, again, let me clarify that, they have not said to me -- maybe they have and Dr. Portier may be able to address -- they have not said anything about anything with Tarawa Terrace. That's on our website that we have released.

DR. DAVIS: Point of clarification. I just want to make sure I understand this. We previously had access to these documents so if any of you made a screen shot of any of this stuff or copied any of it electronically, we have access to it. Would we be violating the law then if we were to share it now, since we had access -- I don't quite understand. What is the legal status of these documents now? Is there counsel that can answer that?

DR. PORTIER: Counsel's not here but I can answer some of your questions. We've not redacted anything off the website from Tarawa Terrace. We've been asked to.

MR. PARTAIN: You have been asked to.

DR. PORTIER: It was part of the original letter that said anything on your web and anything on the

current documents that appeared to indicate locations of current drinking water facilities and infrastructure, we ask that you remove it. We are considering it and we are looking at what it would cost and how difficult it would be. So we are considering it.

MR. PARTAIN: Correct me if I'm wrong, Jerry, Tarawa Terrace doesn't have any active drinking water wells and water treatment facilities?

MR. ENSMINGER: No, no, they got the water --

MR. PARTAIN: Water tower.

MR. ENSMINGER: They got the water towers and I -- correct me if I'm wrong, Morris, but I think they're still using the treated water tank from the old treatment plants?

MR. MASLIA: Yes. That's, that's the reservoir. They treated at Holcomb Boulevard and -- that's on the map.

DR. PORTIER: From what I understand, the maps for Tarawa Terrace also included some of the infrastructure for the other sites.

MR. MASLIA: Yes.

DR. PORTIER: So, it's not just the Tarawa Terrace maps that are there. So we are looking into that carefully, and we will tell you if we get

anything. But right now we're just looking at it.

The -- have we received any official request to take documents that we were given that have nothing on it that says for official use only, and they will now want us to stamp it for official use only. We have not. I have not received anyway request and Morris says he has not, then the bottom line is I'm unaware of any such request.

Do we have for official use only documents that we've received from Navy and the Marine Corps? Yes, we do. And as I pointed out to you this morning, those documents are not ours to release. Those documents, because of that saying, belong to them and they must decide whether we can release the documents or not. I can't, I can't help that. We will keep our copy. And as I said, if somebody needs to see it for a reason that -- to do with scientific integrity of the work we've done, those documents will be available for that person to look at. But beyond that, unless they release it or somebody FOIAs them and requires them legally to make a decision, we can't release it.

Finally, Devra, if you have documents, even if they are top secret documents that you came across in an innocent way and you are not a federal employee subject to the code of conduct of federal employees,

my understanding is that you would not be liable for anything.

DR. DAVIS: So for example, just theoretically for example, if one were to download all of the materials that's currently available at this point and theoretically put them on a public website for open access, and one is not a federal employee, then --

MR. BYRON: I'll be honest with you, even as a victim I might have a problem with it. Like I said, I had to consider my fellow American. My son could be on that base, and -- unless it actually has something to do with getting justice or scientific reason, if it's just to put out there so people can see it, I'm not for that.

DR. DAVIS: Well, let me speak to that as well. As someone who is the aunt of a Marine and the mother of a Marine, I have some interest in this as well; I care for the young people who serve our country also. So I would just add though that as a scientist, a science is based on the assumption of free and open exchange of information and I am no less patriotic than anyone in this room, and would never do anything to compromise our security. At the same time, I think our science is being compromised, and I don’t think that that's what -- none of us is well served by that,

so I think we agree with each other, I understand where you're coming from; on the other hand it does seem like there's a certain frivolous aspect to what's going on right now and it might be --

MR. ENSMINGER: Well, and let me interject something here. I agree with the protection, force protection; however, what is being done by the Department of the Navy and Marine Corps right now is nothing more than petty crap. It's aimed at doing whatever they can to diminish the scientific value of the work that's being done at Camp Lejeune. I know that. Just as sure as I'm sitting here looking at you, Dr. Portier, I know it.

If they had concerns about terrorists accessing their water systems, they would have done something right after 9/11. The fact is that anybody having the actual coordinates or location of these different pieces of infrastructure isn't going to make a damn bit of difference as far as the protection of the people. The only thing that will secure those pieces of infrastructure to where somebody couldn't do harm, is for the Department of the Navy and Marine Corps to beef up their physical security. And what, you have drinking water supply wells that are alongside of public highways in very rural areas, like out Highway

24 towards Sneads Ferry -- or I'm sorry, towards Swansboro, that the only protection around them is a fence -- piece of chain-link fence and a locked door on a pump house? There's not any guards on them. I mean, a van load of terrorists could ride down the road and pull off, put their four-way flashers on, discharge the people that they want to do the dirty work and then come back in a couple hours and pick them up. And they can access that pump house and nobody would ever know it. They're right there. I mean, they're right there on the boundary of the base. They got signs up: U.S. government property, no trespassing. Big deal. I mean if you truly want to protect your people, damn it, put guards on the stuff and don't worry about the damn location of them 'cause the location of these damn wells are already on the internet.

DR. DAVIS: Right.

MR. ENSMINGER: I've got 13-digit grid coordinates for every damn well on Camp Lejeune, and they're still there.

MR. STODDARD: Any other questions for Morris on what he's presented?

MR. MASLIA: I did want to clarify one --

MR. PARTAIN: Well, go back, on Dr. Portier, I do

on the FOUO, I may have mentioned it earlier, I've forgotten, but as a member of CAP I would like to request to be able to review those documents as part of our function in assisting ATSDR with the scientific integrity of their work. I'd like to extend that request for me, Jerry and whoever else in the CAP who would like to look at them.

And tagging on with what Jerry was saying, you know, the manipulation of fear to accomplish the protection of the polluter should be avoided at all cost, and that's what I see going on. I mean, this whole thing about the documents and the redactions and everything, in my opinion, only surfaced because of the success that we have had going through the documents, locating hidden document archives and going through and putting the puzzle together to understand what happened to us. If we hadn't have been successful doing that, the Marine Corps and Navy would not have been taking these actions. They're just trying to close a loophole of exposure for what they've done.

MR. ENSMINGER: They're trying to protect their legal ass too.

DR. PORTIER: I, I hesitate to give Morris any more work, but I will promise you this, as soon as he

finishes the chapter he is now writing, because I do not want him slowing down on any of those, I will have him put together a list of all documents that are FOUO within our archive, and we will send that list to the Marine Corps and ask them to review all these documents and please let us release them. That's the best I can do. If they agree to that, then I can release all those documents.

MR. PARTAIN: Well, I'm talking about, you mentioned earlier about, you know, having a scientific purpose. I mean, from at least what I've done working with the documents and the things that, you know, Jerry and I have uncovered reviewing the documents and other people that worked with us like Jim Fontella, and going through that, that is, you know, there is a value to the scientific integrity of what ATSDR's doing, and we are an official body, members of the CAP. We can sign a confidentiality agreement and do what we need to do. The Navy and Marine Corps, I can tell you right now, they are never going to agree to let Jerry and I look at anything that they have redacted until we force it out in court, which we, you know, we don't have the resources to do that.

DR. PORTIER: I'll write to them with your request.

MR. ENSMINGER: I have a question. Morris, does this Camp Lejeune historic drinking water consolidated document repository, that's a mouthful, formally known as Booz Allen Hamilton, is this an all-inclusive file?

MR. MASLIA: I don't -- I may not know the answer --

MR. ENSMINGER: But does it include --

MR. MASLIA: And I do not know -- it was never a file. Again, --

MR. ENSMINGER: This is a vault.

MR. MASLIA: -- just, just -- no, no, no, no. No, no, no, no. What occurred is after our first expert panel meeting in March of 2005, one of the, I'll call it the recommendations, of the panel was that ATSDR had to devote significantly more time and resources into what they call the information archeology. And the Marine Corps also had to assist in that, and so in November of 2005, they -- the Marine Corps brought together a team under the auspices of the contractor, Booz Allen Hamilton, and went building by building to see what documents may have -- they had a filter in other words. Any box in a building, they had a form, I won't go into it, but they developed a formula or a protocol to select certain boxes if they found it in a building, then did

it have certain key words, did it have certain key dates and so on. And if it did, they gathered that and then they scanned it all in. So no one knows, there was no official filing system because obviously, with the number of documents that we now see that they have found, these documents in boxes, were scattered all over the base. There was no -- to my knowledge, no formal filing system so I cannot answer if it's all inclusive, all I can answer is it is what it is. Okay? And yes, we have found useful documents, especially in the area of reconstructing historical well operations.

MR. PARTAIN: Morris, there was a recent document, the 1977 Oil Pollution Survey Report. It is not branded with tainting that I have recognized before in the archives that I've seen, and that was a very key report, 1977. And where did that document come from? I mean, what library or, I mean, it's got some numbers on it but they don't mean anything.

MR. MASLIA: You would really have to go back and ask the Marine Corps because I'm sure there's a custodial form as to where Booz Allen found it. That was not provided to us, and as to the location of where that was found, the date that it was found and all that sort of stuff.

MR. PARTAIN: So I'm correct in saying that that document would not have been part of CERCLA administrative record?

MR. MASLIA: To our knowledge we have not found that in CERCLA, no.

MR. PARTAIN: And it is not part of the CLW administrative file?

MR. MASLIA: We have not found it in CLW.

MR. PARTAIN: And it was not part of the Navy's UST electronic portal.

MR. MASLIA: We did not find it in the UST portal.

MR. PARTAIN: Where did you find it, buried in the back yard? I mean.

MR. ENSMINGER: Well, now, wait, wait --

MR. MASLIA: No, no. No. No we go through -- again, they provided us with a five, 600-page index and of all the Booz Allen Hamilton --

MR. ENSMINGER: And that, that has the CLW documents, CERCLA documents in there?

MR. MASLIA: Not -- sometimes yes and sometimes there are duplicate documents; in other words sometimes they would have scanned in certain documents as CLW, and listed it as CLW, which are in the --

MR. ENSMINGER: But they gave it their own

number.

MR. MASLIA: But so now -- and then sometimes they found a duplicate of the same document that was not stamped CLW and we just happen to have recognized that we had the same document as CLW. The documents that they found with Booz Allen I will say most likely most of them were not stamped CLW or CERCLA or UST, but that not mean that they may not have a small subset of them may not have been --

MR. PARTAIN: Um, Morris --

MR. ENSMINGER: So these documents that Booz Allen Hamilton found, could we say that some or maybe a lot of them are actual documents that should be part of the CERCLA record?

MR. MASLIA: I'm not a lawyer on that. That's really -- that's a legal question.

MR. ENSMINGER: Are their final reports included in these?

MR. MASLIA: Well, obviously the pollution report says final report on it. Okay? But we have not gone through, again, and determined the status of each report. We look for subject matter, information data that's pertinent, so for example if Jason needs some information in 1952 to see on an operation of water supply well, we may have looked through certain

documents to see if there was a description of well operations.

MR. PARTAIN: Okay.

MR. MASLIA: And pulled it.

MR. PARTAIN: Question, follow-up. You said this index, this 500 pages.

MR. MASLIA: Something like that, right.

MR. PARTAIN: So is it just a list of names, dates and documents?

MR. MASLIA: Pretty much. Yeah, it's their ID. They have a, you know, an ID.

MR. PARTAIN: Now is this on paper or is this a file?

MR. MASLIA: Both, and it's for official use only.

MR. PARTAIN: Well, Dr. Portier, I would like to add to that request. Please, as a member of the CAP and doing research and for assisting ATSDR with the scientific integrity of your work, I would like to request a copy of this index 'cause obviously there are documents that we don't know about. I mean this is yet another, to me this is yet another library that we're finding.

MR. MASLIA: Again, I will say, and to give you warning, and we had to do that, we made several trips

up, it is like finding a needle in a haystack for pertinent documents that we need because something may say Base Management Plan, okay, just on the title of it, but it may or may not have any useful information for us so I'm saying it was helpful to help us go back to Lejeune to say we want you to pull these documents, and then we had a team on several occasions go through those documents on the base, and say yeah, these we need, these we don't and things like that.

MR. BYRON: This isn't a new concern anyway. I mean we went through this when we were told that Booz Allen and Hamilton was going to be reviewing the documents and they were going to use key words and it was kind of known that, you know, -- I never trusted them anyway. They're hired by the Marine Corps and the Department of Defense. And didn't we have some review on that at the time?

MR. ENSMINGER: We never, we never realized -- no, they wouldn't let us in. They -- we never realized that Booz Allen Hamilton had found all of these other documents. Now we're finding out that there's stuff that they've got up there that we've never seen. But we got Congress asking for the access to this file, and we'll see.

MR. STODDARD: Any other questions for Morris?

MR. MASLIA: I just wanted to, in Chapter A, to make sure you understand part of my QA/QC process. Again, I think we discussed last CAP meeting that we provided Frank and Perri with results that they're using. And part of the QA/QC process is as I'm writing Chapter A as a person responsible, if I have questions, what grammar did someone use or why did you use it or that, you know, I'll go back to our water modelers and either say, you know, justify this for me or rerun to make sure I'm, you know, satisfied with it. And that will be done especially with model parameters where we have no site-specific data where we're using literature values and things like that.

So it seems like Chapter A may be taking a little bit longer than Tarawa Terrace or that, it's the reason it's a self-imposed QA/QC process before it ever gets into any kind of review.

MR. PARTAIN: Morris, so can we expect to see a completed water model midsummer or what are we looking at?

MR. MASLIA: Earlier than that I hope. We say completed but not publicly released 'cause it's got to go through both independent, which is internal, and external peer review, and then agency clearance. But in fact any additional analyses or things like that or

changing parameter values or things like that that this month hoping to be completely done with and actually have a draft. I've got actually more than half of the draft for Chapter A done, okay?

MR. PARTAIN: Well the other thing too was last -- one of the other CAP meetings, I don't remember if it was the last or one before last, but you had indicated that there was some roadblocks being faced during the review process that was slowing down --

MR. MASLIA: Not, not, not roadblocks. I would not call them -- it's just that's agency policy. In other words, the reports like Camp Lejeune and stuff get a higher level of -- again, it's policy clearance; it's not a tech -- it's not a scientific review. We're doing the same thing we did with Tarawa Terrace, sending it out to external peer reviewers.

MR. PARTAIN: Well, you mentioned bundling it together. I mean, I just want to make sure --

MR. MASLIA: That's what, that's what I've just showed you.

MR. PARTAIN: Are there any potential roadblocks or, not to use the word roadblock, but slow-downs would affect what we're trying to do?

MR. MASLIA: I think it would actually probably

speed it up because it's one, one package. If we had done each chapter separately, like we had, you would have the same process, independent review, external and clearance going on eight or nine different times, and now we've put that down just to one time, we will have more than the usual, -- and Vik Kapil, I'm not speaking for you, Vik, I'm just saying rather than just three reviewers on a particular subject matter, we're going to have a whole host of reviewers because Chapter A will now contain a whole host of different subject matters, okay? So but from that standpoint, I think it will speed up the review.

MR. ENSMINGER: I have just one comment to make a point. I remember when Morris and his team first started working on the water model, and they were looking for documents and trying to get assistance from the Department of the Navy and Marine Corps. Their token statement was well, we don't have subject matter experts that could determine what or what they wouldn't -- would or would not need. I can guarantee you one damn thing, when this water model's done, you're going to find damn subject matter experts coming out of the damn woodwork at the Department of the Navy, finding fault with this damn report.

MS. BLAKELY: Dr. Portier, can I make a request,

maybe you can... The next time that you're asked to redact something, remember which side of history you want to be on. Epidemiologists are supposed to have dirty hands but clean minds.

MR. BYRON: This is Jeff, I wanted to say something too. First off, I'm not -- I would never question anybody's patriotism. The only thing I wanted to say is that we keep in mind, you know, with all the pain and that that this group has suffered, that we keep in mind the safety and security of others, and I know that Dr. Davis is concerned with that or she would not be here at all. And I know that you all are. I think it's more important to see the documents than to list interconnections on maps. That's just my general statement. I would rather see that the actual information than some little picture that doesn't really mean much to me. It might mean something to somebody else. That's all.

MR. STODDARD: Okay. Thank you. Perri, did we finish with the pregnancy study report? And we have the communication plan.

MS. RUCKART: I don't know. Jana, do you want to just briefly summarize the communication plan or did you have something to hand out? I know we kind of didn't allow much time for that today.

MR. STODDARD: Okay. So the last thing we have on the agenda is, other than the wrap-up and figuring out the date for the next meeting, is Jana Telfer's going to present on the communication plan for the health studies; is that correct?

COMMUNICATION PLAN FOR RELEASING RESULTS OF HEALTH STUDIES

JANA TELFER: Yes, sir. All right, so the communicator always gets 90 seconds at the end of a meeting. It doesn't matter what meeting it is, that's just the label so we're going to do -- some of you may be old enough to remember that old Federal Express commercial where the guy talked really, really, really fast. I used to live in New York state so we're going to do our best to go through our Federal Express-like experience.

If you viscerally disagree with anything I say, please note that the nametag here is Brad Flohr. For those -- the communication plan is a draft, and it's a draft purposefully because we are thrilled to be at the table early. Typically we're asked to develop the communication plan when somebody walks into our office and said we've got this report that we're putting up on the web tomorrow; can you do the news release. And so we're very glad to be here and to be able to chat

with you today.

Also very pleased to have the opportunity to have input from people who are directly engaged in this process in the communication planning aspect of it because we very seldom have the actual audience as part of our communication planning process.

The background section of this is written for people who have much less knowledge about the structure of the studies that you all do, so I'm going to ask you to turn to page two. And we're going to start with the communication objective, which is a way that we start all communication plans. We can do a lot of communicating in a lot of different ways, but if we don't know where it is that we want to get, what kind of outcome we want to see, then it's kind of what I call a hamster day. You know, at the end of the day you spend a lot of time running on your wheel but you really didn't go too far. So these are draft communication objectives, and you'll notice that the first one is that, affected audiences have information about the study findings and the tools to enable them to use the information effectively.

I will seldom as a communicator subscribe to a communication objective that says we're going to achieve world peace. Several years ago, I was working

with a junior communicator, and I said so what do you want to accomplish with this tool kit? She had a terrific tool kit. She said, we want to change medical practice. I said, well, what you have here is a tool kit, and so maybe your objective should be make sure it's in the hands of the people who are going to be needing to use it. Twelve years later, they have changed medical practice, but it didn't happen on the back of the tool kit; that was one step in a long process.

This is in a way kind of the same, so the first objective is really to make sure the people who need to have the information, and I think I heard this repeated several times, particularly in this morning's session, that the people who need to have the information should get the information. And not only get the information but be able to understand it and then be able to use it. We can't guarantee that we're going to improve their health as a result of their having this information but we can work really hard to make sure that they get it, and that they get the materials and the information and the tools that they need to be able to apply it.

I'm going to suggest to you that we really need to work with people like you and other partners to --

as key information mediators because as a federal agency we can reach only so many people. Typically we practice on a population level, and the population of the United States is greater than 300 million so there are four people in my office who will be working on this, probably two of us primarily, and you can do the math. So we need your help, and so I'm going to suggest to you a sort of third party approach to this.

And then thirdly, the government agencies, particularly those that interact with personnel who were stationed or worked at Camp Lejeune receive and understand the study findings. And we will work with them to get some information out as we did with the, to greater or lesser effect, with the survey.

The audiences, the two sides of the table do not link up with each other. I simply rate them in tabular format in the interest of not mutilating any more trees, so the non-governmental is one column and governmental is another. Just because CAP is across from CDC/OD is accidental. I usually array audiences in order of importance so as far as I'm concerned, for non-governmental audiences, you guys are at the top of my list, and for governmental audiences, our own hierarchy is at the top of the list.

Strategy-wise I've made some adjustments as we've

gone through the day. Just one minor adjustment but I would welcome your input first of all on communication objective, secondly on audiences. Do we have them and do we have them detailed enough? I don't need to tab it down to the person but we need the major groups identified, and your input on this would be very helpful.

Strategy-wise, you all probably -- especially those of you in the military, know more about strategy than I do, but first strategy is that we have the internet site. It's a resource, and what we are going to do here in the interest of efficiency, effectiveness and budgetary awareness is to house information on the website and do a push-pull so that people can get information there and we use that as kind of our home base. We want clear understanding of findings. One example would be developing fact sheets and then I changed the third strategy to connecting with key partner and intermediary audiences to extend our outreach.

These are all draft strategies. We could have different, we could have more, we could have fewer. So methods, we are way too early, which is very exciting, as I said, in the communication process to know what we're going to do because we don't know what

the study findings are. Perri was not able to share them with you today. I guarantee you she has not shared them with me either. So until they have scrubbed and rescrubbed the data and validated everything, they're probably not going to be telling me too much.

So this is a menu, and we can choose all, some, some for some of the studies, some for others; we don't know if studies may be released at the same time, if we're going to be releasing studies consecutively, if it's going to be over a period of months, so I don't have enough information now that where we stand in the process to tell you specifically what we'll do. I can suggest to you that based on what I know about this topic, now that we definitely want to do internet, I'm going to advocate really strongly that we do direct mail, and that we do, and this is -- shareware is not exactly it, but that we do partner outreach, and that we work with people to give them information that they can extend to others.

And one of the terrific suggestions that was made today that I made a margin note on is something we've done previously, Mr. Akers, and that was to work through alumni groups. So if we can identify alumni groups that is a great way to get information out.

In one activity that where we had exposure that occurred in the 1950s, and with a long latency period, and people had grown tired of hearing from the federal government, we had an extraordinary degree of success by going to alumni groups, physicians and local television stations, where these people were clustered. Much smaller area, it was not the entire United States; it was three states in the northwest but the alumni groups were highly effective.

Clinicians can also be highly effective if they know what they're looking at, and if patients know what to tell them. So that may be another thing that we would suggest. One of our experts mentioned recently that in a certain aspect of physician care, I believe it's radiation exposure, doctors tend to see one in every, say, 1,400 patients. So between patient one and patient 1,401, they may just forget. They may forget that knowledge because they're not seeing enough of them. So if physicians, because the Camp Lejeune population is distributed across the country, aren't seeing enough of them, then they may need a reminder and the people who have received the exposures may also need a reminder that here’s how you talk to your doctor; here's some things you need to say.

So these are some suggestions. There's a timeline that is entirely fantasy because we don't know what our -- what studies are going to be or exactly what we're going to be doing so this just gives you an idea of some timing for different elements that might occur, and we would adjust this as we get closer. Did I stay within my time?

MR. ENSMINGER: Yeah. Great.

MR. PARTAIN: The Marine Corps Camp Lejeune Registry, how is that -- are you guys going to go to the Marine Corps and say, hey, send this out or are you going to get the information from them and send it out yourselves?

MS. TELFER: Yeah, I don't know yet. But I do think we should do direct mail.

MR. BYRON: I got a question. Melissa, did they give you anything to tell us or did they just leave you in the dark and tuck you out here like cannon powder?

MS. FORREST: I really came more in the receive mode. And I saw, it's where I'm new and -- but I took away several, you know, areas where I heard repeated concerns and questions that I'm going to take back to them. We'll bring some more information back next time, just based on the questions and the concerns

that I've heard today.

DR. DAVIS: Well --

MR. BYRON: I've got one more request for you.

MS. FORREST: Okay.

MR. BYRON: When the results come out at the next meeting, not only do I want the Secretary of Health and Human Services, it'd be real nice to have the Commandant here to show that he actually cares about his Marine Corps family.

MR. ENSMINGER: Shit.

MR. BYRON: I'd like to see the proof in that.

MS. FORREST: I will take that back along with the other.

DR. DAVIS: Well, I'd like to just offer clarification. In that case, perhaps you want to move this meeting to Washington, D.C.; it might be more convenient for the two of them to join us. And I also think that with respect to some of the questions that Melissa's been asked, it would be helpful if you could provide some answers before the next meeting, because we realize that you're new, the new kid on the block, and you obviously can't be responsibility for having the knowledge that we would like here now. At the time same time I think there -- these answers are overdue for some of the questions. It would be nice

to get some of them, so if you wanted to just in the constructive spirit perhaps share with us what you think the major questions are, either in writing or now, then we could comment on them and help you to get those answers to us in a timely manner, say within the next month rather than -- 'cause we don't know when our next meeting's going to be yet, and given how hard it is sometimes to schedule meetings, it might be a while.

MS. FORREST: Well, in the interest of time it'll be okay if I go back and go back through my notes and then develop a summary of what I heard as your biggest concerns, questions, and then -- I don't know the mechanism to get it out --

MS. RUCKART: Email it to me and I'll share it.

MS. FORREST: Okay. I'm sorry, I'm learning here, okay.

MR. ENSMINGER: I can guarantee you your hierarchy will not allow you, and no slight at you, believe me, but if you go back there with these, they're going to turn these over to a bunch of lawyers; they're just going to tell you to shut up.

MS. FORREST: I'll do my best.

MR. ENSMINGER: I know. Thank you.

DR. DAVIS: Thank you.

MR. STODDARD: Any other questions for Jana? Chris?

(no response)

WRAP-UP

MR. STODDARD: The only thing we have left is to decide when your next meeting is, and there's some caveats to that. Frank, Perri, did you want to address those? What was your thinking about the next meeting?

DR. BOVE: Well, the major caveat is -- well, not a caveat. What we were thinking of is the next meeting probably should focus on the results of the water modeling. I was talking to Morris about this earlier, and have Morris's whole team here and we go over all of it. And I think that's enough material for a meeting. Enough discussion to do that. And then have -- no?

MR. ENSMINGER: Morris was sitting over there.

DR. BOVE: Does it look like he's a deer in the headlights? Is that what?

MR. MASLIA: Requesting at least June.

DR. DAVIS: I have a suggestion. I recently participated in some meetings with some agencies in international where the meetings had been online. And I think that it might be worth trying that,

particularly for something as detailed as what Morris has to present. That would give us the advantage where people would actually see whatever report he wants to share in advance.

MR. MASLIA: I would like to actually suggest for the first time, since this would be, and again, I've got to clear it with Vik and Dr. Portier, because there are probably some clearance issues with --

MR. STODDARD: Morris, could you go to the mike, please?

MR. MASLIA: But my preference would be to do it in person, not online, because of the nature of the results is a whole lot of effort in preparing them for electronic viewing at this point. As a second go-round or whatever that might be a possibility, but I'm telling you right now we are really, really pressed for time. And I don't want, at this point, 'cause I would have to start now in pulling people's efforts away to do that.

MS. RUCKART: Morris, what I suggest is a month, about a month or so out from when you think you'll be ready to present, you let me know and then we start -- or sooner, I mean, you know, no --

MR. MASLIA: I still think it's a decision between science people talking to Dr. Portier and

others as to what they are -- under what conditions allowed to release because it will not have completed external or agency clearance (unintelligible).

MS. RUCKART: Then I don't know what we could --

DR. DAVIS: Then why would we bother to have a meeting then if we don't have -- if we're not going to see -- get results?

DR. BOVE: Right. That's why I'm saying what, at the next meeting should be focused on his results when we're ready, when we can present them. And then have that discussion and it's going to take a whole meeting. And then the follow-up meeting would be on the health study results, so I see two CAP meetings, unless you see additional ones, coming up. But I don't know exactly when the next meeting will be because again, what Morris just said. You have to figure out when he can actually release that. And then probably the same thing for the health study. When we go through all the clearances and have a meeting to discuss it.

MR. PARTAIN: Will these be done at the same time as far as health study, water modeling; maybe do a two-day meeting back to back?

MS. RUCKART: It depends on the timing of when things are able to be released. We wouldn't want to

hold up the water modeling if it was available and finish this peer review for the health studies, but I would like to suggest, we've done this in the past, we didn't have enough information at some point in the past for a full meeting, but we had a conference call so, you know, as we said, we can't share the results of studies but we can update on progress, we can talk about the health survey, we could always meet and have a conference call in the meantime so that we're not, you know, completely out of touch.

MR. ENSMINGER: Trying, yeah, but trying to discuss a water model over a conference call?

MS. RUCKART: Not the water modeling, just progress of where we are with the getting things reviewed and the health survey, because that is, you know, not as much material for a face-to-face but that way we don't lose touch and, you know, we can have discussions. I just suggest that, we've done it before and this way it wouldn't mean that we meet now and we don't meet for eight months. We could have some communication in between.

MR. ENSMINGER: Yeah, but I mean this is April already. We were looking at June.

DR. DAVIS: Yeah, and certainly Eddie should have -- you should have the cases that well underway.

MR. ENSMINGER: What're you shaking your head about, Frank?

DR. BOVE: We won't be able to have a -- we won't have a discussion of water modeling in June. That's why I'm shaking my head. We could have an update on male breast cancer. That can be a conference call. That, that's pretty simple.

No, I was envisioning a real good fruitful discussion with Morris's whole team present to discuss all of the aspects of the water modeling, and I think that that takes a meeting and I think it has to be in person, and I think that we have to have all the material here and have a good discussion, and I think this similarly with the health study results. That needs to be a CAP meeting on its own and I don't think they, they necessarily fall back to back, and I think that the water modeling would be ahead of the game, I think. And so that we should wait until we have a full-fledged CAP meeting then.

DR. DAVIS: I know it sounds like Perri made a lot of progress on the birth defects report, I'm not sure.

MS. RUCKART: Well, that's true but it hasn't -- I am far along in my initial phase. We still have to do some sensitivity analysis, we're going to have

checking, you know, it's my first round.

DR. BOVE: There's sensitivity analysis. We have a ways to go.

MR. PARTAIN: So we're talking July? August? September?

MR. STODDARD: So we're talking about a conference -- I heard a conference call in June?

MS. RUCKART: Well, we can have a conference call at any time, I mean, they're very easy to schedule, we're not -- we don't have so much, you know, restrictions on when people can meet or getting the room. We can have conference calls very frequently, as often as people would like. And that's just --

MR. STODDARD: Well, let's just go ahead and talk about --

MR. ENSMINGER: We need to have our meeting at least in July.

MR. BYRON: This is Jeff. I'm not only interested in the results of the study but I'm interested in your conclusions. In other words, like my next meeting was going to be my last. If I have to sit around for another year waiting for somebody's conclusions or your opinions... I don't want to wait another year; I'm not going to wait another year. I mean, you may not have them for a year; you'll have to

give them to somebody else 'cause... I'd like to know whether the Secretary of Health and Human Services'll be at the next meeting before we have the meeting. I don't want that dropped.

DR. DAVIS: I'm sorry, Jeff, I thought you said you wanted her at the meeting when we have results.

MR. BYRON: Yeah.

DR. DAVIS: We're not going to have results at the next meeting is what I hear.

MR. BYRON: Right.

MR. STODDARD: So you all want to meet in June or July regardless of whether you have results or not?

MR. PARTAIN: July.

MR. ENSMINGER: July.

MR. STODDARD: July.

MR. PARTAIN: Let's get the results of the water model done.

MR. STODDARD: Okay, and then you'll meet again when you have the water modeling results.

MS. RUCKART: Yeah, we can't say, it's a little too premature to say if we will have water modeling results to share in July. Of course we could meet in July and talk about the male breast cancer or we can update you on confirmation, you know, how things are progressing with the health survey and just where we

are with the timeline. Possibly as it gets closer we'll be able to say more about what we can share with the water modeling. It's just not something we can say now but if you want to meet in July, we can start setting that up. Setting schedule dates.

MR. PARTAIN: I was thinking along the line if something happens with the water model's going to be done a week later, just push the meeting back like we did this one. I mean.

MR. ENSMINGER: Yeah, let's just schedule something.

MR. PARTAIN: Schedule it, put it on the calendar.

MR. ENSMINGER: I'm tired of leaving here without any damn --

DR. PORTIER: Yes, let's, let's -- my suggestion. We'll schedule something. That gives me a target to bug Morris. We will also do our best. There are different levels of what we can communicate and what we can't communicate, and different formats of what we can and can't give you.

If it looks like we will not have cleared the full documents by then, there may be things we can clear that we could tell you and show you, that we know are not going to change. Many times after the

document leaves here, it's not the actual results that are changing, it is the way they're presented, the way they're interpreted, the way they're discussed. And so and sometimes that takes a bit of time.

Before we go, Mike, before you run out the door, I want to make sure I've captured everything. I see, and Jeff, I see a whole bunch of requests: copy the Booz Allen index; access to complete unredacted information as representatives of the affected population; review the things that are FOUO; ask the Secretary of Health to come to the next meeting; and see if we can get a presentation of the results with the full story available for that next meeting. I will pursue these. I'm not saying we're going to do them. I'm going to request them. I'm going to go through proper channels to try to get this to happen. But that's the things I hear. Is that the list?

MR. ENSMINGER: No. I asked for a seat at the table.

MR. BYRON: And with the Secretary, I would like her to be here when we get the conclusions.

MR. ENSMINGER: You, you faked writing that down this morning.

MR. BYRON: And what will the next steps be for their --

DR. PORTIER: I asked about that one before. Okay.

DR. DAVIS: You mean to meet the head of CDC? As well as -- to meet the head of CDC and the Secretary?

MR. ENSMINGER: Oh, that too. But I'm talking about a seat at the table when they have their meetings with the Department of the Navy and the Marines, as representatives of the affected community.

DR. DAVIS: Right.

MR. ENSMINGER: Okay, I'm out of here. Sayonara.

MR. STODDARD: Is there anything else for the good of the order?

MR. PARTAIN: We get the dates on the July?

MR. STODDARD: Very well, we'll take care of that. You are adjourned.

(Whereupon, the meeting was adjourned, 2:10 p.m.)

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 April 2, 2012; 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 12th day of May, 2012.

_____

STEVEN RAY GREEN, CCR, CVR-CM, PNSC

CERTIFIED MERIT COURT REPORTER

CERTIFICATE NUMBER: A-2102