THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

TWENTY-FOURTH MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

January 17, 2013

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 January 17, 2013.

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

C O N T E N T S

January 17, 2013

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)

BLAKELY, MARY, CAP MEMBER
BOVE, DR. FRANK, ATSDR
BRIDGES, SANDRA, CAP, CLNC (via telephone)
CLAPP, RICHARD, SCD, MPH, PROFESSOR
DICK, WENDI, VA, OFFICE OF PUBLIC HEALTH
ENSMINGER, JERRY, COMMUNITY MEMBER
FLOHR, BRAD, DEPARTMENT OF VETERANS AFFAIRS, COMPENSATION SERVICE
MARKWITH, GLENN, NAVY MARINE CORPS PUBLIC HEALTH CENTER
MASLIA, MORRIS, ATSDR
PARTAIN, MIKE, COMMUNITY MEMBER
PORTIER, DR. CHRISTOPHER, DIRECTOR NCEH/ATSDR
RUCKART, PERRI, ATSDR
SINKS, DR. TOM, NCEH/ATSDR
STALLARD, CHRISTOPHER, CDC
TOWNSEND, TOM, CAP MEMBER (via telephone)
WALTERS, DR. TERRY, VA

P R O C E E D I N G S

(9:00 a.m.)

WELCOME, INTRODUCTIONS AND ANNOUNCEMENTS

MR. STALLARD: Welcome, everyone. Welcome to our January 17th CAP meeting. Happy New Year to everyone. Before we go around and do introductions, as is our custom, I'd like to go over some guiding principles, and then go around to do introductions and get into the agenda. And if you have anything to add to these guiding principles, please let me know that. If you recall --

MS. BRIDGES: Sandy Bridges on the phone.

MR. STALLARD: Hi, Sandy, we're going to get to introductions in just a minute.

MS. BRIDGES: Okay.

MR. STALLARD: All right, and welcome.

MS. BRIDGES: Thank you.

MR. STALLARD: Please turn your cell phones on stun, silence or off so that we cannot disrupt the proceedings here today. As you know the audience is here to listen. That includes the audience that's receiving this broadcast right now. For the audience that's in the room, we ask you to refrain from jumping into the conversation unless asked to by members of the CAP panel.

For those of you on the CAP meeting, please use your microphones when you speak, if you recall, and you have to push it so the red light comes on -- or green light, and state your name for the court reporter. Respect the speaker. One speaker at a time, and it's not generally our practice to have any shouting matches here but I just want to remind you that one speaker at a time so that we can record what's being said. Again, no personal attacks. We ask that you refrain from emphasis with profanity, please.

And given the fact that we are here in a public health environment, this is an opportunity for a public health message. This is flu season; it's very bad. Please be sure that you practice good public health hygiene, if you have to cough, into your elbow and wash your hands frequently. So with that, let's please go around the room and introduce yourself, your name and your affiliation.

DR. DICK: Wendi Dick, Office of Public Health with Veterans' Affairs. Oh, sorry. Wendi Dick, Office of Public Health, Veterans' Affairs.

DR. WALTERS: Terry Walters for the VA.

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

MR. MASLIA: Morris Maslia, ATSDR division of community health investigations.

DR. BOVE: Frank Bove, ATSDR.

MS. RUCKART: Perri Ruckart, ATSDR.

DR. PORTIER: Chris Portier, Director ATSDR.

DR. CLAPP: Dick Clapp, member of the CAP.

MR. MARKWITH: Glen Markwith, Navy/Marine Corp Public Health Center.

MR. ENSMINGER: Jerry Ensminger, Camp Lejeune CAP.

MR. PARTAIN: Mike Partain, CAP.

MR. TOWNSEND: Tom Townsend, CAP.

MR. STALLARD: Okay, welcome Tom, thank you.

MS. BLAKELY: Mary Blakely, CAP.

MR. STALLARD: Thank you, Mary.

MS. BRIDGES: Sandy Bridges, CAP.

MR. STALLARD: All right, Sandy, welcome.

MS. BRIDGES: Good morning.

MR. STALLARD: Good morning to you. Dr. Portier, do you have any comments before we move on?

DR. PORTIER: No. Let’s...

MR. STALLARD: Get right into the agenda? Well, I have no other formal announcements to make. There's been no changes in CAP membership. We'll allow Dr. Sinks to introduce himself for the benefit of all.

DR. SINKS: Tom Sinks, deputy director NCEH/ATSDR.

MR. STALLARD: All right. One announcement in terms of CAP transitions. I ask that you do all sign on the sign-in sheet when you came in; that's important for us to keep track. And with that, we're going to move right into Perri providing us action item update from the previous CAP meeting. Perri?

ACTION ITEMS FROM PREVIOUS CAP MEETING

MS. RUCKART: Okay, good morning. I handed out to everybody a summary of the last meeting, and I'm not going to go over that in detail but you can read through it and refresh your memories there. I just want to hit the highlights and go over the action items from the last meeting.

So at our last meeting, there was some discussion regarding Chapter D on the RCRA sites and the ground water contaminants. Dr. Portier stated that the DoD would receive the document before the release as a heads-up, informational copy, not for their review. And the CAP requested that they have the same opportunity as the DoD. And Dr. Portier said that would be fine.

So a conference call was held with the CAP on December 4 to discuss Chapter D, and the CAP was

provided with an advance copy of the report the morning of the call. During the last meeting, Mike asked that we email the CAP the total number of cancers and other diseases, among both Camp Lejeune and Pendleton, that we're seeking confirmation on from the health survey as well as the list of diseases, and all that information was shared with the CAP later on in the afternoon, after the meeting ended in July.

Mike also asked if he could share his list of self-reported male breast cancer cases so that we can cross-reference them with the names identified from the VA cancer registry, and tell them the number of cases that matched, and how many more were added, of course not to share the personal identifying information. However, we’re unable to provide the number of matches between your list and the cancer cases in the male breast cancer study because of confidentiality.

There's likely to be few matches because your list is going to include a lot of people that wouldn't be covered by the registry. So for that reason, it might be possible to identify the cases and the identities need to remain confidential.

Glenn Markwith said a letter will be forthcoming to the CAP, explaining the server problem with the

USMC registry website, and that information was provided and shared with the CAP in late July. That's it.

MR. STALLARD: Good, thank you, Perri.

MR. PARTAIN: Perri, this is Mike Partain.

(loud noise interference)

MR. STALLARD: It's me. Sorry.

MR. PARTAIN: On the -- with the male breast cancer study, they were going to -- y'all were going to get a letter to me, a formal request, so I can give the information. I'm still waiting on that. With a letter basically saying that you weren't going to share the information, so I could have it for my records.

MS. RUCKART: Well, at the time that you made the request, I wasn't aware of what the response was, so I -- this decision was recently made, when we were preparing for this meeting, so I didn't realize you wanted a formal request. Your request to us was verbally. I think normally we respond in writing when we get a written request.

MR. PARTAIN: Well, I can get a written request. The main purpose of it is, you know, to show the list. I just wanted to have something from y'all stating that you would like to see it. I understand the

confidentiality part and what have you; I'm not disputing that. I just want to, you know, have something to CYA myself.

DR. PORTIER: That's fine. We'll get you. Basically you just want a letter that says: We want your list and we won't share it with anyone; keep it confidential. We can do that.

MR. PARTAIN: Yes, thank you.

Q&A SESSION WITH THE VA

MR. STALLARD: Thanks. Well, then, moving on, this is our opportunity for our update question and answers with our Veterans' Affairs colleagues. You do have a presentation?

DR. WALTERS: I have a presentation. Brad, do you want to go first?

MR. FLOHR: Yes.

DR. WALTERS: Okay.

MR. FLOHR: We are continuing to process claims in our Louisville regional office. There was some concern about numbers of claims we might receive following passage of 112-154, so some of our folks have been looking at perhaps decentralizing, if necessary, but so far we have not received really a big increase in the amount of claims that we've got.

There's not been a big increase in the numbers of

claims coming into Louisville since the -- since August, since that legislation was passed. So for time being, at least, they will remain there.

There also is a big reporting change that we are making. Not all claims based on Camp Lejeune service are actually done in Louisville. There are certain categories of cases, claims that we do electronically. They are only done in a couple of offices and they remain by being processed there. We're going to be able to track all of those cases in the new report that we have developed. It's in the final stages. Louisville itself will not have a run of numbers and it will be done by our data folks, accumulative total, and we update it whenever we need it or when we're asked to provide it to press or whomever needs it. We will have all the data available.

We have also worked with Dr. Walters' staff, not necessarily Dr. Walters' staff but Veterans' Health Administration. We went to Louisville. We sent several medical physicians, clinicians and VA claims processors to Louisville, and we looked at every decision that had been made, every grant, every denial, to see how, in fact, how consistent we were being, 'cause our goal was to be as consistent as we can possibly be in making decisions on claims.

We decided to, to develop a list of subject matter experts. These are clinicians in environmental medicine, people that are up-to-date on all the available information about Camp Lejeune, about the water contamination. And what happens now is that Louisville will make a request to one of these SMEs, the claims file will be sent to them, they will review the evidence in the claims file and make the decision. Again, our hopes are that it will be more consistent, that when something needs to be -- should be granted, it is. And we'll see how that works but I think it's -- so far it's going to be working pretty well.

We continue -- our data that we have shows that we're providing at least one granted disability in 25 percent or so of the decisions that we make; that has not changed over the last year and a half. I think that's a fiscal type anomaly. Once a baseline is attained it tends to stay that way.

Other than that, I don't have anything else to update you on. I'll be glad to answer any questions.

MR. PARTAIN: Brad, you mentioned there's been no significant increase since the pass of the legislation. Can you give an idea --

MR. FLOHR: In claims per compensation.

MR. PARTAIN: Claims per compensation. Can you

give an idea, like is there a number of claims per month that you're getting in for Camp Lejeune with the VA?

MR. FLOHR: It is -- I don't have the numbers with me, Mike. I think it's somewhere in the order of a hundred or so.

MR. PARTAIN: All right.

MR. ENSMINGER: What's the main reason for any denials?

MR. FLOHR: The main reason for denials is the negative medical opinion. We're looking at all the evidence and when requested, if medical opinion comes back indicating that it is less likely than not that it's not due to the water contamination. It's similar to, yeah, all of our claims that we get medical opinions on, so that's fine.

MR. ENSMINGER: When we're dealing with the lack of information right now pre-'57 concerning claims that -- from veterans that were at Camp Lejeune prior to 1957, I've got one guy that's a metastasized male breast cancer patient who is dying. I got a call from him on my way here yesterday, and he received another denial. And they cited the fact that they, the VA, does not have information on exposures prior to 1957 at the Hadnot Point system.

MR. FLOHR: Yeah, well, of course I'm aware of that case, and I did some work on that case when I heard about this particular veteran was at Camp Lejeune between 1954 and 1956. When the claim was received, it was submitted to Louisville. Louisville looked at it and said, well, he wasn't there when the water was contaminated because as far as we know it was 1957 to 1987. So they sent it back to the St. Petersburg office and denied the claim.

This has been in the press so we were looking at it. And I was surprised, I went on the ATSDR website and I saw where for Hadnot Point, this information that it may have been possibly contaminated as early as the late 1940s or the early 1950s, and I had not known that before; I had not heard that before. But on that basis we, we returned the claims file, because we had the claim, to St. Petersburg, giving them our opinion that it was possibly, at least as likely as not, that he was exposed based on the information on the ATSDR website; therefore, they didn't request a medical opinion on that basis and sent it to one of our SMEs. And I had not heard what the decision was. The SME, I'm sure, did what they could do. They're very up-to-date on everything. But there's no information about that pre-1957.

MR. ENSMINGER: Nothing in concrete, no. I mean, we need dates.

MR. FLOHR: Yeah.

MR. ENSMINGER: And this information, from what I understand, is available now. That information is -- and we have a, a predecessor, a executive summary for the Tarawa Terrace water system that got issued in early June of 2007. The executive summary was released in anticipation of the hearing that was held on 12 June.

And the actual Chapter A for Tarawa Terrace was not -- was subsequently released in late July. Why can't we do that for Hadnot Point? What's wrong?

MR. STALLARD: Yes, Dr. Portier?

DR. PORTIER: Jerry, we're going to go over this with Morris's talk. There are certain things we're going to cover at that point, and this is one of them.

MR. ENSMINGER: I mean, but this information is available. We got veterans out there who are life -- I mean life-ending diseases. These people are terminal. And they need this information. I mean, isn't that what the public health service does?

DR. PORTIER: So after your message to the Marine Corps five weeks ago, we have been working diligently to get this information to the VA. This morning we

have transmitted to the VA formally the information we will show you when Morris gives his talk.

MR. ENSMINGER: Thanks.

MR. STALLARD: Any other questions for Brad?

MR. TOWNSEND: Yes. Yes, I have a question.

MR. STALLARD: All right, Tom.

MR. TOWNSEND: Tom Townsend in Moscow, Idaho. This is a VA representative speaking, right?

MR. STALLARD: Yes.

MR. TOWNSEND: I would point out that I've had a veteran's claim for six years for neuropathy. I've had 16 neurological consults with a board certified neurologist who indicated -- whose diagnoses have been provided to the VA. My claim was not at Louisville but it was at the Board of Veterans' Appeals, and I have yet to have a physical exam by a VA-directed neurologist. And I all of a sudden out of nowhere on the second of this month I get a supplemental statement of the case from Louisville VARO, VA regional office, denying my claim. And then it has with that a report by an unnamed physician that alleges that I don't have any neuropathy, which is very difficult to make me walk. And then it has a diagnosis by a Vietnamese, Dr. Pham, P-h-a-m, who I've never seen. So what's going on?

MR. FLOHR: I really can't answer that. I have no idea. I don't know -- I've never seen the claim. I don't know what stages it's in or where it's been. So I really can't comment on individual circumstances, but if you give me your information, I can perhaps find out where it is and what's going on with it. If you want to give me your name and claim number, I'll check on it.

MR. TOWNSEND: First name is Thomas, Tom. Last name is Townsend, T-o-w-n-s-e-n-d.

MR. FLOHR: Okay.

MR. TOWNSEND: The phone number is 208 --

MR. FLOHR: No, I need your claim number.

MR. TOWNSEND: 208-882 --

MR. ENSMINGER: That's his phone number.

MR. FLOHR: Go ahead.

MR. TOWNSEND: Wait. Do you want my phone number?

MR. STALLARD: No, we want your claim number, Tom.

MR. TOWNSEND: Oh.

MR. STALLARD: I mean, this is a public forum. Is there some other way that we could transfer that rather than in this public forum? I tell you what --

MR. FLOHR: Why don't you send your VA claim

number to Jerry, and he can then give it to me.

DR. PORTIER: I'll have my secretary call him and get it and bring it to you today.

MR. STALLARD: Okay. Tom, we're going to call you later today on a more private line and get your claim number and deliver it to Mr. Flohr.

MR. TOWNSEND: Okay. Well, I'll put the phone call in.

MR. STALLARD: You will expect a phone call, which means that when we take a break, you're going to have to disconnect so that we can call the number. Do we have his number?

MR. ENSMINGER: Yeah, yeah.

MR. STALLARD: All right.

MR. TOWNSEND: Okay. I just wanted to make -- I find it very unusual that all of a sudden my claim shows up at Louisville and no one tells me it's down there. Last time I heard it was in the Board of Veterans' Appeals. And I wind up with inspections with unnamed medical people and some comment by a Vietnamese doctor with a Vietnamese name that I've never seen or been seen by. I mean, and it, and it just ignored completely 15 neurological consults, and it never mentions the consults that I've provided to the VA over the last five or six years.

MR. STALLARD: All right, Tom, well, it seems like it's going to have to be sorted out on an individual basis, and I'm sure that when we get your claim number and Mr. Flohr looks at it, he may be able to address the anomalies that you're raising.

MR. TOWNSEND: Well, the, the VA up in Boise, Idaho has made contact with the VA in Louisville, and yeah, okay. But I want to get this squared away; it's been going on for six years. I'm 82 years old and I've been shoveled off too damn long as far as I'm concerned.

MR. STALLARD: And you're probably buried in snow and it's 6:30 in the morning in Idaho, right?

MR. TOWNSEND: Yeah, right. There's plenty of snow outside and it's 6:30 in the morning and it's colder than hell. I'm back in bed.

MR. STALLARD: All right. We feel your plight.

MR. TOWNSEND: Okay. Thank you.

MR. STALLARD: Thank you, Tom.

MR. PARTAIN: Hey Brad, the numbers for the VA, as far as claim stuff, you mentioned about an average run a hundred a month. When was the commencement day as far as the VA tracking and tallying numbers; when did you start doing that?

MR. FLOHR: Well, when we consolidated the

process in Louisville.

MR. PARTAIN: Then last year?

MR. FLOHR: December -- no, that was December of 2010.

MR. PARTAIN: 2010? Okay. So did any claims -- did y'all, and I know we talked about it before, I just want to make sure I'm straight, but did -- the numbers that y'all have and been reporting to like the Senate Veterans' Affairs Committee commence December 2010, and you didn't go back and comb through anything to find prior numbers?

MR. FLOHR: Yeah, we did.

MR. PARTAIN: Okay.

MR. FLOHR: And then it was not -- it was not something we could easily do.

MR. PARTAIN: Yeah, I understand.

MR. FLOHR: We've identified them but we did -- we were able to identify about 195 cases.

MR. PARTAIN: Prior to?

MR. FLOHR: That had been -- prior to consolidation. I think I gave you the numbers before. And there was well, 23 or 24 of those that had been granted. That's all we were able to...

MR. PARTAIN: Okay. And specifically do you know or are you able to provide an idea how many male

breast cancer cases have been granted with the VA to date?

MR. FLOHR: Yeah.

MR. PARTAIN: Has it changed since last year? Somewhere of five.

MR. FLOHR: As of the end of September of last year, the end of FY '12, there have been 17 claims granted.

MR. PARTAIN: For male breast cancer?

MR. FLOHR: For male breast cancer -- well, for breast cancer, not necessarily male, but female, too.

MR. PARTAIN: Okay. There's no way to delineate the two?

MR. FLOHR: Not at that time. We're trying to get an identifier for that put into our systems.

MR. PARTAIN: Okay.

MR. FLOHR: That's it that I'm aware of. Seventeen granted and 13 denies.

MR. PARTAIN: Okay. And do you have a total number of VA cases that have been presented to the VA for Camp Lejeune, to date?

MR. FLOHR: Again, as of the end of FY '12, there have been 1,822 claims decided by the VA.

MR. PARTAIN: Decided? Okay.

MR. FLOHR: Decided.

MR. PARTAIN: Okay. Do you have a total number of cases presented, including ones that are still in consideration? And you said FY 2012; you're talking October 1st, right?

MR. FLOHR: Right. We do not have the number of claims pending.

MR. PARTAIN: And roughly of the 1,822, 25 percent approval rate? And now, are you guys tracking the different types of cancer, kidney and what --

MR. FLOHR: Yes.

MR. PARTAIN: Okay. And --

MR. FLOHR: What we provided to Senator Burr's staff and the last one was dated in September. That's got a breakdown of the diseases. That's going to be a new report going forward.

MR. PARTAIN: And the report being made, I know it's being made to Senator Burr, but can we get a copy of the report as the CAP, too, or is that something that we --

MR. FLOHR: I would not see why that would not be possible.

MR. PARTAIN: Okay. I would like to have that, if possible. Thank you.

MR. STALLARD: Any other questions for Brad? Okay, let's move into -- I do believe we have a

healthcare benefits update with Dr. Walters.

DR. WALTERS: Oh, sure.

DR. DICK: I've got a fact sheet that I'll hand out as --

DR. WALTERS: Okay. Good morning, I have my Diet Coke so I am at least publicly presentable. My name is Dr. Terry Walters, and I am the deputy chief consultant for environment post-deployment health. And my purpose here today is to speak as the co-chair of the VA task force that is implementing the section 102 of the Honoring American Veterans and Caring for Camp Lejeune Families Act of 2012, the Janey Ensminger law. So as I said, I am the co-chair along with the chief of the business office, Ms. Katie Shebesh on the implementing this law, which was passed on the 6th of August 2012.

And first, what I'd like to do is I'd like to go through my entire presentation, and if you could hold your questions to the end 'cause there -- some of your questions might be answered in later slides, and then we can have a discussion.

First of all, I'm going to go over what this law, as written, includes, and I have a copy here so we can go to the exact language. It provides healthcare for 15 conditions for veterans and family members who

resided at Camp Lejeune for at least 30 days or more between the dates of January 1, 1957 and December 31, 1987. The veterans who were on active duty and the family members who had to reside on Camp Lejeune or were in utero. And this is the list of the 15 medical conditions.

The care provisions include: VA cannot provide care for conditions found to have another cause. So if a veteran or a family member had a broken bone because of a car accident, we cannot provide care for that because it obviously is not related to Camp Lejeune. Family member care requires congressional appropriation prior to VA giving care. Let me read you the language: So the Secretary may only furnish healthcare and medical services under subsection a, to the extent and any amount provided in advance in appropriations acts for such purpose. And to date that appropriation has not been passed.

So what VHA is limited to right now is preparing the grounds for when that appropriational act is passed so we can hit the ground running like we did for veterans. We started providing care for veterans, Camp Lejeune veterans, the day the law was signed on the 6th of August.

Also in the law the VA is the last payer. So if

the family -- and this is for family members, not veterans. If a family member has Blue Shield/Blue Cross, and they have breast cancer, Blue Cross will pay for an episode of care, and anything that is not covered, VA will pick up the rest of that cost. If they don't have healthcare insurance, obviously VA is the entire payer for that care. But again, if that family member has a broken leg, VA is not going to pay for that care. So for them not to have healthcare insurance exposes them to risk for everything else that isn't one of those 15 conditions.

The act also requires VA to provide annual reports to Congress on the following conditions: The numbers seeking care, broken down between VA and veterans; the number of medical conditions for which care is sought; the number denied care; and the number awaiting termination of status.

In response to the act, VA began responding by providing care to Camp Lejeune veterans the day the act was signed, on the 6th of August. And we also instituted a tracking mechanism on that day, according to the CLEAR report, not to Camp Lejeune environmental report. I think we kind of fit that up into that. And to date, the total number of veteran inquiries has been 1,429, and this as of last Friday, and the total

family member inquiries up 291.

So the VA initial implementation steps, as I told you, we started providing care to veterans on the 6th of August. We created a mechanism to track requests for care by veterans and family members, called the CLEAR report. We updated our web page, placed a banner on all the ^, these are the large area VA providers, alerting people to this new law. We created an implementation task force, of which I am a co-chair, Katie Shebesh is the other co-chair, and because of this inability to provide care to family members right away, we were very concerned that if a family member comes to a VA medical center saying, hey, I have breast cancer and I need care today, we are legally prohibited from providing care but we're not legally prohibited from helping that family member find other sources of care. So we have created a mechanism by which the eligibility clerk says, I can refer you to our care coordinators, which within the VA are the social work services, to find other sources of care. And for some of these cancers, particularly the gynecological cancers and breast cancer, there are federal and state programs out there which provide care, and it varies by state. But the care coordinators in the social work care services know

about these services, and they've also researched these so we can help these people find these sources of care.

The vision of the task force is to implement the Caring for Camp Lejeune Families Act using an interdisciplinary team from across the VA to provide healthcare to Camp Lejeune veterans and their family members as quickly as possible. And this requires not only doctors and nurses, it requires fundamental changes in business processes, information technology processes, because VA does not routinely provide healthcare to family members.

And the purpose is to develop and implement policy system and process changes so we can provide high-quality healthcare to all eligible Camp Lejeune veterans and their family members, as specified in this act.

Our guiding principles are to be, and these are followed from VA principles, are to be people-centric, make sure that implementation is fair, simple and easy as possible, improve the accessibility of healthcare for Camp Lejeune veterans and their family members, and most of all decrease the hassle factor for all.

Now, this is healthcare; this is not compensation. And a lot of people make that mistake

in assuming it's compensation. VBA is a separate administration within the VA. We are Veterans' Health Administration. We need to be timing- and results-driven; needs to be a transparent process with regular updates, all involve stake-holders. That's the reason I'm here today is to provide you an update of where we are and to be transparent in the process.

Be adapted to previous lessons learned. About a year and a half ago there was legislation passed called the Caregivers' Act. And it again provided some care and mostly renumeration(sic) to caregivers of seriously injured combat veterans. And so there were many lessons to be learned in writing regulations, in changing the information technology systems that we're trying to use in implementing this very complex process. It sounds simple; the devil is in the details. And we want to be forward-looking and implement efficiently and effectively towards other -- so that we can be ready when the appropriation is passed.

So these are the implementation stages: Enroll veterans, assemble a task force, identify key issues, gather information, define processes, develop a six-month plan, obtain legal opinions, define key elements, assemble resources to implement family

member programs. Those of you in the six-paragraph operations order in the military will recognize many of these steps. Draft veteran and family member implementation regulations, and we're right there at this point. This is where we are in this process: Implement family member care upon appropriate approval. Outreach to family members, which I'm going to need your help in, which I would like to discuss. And annual reports and program review.

So what we've accomplished so far, we've assembled a task force; we have a method to track inquiries; we have our legal opinions on enrolling veterans program for family member care, screening, and I will go over these; we've defined important processes such as verification of clinical eligibility, administrative eligibility; we've defined important terms, because what does Camp Lejeune mean? Does it mean everything that has the Camp Lejeune label or does it mean the contiguous geographic area? Does it mean the air base? So we have -- and when we write regulations, we have to be very, very explicit because all our regulations, one of the slow-downs in the regulation process is that they have to go out and get public comments. They have to be published in the federal register. They have to go through the OPM,

all these legal steps, which are beyond the VA. So we have to be very specific in our regulations.

Outreach. I have talked to congressional representatives; I have talked on the phone to Mr. Ensminger; I've talked to veterans' service organizations, and today part of the outreach is talking to you, the CAP. We've identified with the Marine Corps critical sources of information, for example, the Marine Corps is digitalizing all the housing records. Because there is not a --

MR. ENSMINGER: Really?

DR. WALTERS: Yeah, really.

MR. ENSMINGER: Since when?

DR. WALTERS: Since two months ago. So they're scanning all those cards and putting in optical character recognition.

MR. ENSMINGER: Well, there was a bunch of those cards missing.

MS. RUCKART: Yeah, from our records, not from the source.

MR. ENSMINGER: Oh, really? Oh, but they found them now so --

DR. WALTERS: Any source of information is going to be incomplete. We have to get, you know, what we can.

MS. RUCKART: But the Marines' records were never incomplete. We took 90,000 records from the beginning, well, all the housing records that were there in the 90s, whenever this effort took place, and then at some point during a move or something, ATSDR lost a box. The source records were never in a box. But we didn't know what records were lost and try to work with them to get them. That was the whole thing right there.

DR. WALTERS: So things like the housing records are being digitalized; we're trying to use lessons learned from the atomic veterans and how those veterans were identified, to try and define a process by which VA can verify that a family member or an active duty service member was at Camp Lejeune during these dates. Ultimately I believe that it's going to be DoD's responsibility to do that initial step of administrative eligibility, because simply VA does not have access to those records.

We have a draft definition of what those 15 medical conditions comprise. And you would think the defining medical lists is easy but it isn't because, as you well know, you can have leukemia and have high blood pressure or vomiting or diarrhea but that counts as secondary to your treatment for leukemia. So a

person may come in for vomiting and diarrhea and we're going to have to relate it, if possible, to that diagnosis. And so that includes the whole gamut of medical conditions. Again, as I said before, if someone comes in with a broken leg, that could or could not be related to their primary condition. If it's a metastatic lesion, causing a bone breakage, then it is related. If it's secondary or car accident, it isn't related.

So there has to be, in every episode of care, a medical decision: Is this related to those 15 conditions? Yes or no. Because if it's not, VA is legally prohibited, for family members, for providing care. And there's slight differences between veterans and family members. And I'll get into that with the next slide.

We've identified additional resources. There's a funding estimate, because to make the change in the VA system to flag veterans when they come in, so they don't get charged a co-pay, it's going to take about five million dollars and 18 months. So right now we have to do a manual process. So again, the law sounds simple but the devil is in the details. And that care coordination process prior to the appropriations of family members, that process was implemented.

So we have got several legal opinions. So care for veterans, what we do for veterans is VA has eight categories of priority. From category 1, you're a combat-disabled veteran, missing a couple of limbs, clearly you are our priority, category 1. To category 8, you make over an income threshold, say you make $200,000 a year, you're a veteran, right now you cannot -- and you don't have a service-connected disability, right now you do not get care within the VA because the VA has limited space to take care of veterans.

So there is a priority 6, which means that you -- other veterans, like with Agent Orange, Gulf War veterans, atomic veterans and now Camp Lejeune veterans are in this priority 6 category. So care for those 15 conditions, no -- care is free, no campaign will be required.

So if you have a veteran coming in, say they have breast cancer and they have diabetes. So the breast cancer will be -- for everything associated with the care of that breast cancer will not need co-pay. But now they will be eligible for the entire package of care, because veterans, we enroll veterans, we provide all care for veterans. So for their care for, say, their diabetes, which is service-connected but not

connected to Camp Lejeune, they will be charged a minimal co-pay. Okay, but they will still be provided care, and it is a good deal. But prior to that, if this person was a category 8, they wouldn't have been able to enroll in VA at all -- VHA at all. So this law gets the veteran in the door eligible for care.

On the family member side, we are -- we're in a policy decision pending as to how to provide care to family members. And there are three basic choices: One, we reimburse care that is provided to the family member. Say they go to their local clinician who they've been seeing, and the bill, then, goes to the insurance company, Blue Cross/Blue Shield, and then it goes through a central office in VA to provide -- to reimburse the remainder. Or if they don't have insurance, the entire bill goes for that -- those 15 conditions to that central office. That's one model.

A second model could be that the family member receives their care within the VA for only those 15 conditions, okay. And then a third model could be a hybrid of those two, some care is within the VA, some care is with reimbursement of their private physician. So right now we're engaged in a policy decision as to what is best for continuity of care; what is best for quality healthcare; what is easiest to actually

implement; and what is the least hassle for the beneficiary.

The other policy decision was on screening. So, what if you are a family member or veteran and you're concerned about your exposure; you're concerned that you may have, say, leukemia. How do we -- but we don't want people paying for a screening exam to prove that they have a disease. So we made a decision, policy decision, that all screening for these 15 conditions, of which the only test that is on a regular basis is a mammogram for breast cancer, we will pay for a screening examination, family member or veteran, okay. So if you are a family member, once the appropriation is passed, once regulations are written, we will pay for family members to get a visit with their doctor and a mammogram, and any indicated blood tests.

So say you come in, you have fatigue, you're coughing blood, well, then, we're going to go down that clinical pathway to see if you have lung cancer or why you have coughing blood, hemoptysis. So again, we're trying to decrease the hassle factor. We wanted to get some determination specific covered medical conditions, and there are several conditions that are somewhat, they're not accepted routine medical

diagnosis. One of them is neural behavioral effect. What does that mean? That's a research term. Basically when this law was written, they took those 15 conditions out of the NCR report.

MR. ENSMINGER: NRC.

DR. WALTERS: NRC report, excuse me. But neural behavioral effects is a research term. What does that mean clinically? So we're trying to come to a decision as to what that exactly means in terms of a disease or a diagnosis.

I talked about screening, regular updates, that's why I'm here. We have to develop and disseminate educational materials. And the two groups that we need to educate are the providing physicians: What does exposure to Camp Lejeune contaminated water mean for your patient that's sitting before you today? We also have to have a mechanism by -- you know, 'cause all you, you know, Camp Lejeune people don't come in with a C-L on their forehead. How can we identify people if they don't self-identify? And we have to educate clinicians seeing the patient, and that's both within the VA and outside of the VA.

So a family member goes to -- say we decide to reimburse family members, to reimburse their regular physician, excuse me. We want that physician to know

exactly what exposure Camp Lejeune contaminated water means to that patient's health and what their coverage is, that VA is going to reimburse for those 15 conditions. So we have to inform or educate civilian clinicians, VA clinicians, and we also have to educate all the affected family members and Camp Lejeune veterans. So that is quite an educational effort. And how I would see this going for family members is family members apply; we determine that they were -- DoD determines they were at Camp Lejeune; we determine they have one of these 15 conditions; and we send them a package going, you know, -- a pamphlet: Here's what's covered; here's how to make a claim; here's where to send the bill; those kind of efforts. But again, we're still at the start of this is actually determining the processes.

And we have to write regulation. These are mandated by Congress. Whenever we make a change to providing care, we have to write regulations. Obviously providing care to family members is a huge change to us. We're going to have to write a set of regulations for family members, and we have to write a set of regulations for veterans, and it covers all these things I've talked about: the screening, the fact they're category 6, that there will be co-pay or

no co-pay, what's covered, what does Camp Lejeune mean. That all has to be in that regulation.

We've written the veteran regulation and that's in coordination, and what will happen is, then, that will go through various and sundry legal hoops. It has to be in the federal register for 90 days; there has to be a public comment period. We have to reply to every single comment. Then it goes back, there's another set of legal reviews. Bottom line, this takes an incredibly long period of time. It can be expedited to the amazing snail's pace of six months or usually it takes two years.

And we cannot provide care to family members until there is published regulations. So in like the Caregivers' Act, they fell in this -- the appropriation was with the law, and we weren't providing care to the caregivers because we couldn't pump out a regulation quick enough. Well, they did it in eight months. But that's with everything pushing. Right now there is nothing pushing because we don't have an appropriation. But I pledge to you we are pushing -- we've got most the family member reg written, just a few holes here and there because of policy determinations, but we will push this. And our goal is to have a regulation out on the street before

an appropriation hits.

MR. ENSMINGER: The appropriation's supposed to hit in March.

DR. WALTERS: Well, we're going to do our best. But there are many processes beyond the VA that we have no control over. So, you know, the legal, you know, the legal review, they say they take three months. They have 90 days to do it and they take every single second of that 90 days. There's nothing we can do to speed it up. And then a wait of congressional appropriation, and then provide these annual reports to Congress.

So what are the potential barriers and risks and places where we could have problems? Well, the first family members with serious illness may seek care prior to congressional appropriation. We've tried to ameliorate that as much as possible but our hands are somewhat tied. There could be a perception that the law is being unfairly applied between veterans and family members because veterans get the entire VA benefit. But they're veterans with the VA. That's what we do. Family members will only get probably reimbursed for care for those 15 conditions. Congressional appropriation may well occur before implemental regulations are published, and we're

trying our best to minimize that but that is a reality.

And there is also the perception that this also covers VBA compensation. We, again, this is not compensation; it's healthcare. As you saw with this case of the gentleman who had breast cancer from 1956, everybody's going, well, doesn't the law cover it? No. We have to implement the law as written. So what happens when it comes out that there was exposure before 1956? Are we going to provide healthcare? Well, not under -- the way the law is written now. It'll have to be amended.

MR. ENSMINGER: Well, the law's going to be amended because of the new information --

DR. WALTERS: So, so again, we, we are here to implement the law as fairly as we can. And I'm open to your questions.

MR. PARTAIN: Dr. Walters, first of all, thanks. I'm a little surprised at some of the things I'm hearing. I do like the screening 'cause that is one of the most frequent questions we get from our members with the website, is where do you go for screening.

DR. WALTERS: Well, there's no other way of doing it fairly.

MR. PARTAIN: Well, just the fact that y'all are

going to do that. 'Cause we do get a lot of people asking about it and I'm sure once we get the appropriations, it'll be a good thing.

DR. WALTERS: Now, I will tell you, you know, screening is a widely misunderstood term. I mean, there's no blood test there to say: Yep, you were exposed, you weren't exposed, as you well know. And for these 15 medical conditions, there's, you know, screening is a big issue. I'm sure you've seen the talk: Should you get a mammogram? Should you get a PSA? All these things, it's very, very controversial. There's a thing called the United States preventive task force in screening, and right now, for these 15 conditions, the only test that should be done is a biannual mammogram between the ages of 45 -- excuse me, 50 and 74. Now, so if you have someone who's completely asymptomatic and no symptoms at all and female, the screening is a mammogram as appropriate by age and when your last mammogram is, and a good history. A blood test, doing a complete blood count in the absence of any symptoms, really, is not medically indicated. It's the symptoms that drive the future work-up. Okay?

Now so the question is, you know, you've got someone who smokes two packs a day. The question

always comes to me, you know, I'm an internal medicine specialist: Well, shouldn't you do an x-ray every year? No, because that hasn't been shown in clinical trials to increase your chances of detecting that lung cancer. Now if they come in and they're coughing blood, you forget the chest x-ray, I'm going to go straight to a CAT-scan. Okay.

MR. PARTAIN: So if they're symptomatic with the disease --

DR. WALTERS: If they're symptomatic, then you follow -- you go with what the clinical guidelines would say.

MR. PARTAIN: Like for example if I show up -- if I was 39 and the bill was passed and funded, and I show up as a male with a lump in my chest, they're going to do the screening? They're not going to --

DR. WALTERS: Well, no, if you see that there's a lump in your chest, you're past the screening stage. Then there's a diagnostic work-up. And if you came in, as a 39-year-old and had no symptomatology(sic), would I do a mammogram on you? No. Because --

MR. PARTAIN: It doesn't make sense.

DR. WALTERS: It doesn't make sense. So screening is widely misunderstood because, you know, screening includes a good history to elicit symptoms.

But just listening to your chest, you know, the laying on of hands and doing blood tests is not clinically indicated. That's not screening.

MR. PARTAIN: Okay. Well, one thing I do -- when you talk about the devil in the details, and that was one of the other things I was pleased with, concerning the payer of last resort, with insurance. Like, for example myself, I do have health insurance with my employer. When you mention they pay first, and being a claims adjustor, I completely understand how that works. And hence my question here. Once the funding is passed, like I have my health insurance, I go to my provider, are you, for the families and everything, you know, for example, I have a deductible. My insurance pays my claim but I do have a deductible I have to meet. Will the VA look at that deductible?

DR. WALTERS: Again, prior to policy it would be my assumption that we pay that deductible because that's a cost to you associated --

MR. PARTAIN: With Camp Lejeune.

DR. WALTERS: With Camp Lejeune.

MR. PARTAIN: And 'cause --

DR. WALTERS: But don't hold me to that. I mean, that's going to have to get a legal review and all that but that would seem that that was the intent of

this law, is that you were made whole, that's a legal term, as whole as can be. And so, you know, we should pay your costs.

MR. PARTAIN: Yeah. And as I just said, I work as a claims adjustor so I deal with a lot of that.

DR. WALTERS: So if you work as a claims adjustor you understand what the policy decision we're faced with right now is: Are we an insuring function or are we a healthcare providing function? 'Cause if we provide healthcare within the VA, we're a healthcare provider function. And one of the reasons why I leaned, and this is not my decision to make -- I only make the choice -- I only may present the alternatives -- if we say that family members have to get care within the VA, and you live, you know, 500 miles away from a VA medical center, that's not good for you. Even if you lived right next door, and you said you had breast cancer and diabetes, well, you'd go to the VA for your breast cancer care but your diabetic care could not be provided by the VA; you'd have to have a civilian provider.

So that would be fracturing care, which is not good quality care, because then you have to make sure that the, you know, the person taking care of your breast cancer talks to the person who's, you know,

who's providing diabetic care. So we don't want to -- we want to insure continuity of care. And for a family member, you know, if you only have -- if the clinic only -- say the oncology clinic only has 100 appointments a month, and you suddenly -- or your family member suddenly has an emergency, you have to see that oncologist, I'm not sure you can -- you should bump veterans from their appointments to fit someone in, because again, the VA is here to provide care -- and needs to provide care to veterans.

So, you know, I think what we're going to go with is the insurer function, where you pick your doctor and we pay your bills. 'Cause that's probably the least hassle. There's no -- there's transportation. It will be easier for the VA to implement. We have similar programs, somewhat similar, for children of Vietnam veterans, who were exposed to Agent Orange, for spina bifida, we pay their bills. So this is -- we have some similar programs, and we can build on those programs.

We have an office in Colorado who could do this claims adjustor process. But there's going to be a couple of -- so we're going to have to determine, administer the eligibility: Were you there? And then do you have one of these 15 conditions or is this

episode of care associated with one of these 15 conditions? So there's going to have to be a clinical assessment on every episode of care: Is this related to one of these 15 conditions? Yes or no. And then we pay the bill.

MR. ENSMINGER: Have you provided this briefing to the Senate Veterans' Affairs Committee?

DR. WALTERS: Yes, I have.

MR. ENSMINGER: When?

DR. WALTERS: When I talked to you, I fleshed it out since I talked to you because we're further along in the process. But I think, yeah, it was in September.

MR. ENSMINGER: Are you planning on giving them another brief as to the --

DR. WALTERS: Not at this time. I think we need to be a little bit further along, make the determination of how we'll provide family care. But I'm willing to do it at any time.

MR. ENSMINGER: Okay. Because the appropriations are coming. I mean, I know that. They're going to be made in March, from what I understand, for the family healthcare. And we got to have some rules in place so that this can be implemented.

DR. WALTERS: Yep. But as I said, the regulation

writing process is really long, sir. And that's authored by Congress.

MR. ENSMINGER: You got my daughter's name wrong on your slide.

DR. WALTERS: I'm sorry. How do I have it wrong?

MR. ENSMINGER: Her name is Janey, J-a-n-e-y.

DR. WALTERS: J-a- --

MR. ENSMINGER: N-e-y.

DR. WALTERS: I apologize.

MR. ENSMINGER: That's fine.

DR. WALTERS: No, I really do 'cause that's important. I apologize.

MR. PARTAIN: Going back to some of the questions, what about secondary conditions that arise as treatment? For example, I'm going in treating for cancer, I have chemotherapy, and then there are resulting health conditions that come out of that. The primary condition is covered by Camp Lejeune, but like, for example, diabetes, I go in -- I have cancer, go and get treatment, and then develop diabetes during the course of chemotherapy.

DR. WALTERS: Well, usually, again, a medical decision will have to be made. Usually diabetes is not secondary to chemotherapy.

MR. PARTAIN: Okay. Well, I was just using that

--

DR. WALTERS: Yeah, I understand you're using that. But neuropathy is or, you know, problems with, you know, neomycin in the lungs. So, you know, if it's secondary to treatment for chemotherapy, which is, you know, can be very, very deleterious to your health, yes, you should be covered.

MR. PARTAIN: Okay. And what about chronic conditions, like for example, you know, 'cause, you know, cancer's not just a said-and-done thing; it's something that progresses over time and you --

DR. WALTERS: Well, hopefully it doesn't progress over time.

MR. PARTAIN: Well, I mean, progressive over time. For example you're cancer-free but you're still going for maintenance check-ups and maintenance reviews and things like that.

DR. WALTERS: Well, that should be covered 'cause it's secondary to that disease.

MR. PARTAIN: Okay. And then, you know, understanding everything's contingent upon funding with Congress and everything, people calling in now, and I appreciate the sheet -- we're going to get this up on our website in the next day or so.

DR. WALTERS: And it's up on the VA website.

MR. PARTAIN: I want to get that out to our members but, you know, we get a lot of people asking: Who do I call? What do I do? Say, I call in now and get myself on there. When the funding is appropriated is the VA going to --

DR. WALTERS: And the regulations are published.

MR. PARTAIN: -- and the regulations are published, is the VA going to, then, contact and let me know?

DR. WALTERS: Well, and that's what I, I'd like to talk to you about because obviously the CAP members have a lot of contacts. There's the Marine Corps registry website. We've talked to the Marine Corps about our idea is to, once all this occurs -- and while we haven't done it right now, is to send a letter to family members going: Hey, you know, we're open for business and this is where you send your claim or your request for care. You know, I think a letter will be good, obviously using social media, Facebook, website, but I think an active outreach would be a very good thing.

MR. PARTAIN: Well, an active outreach, not to interrupt you, but an excellent active outreach would be for the VA to send this little flyer with a request to the Marine Corps to disseminate to their, what,

200,000-plus registrants that they have in the Camp Lejeune registry.

DR. WALTERS: We're willing to do that.

MR. PARTAIN: Okay. I think the CAP would like to request that that be done as soon as possible, 'cause that is something we get a lot of questions on, and it'd be nice to have people get that type of thing.

DR. WALTERS: Well, if you could do me the favor of looking at this fact sheet and going: Is it complete enough? Does it cover the bases, the questions you're getting? Do we need to add more information to it? We'd be more than willing to do that.

MR. PARTAIN: Sure. We'll do that.

MS. BLAKELY: I have a question.

DR. WALTERS: And I'll speak to the Marine Corps, you know, if they're willing to --

MR. PARTAIN: Well, if you could do your part and send the letter and the brochure, we'll make sure that -- we'll make enough waves.

DR. WALTERS: I've talked to the Marine Corps, and they -- 'cause we want to get that list. And they said that they are updating it and scrubbing it and improving it. But the Marine Corps, the DoD and VA

are working hand-in-hand with this. I'm also a co-chair of the point^ health working group, which is a group that does this on a regular basis.

MR. PARTAIN: Well, the Marine Corps is, you know, serious about their decorations for the health, safety and welfare of the Marines and their families, and I think this would be part of it here, so...

DR. WALTERS: We can give you -- as I said it is on our website. We can give you the website address today.

MR. PARTAIN: Okay. And just to make it clear, you know, one thing I would not think would be very feasible would be just to put this on the Marine Corps's website for Camp Lejeune as a link or something like that.

DR. WALTERS: We've already done that.

MR. PARTAIN: That's why I'm saying, you know, something like this needs to be disseminated out rather than just put on a static link. And before we go, if I can get your cards because I lost -- I moved and my stuff is packed up and I've lost your emails address. And Brad, you too.

MR. STALLARD: Before we get to Mary, let me just be clear on what I think I heard here. You're willing to share that with the Marine Corps but you've asked

that the CAP look at that fact sheet and say --

DR. WALTERS: Give us --

MR. STALLARD: Give us some feedback on it.

DR. WALTERS: -- some feedback on it. You know, I'm telling you we don't have all the decisions made yet and all the policy decisions but we want to be as transparent as possible, and we want to answer as many questions as possible. So does that do that or have we missed the boat on something?

MR. STALLARD: So the action is CAP to review that and provide feedback before Dr. Walters --

MR. PARTAIN: And we'll have the feedback to you next week.

MS. BLAKELY: My question might pertain to that.

MR. ENSMINGER: That the Marine Corps is concerned about the health, safety and welfare of their people is evidenced by the number of people they have represented at these meetings, zero. There's not one person here from the United States Marine Corps.

MR. PARTAIN: And they've been gone for quite a while.

MR. STALLARD: We have not had their participation here for some time.

MR. PARTAIN: And just for the record -- I'm sorry, Mary, I'm getting back to you. Just for the

record I'm, since Jerry brought that point up, and this is an excellent point here, with the Marine Corps not being present at these meetings, with the VA talking, we have something that's critical to the Marines and their families here, right in front of us, and it'd be nice to have some type of feedback from the Marine Corps or at least be able to bounce some ideas off them. But, what, roughly a year and a half, two years ago, they declared that they felt that their presence here was more of a detractor to what is supposed to be going on at these meetings and removed themselves from our meetings. This is, you know, like Jerry said, here we are, this is a demonstration of their true concern for the health, safety and welfare of the Marines and their families.

MR. STALLARD: Thank you for that, and Mary, before we move on, it was two years ago that we wanted the VA to be part of this --

MR. PARTAIN: And they've been here. Thank you guys.

MR. STALLARD: And this is a tremendous turn of event in that regard.

MR. MARKWITH: Can I just add something to what was just stated?

MR. STALLARD: I feel like I've been shutting

Mary down here.

MS. BLAKELY: And you all know I might lose my track of thought.

MR. STALLARD: Yeah, so bring it on.

MS. BLAKELY: My question is about the neural behavioral effects. If it's so hard for people like Tom, you know, our CAP member on the phone? For him to make his way through getting analysis for his medical problems and help with his problems, what kind of problems are family members going to have that are uneducated and suffered these neural behavioral effects of the water going to have dealing with the red tape? What kind of sources are they going to have to go to to get help with that? Because they won't be able to do it.

DR. WALTERS: Okay. First of all, the gentleman on the phone, Tom, I don't know his last name, was talking about VBA claims. This is healthcare so it's completely different. And the family member will hopefully get a package in the mail explaining to them, hopefully they have someone -- assistance in understanding what we're sending them.

They can go to the health eligibility clerk in any VA medical center or clinic, and part of our education process will be educating those health

eligibility clerks: Here, this is where you need to apply for this, this and this. This isn't compensation; it is healthcare.

MS. BLAKELY: Okay, well --

DR. WALTERS: So, if you were there, you have one of these conditions, you are eligible for healthcare. It is completely independent from the claims process.

MS. BLAKELY: And that's why the outreach, the information shared will be so important. And we need to be able to share it like more publicly.

DR. WALTERS: Yeah, and that's why we brought this fact sheet today. Part of our concern with being very aggressive on outreach right now is this problem with the regulations and the appropriation. We were kind of holding back until we thought we were almost ready to provide care. Because I don't want to raise people's expectations and dash them because, you know, we are mired in this, frankly, bureaucratic process, of which we have no control.

We can make sure that we get the written word, you know, the draft regulation in, but after that, we have very little control. You know, once it goes through the legal process and the federal register process, I mean, it's mind-numbing. You know, 'cause my initial reaction was unprintable, unprintable.

What do you mean it's going to take two years? This is, you know, 'cause I mean we want to provide the care. We have been told by Congress to provide the care. Once we're given the money, we want to provide care.

MS. BLAKELY: And that's why it's important for the VA, or whoever's in charge, to realize that the population you're dealing with. Many, you know, civilians aren't veterans, and they don't have the resources or the knowledge that veterans have. People like me, you know, don't know the way to go or who to call or even to get the information to them.

DR. WALTERS: Yeah and part of what we're trying to do with this task force is make this as easy as -- and this you're going to laugh -- as health insurance. 'Cause that's what we're going to be, a health insurer for family members. And again design the process so it is as hassle-free as possible. But that is difficult. You're dealing with the U.S. government here.

MR. STALLARD: Thank you. Thank you. Let's hear from Glenn before we go to break, please.

MR. TOWNSEND: Can I come back in?

MR. STALLARD: Yeah, Tom, we'll bring you back in in just a moment, okay? Hold on.

MR. TOWNSEND: Thank you.

MR. MARKWITH: I just wanted to reiterate my role at the meeting. Even though I'm from the Navy/Marine Corps public health center, I work for the Navy, the reason I write so much is I take all this information back to Camp Lejeune. I'm an information conduit to take the information back so that they can best decide how to assist in the mission of the CAP. I can assure that they are vested in this process and that they are interested in doing whatever they can to support the issues here of the CAP. And that's why I'm writing all these notes down. One of the first things I will be asking them is a question about utilizing the registry for getting that information out there. That certainly makes very good sense.

DR. WALTERS: I've talked to Scott Williams, and, you know, he's the person who is digitalizing the records. But, you know, a big decision is going to be is who is responsible for administrative eligibility? Were you there?

MR. MARKWITH: Absolutely.

DR. WALTERS: And that is going to take people and money and resources. For atomic veterans, so you had people in Hiroshima, Nagasaki, obviously a long time ago, people who were at tests like Bikini Atoll.

So VA has to provide a level of care and compensation to atomic veterans. So we have this problem of we get a veteran in, you know, say veteran Schmidlap -- Schmidlap is my name for everybody by the way -- and I was at Bikini Atoll on the 6th of August 1967. Does he have a piece of paper that says that? No. I mean, where's the documentation? It could be anybody.

MR. ENSMINGER: Just put a Geiger counter on his ass.

DR. WALTERS: Well, no, that doesn't work. 1962, you can tell how much I know about atomic testing. So what happens is they go to an agency within the OD, who has a team of researchers in Reston, has people at the National Record Center who actually pull the records and they do research: Was this person at Camp Lejeune? Take a family member, how are we going to know if a family member -- a kid. So wife, we may know, a kid was at Camp Lejeune in 1958. And that's 54 years ago.

MR. ENSMINGER: But every person's service record book had a dependents' page in it, okay? Which showed the name of each and every dependent, legitimate dependent, that that service member had. Their birth date and their address.

DR. WALTERS: Yeah. So we're going to ask the

DoD to provide that to us.

MR. ENSMINGER: And I mean it's in the record.

DR. WALTERS: Yeah.

MR. ENSMINGER: And they just don't want to go look.

DR. WALTERS: Well, because it's going to be difficult and require people and resources.

MR. ENSMINGER: Oh, my God. Look at that.

DR. WALTERS: I'm telling you.

MR. ENSMINGER: It's tough.

DR. WALTERS: So, and, you know, then there's the issue of someone who is on temporary duty at Camp Lejeune. So say they went to the, I don't know, the infantry school, and they were there for six weeks. You know, I was in the military for 30 years. I went TDY -- the Army. I went TDY and God knows, everywhere else. And is there a record of that in my service record? No. But they were there for 30 days or more.

MR. ENSMINGER: If it was a formal school, it will show up on your record.

DR. WALTERS: Well, we hope but the Marine Corps has told us that not all the records are complete.

MR. STALLARD: Okay. So clearly there is opportunity --

DR. WALTERS: So there are challenges here with

administrative eligibility. And I think for probably 90 percent we are going to be okay, but again, the devil's in the details. There's going to be that 10 percent who were there, who are going to have very little proof. So what do we do then?

We take, you know, VBA takes buddy statements: Yeah, I was in Vietnam, and I got my buddy over here to certify Vietnam. Well, that's a process. And we have to write that in regulations and it has to be legally verified and okayed. So this is -- it's difficult.

MR. ENSMINGER: If you can't prove you were in Vietnam in your own records, tough.

MR. STALLARD: Excuse me. Tom has asked to speak. Tom, go ahead with your question.

MR. TOWNSEND: Thank you. I wanted to pass on to the -- as an addendum to my comment to the VA representative, that I am sending back a denial of a VA resolution that somehow found its way down to Louisville. But I would throw in the fact -- I wrote in the fact that the VA seems to deny totally that I ever had -- it's not that I have never been at Lejeune, they've now verified that. The VA seems to want to discount totally my neuropathy that I've had verified by outside neurologists, but not by a VA

neurologist, and I'm throwing in the point that my son died at Camp Lejeune at age 102 days and my wife passed away five years ago, and had an autopsy done, and it said secondary cause of death was written into the death certificate as exposure to contaminated chemicals, contaminated water, of about 40 years. So I think the Louisville VA regional office is just trying to throw us off a claim. So it's coming down the pike, and I hope that there's some decency and honesty left in the Veterans' Administration.

MR. FLOHR: Mr. Townsend, we will get a hold of your records and find out what's going on, make sure you understand what is going on, what has happened and where it is in the process. Generally if it was at the Board of Veterans' Appeals, we can send it back to the VBA for something -- you do get a letter from VBA saying they have sent you ^. So I don't know why you would not have gotten that.

MR. STALLARD: And Tom, so we're going to go into break now, after Mike asks a question. And when we do, we're going to ask you to turn your -- you know, hang up so we can call you and get your claim number. So Mike, we have about two minutes.

MR. PARTAIN: Just a quick question here, and a statement over Glenn, but on the number to call in for

a veteran family member or someone who wants to register, you know, prior to the funding here, there are a couple numbers on the sheet here. Is there one that's better than the other to get registered for Camp Lejeune?

MR. ENSMINGER: One is for disability.

DR. WALTERS: One's for disability and the other one, I think, is the better number.

MR. PARTAIN: Okay.

DR. WALTERS: But again, a lot of this is again, you know, the fact that you have that question is maybe indicative that we haven't, you know, we're not explicit enough or --

MR. PARTAIN: We need the Eat At Joe's sign.

DR. WALTERS: What?

MR. PARTAIN: The Eat At Joe's sign flashing for people to know.

DR. WALTERS: Eat At Joe's sign. Okay, got it.

MR. PARTAIN: And by the way, Glenn, thank you for being here. And we do appreciate you but there is no substitute for the real thing. 'Cause things do get lost in the translation. I'm not saying you're stupid or anything like that but things get lost in the translation.

MR. MARKWITH: I just wanted to make...

MR. PARTAIN: I understand.

MR. MARKWITH: I just wanted to make the point that the things that you discuss here does find its way back to Camp Lejeune in a timely fashion.

MR. ENSMINGER: Now, a couple years ago, whenever we discovered the presence of the benzene, the ATSDR did pull their public health assessment for Camp Lejeune down. It was like somebody threw a hand grenade in the middle of the Marine Corps and Department of the Navy representatives out there in the audience. They were like a bunch of rats; they just disappeared and haven't shown back up again.

MR. STALLARD: Thank you for that historical reflection. That's a perfect segue for us to go into break.

(Whereupon, recess taken from 10:25 a.m. until 10:40 a.m.)

WATER MODELING UPDATES

MR. STALLARD: We're going to go in -- and let’s see, Tom, Sandra, are you back on the line? They will join us shortly. I'm giving my microphone over to Morris at the moment. Yes, Dr. Portier?

DR. PORTIER: I just want to take one moment before Morris starts. One thing Morris is going to show you is the time at which the exposure, we estimate that the exposures in the water at Camp

Lejeune exceeded the maximum contaminants level. He'll show you that information. That information has been passed on to the VA in the form of a letter.

I've not gotten confirmation that the person at the VA I directed the letter to has received it. I have copies for you but I won't give them to you, as I believe it would be discourteous to not make sure the person who's getting the letter gets it before I give it to you. So as soon as I know that they've got it, I'm giving you copies. I'm breaking my rules, giving you copies of a letter between two federal agencies. Okay, Morris. Thank you.

MR. PARTAIN: When was that letter sent out?

DR. PORTIER: This morning.

MR. MASLIA: The remote is being repaired so I'll try to use this but I'll have to walk around so -- okay. Good morning. My name is Morris Maslia, and I will provide you with an update on ATSDR's water modeling activities at Camp Lejeune. I'll be happy to answer questions but remind you that we have a lot of time at the end of my presentation for discussion, or further discussions.

I'd first like to just take this opportunity to thank all the water modeling staff and health study team members and other ATSDR colleagues who have

assisted with the water modeling analyses and the preparations of the slides, as I was partly on leave when they were being prepared. And those are Barbara Andserson, Rene Suarez-Soto, Jason Sautner, who's here in the audience; Ilker Telci, who just got his Ph.D. from Georgia Tech; Mustafa Aral, Bob Faye, Susan Moore, Tina Forrester, Stephanie Dunn, Perri Ruckart and Frank Bove.

Am I audible? The focus of the presentation this morning will primarily be on the Hadnot Point and Holcomb Boulevard study area. Those not familiar with that area, it was in the rectangle there. But during discussion, it might be necessary also to refer to our previously published work at Tarawa Terrace. The Hadnot Point, Holcomb Boulevard water modeling reports are grouped into three general categories and subject matter areas.

We have data reports, which contain compilations of data required for model development in historical reconstruction, and those will be the Chapters B, C, D and Supplements 1 and 3 of Chapter A.

We have interpretive reports, which contain data analyses and model simulations that are presented and discussed in the Chapter B report and Chapter A, Supplements 1 through 8 in detail.

And then we have the Summary Report, which is the Chapter A report, and that contains the data, analyses and summaries of results, such as finished water concentrations for contaminants of concern at Hadnot Point water treatment plant. And those are presented and summarized and discussed also in the Chapter A report.

The next few slides I will review the status of the specific Holcomb Boulevard chapter reports and supplemental texts. And on these slides I'll only provide the short titles due to space limitation on the slides. The more finalized titles will obviously be on our website with the Chapter A report.

The Chapters B, C and D reports have all been published and are publicly available on the ATSDR website, and the three-DVD set of publicly releasable Department of Navy, UST management web portal files are available by request from ATSDR.

The Chapter A report provides historical concentrations of contaminants of concern in ground water, water supply wells and at the Hadnot Point water treatment plant and within the Holcomb Boulevard housing areas. And it describes the processes and the models used in the historical reconstruction process. It also contains details of water modeling

investigations in the supplemental sections of Chapter A and the results used to support the ATSDR health studies. And it's on track to be released during the spring of 2013.

Chapter A will have eight supplements, and these are supplements, 1 through 8, will have gone through external peer review. All the review comments are being addressed currently or have been addressed by the authors. And they will be released with the Chapter A report. On the next few slides I will just quickly summarize, again, using short titles, of the eight supplements.

We have Supplement 1, which describes -- provides data of water supply well operations, and it is the most comprehensive and complete description of all the water supply wells at Camp Lejeune in the study area from 1942 through 2008.

Supplement 2 uses data from Supplement 1 and derives a method whereby we can -- we obtained monthly operations of these water supply wells that we needed for the historical reconstruction process.

Supplement 3 presents water level data and develops a conceptual model of ground water flow that was needed to conduct the three-dimensional ground water flow simulations that are reported in Supplement

4.

In Supplement 5 we developed an alternative method, a simpler computational method for reconstructing concentrations in contaminated water supply wells, and we used a method called linear control model methodology. And that supplement is devoted to the development and application of that methodology.

In Supplement 6 we used the ground water flow simulation from Supplement 4 as well as chemical and transport properties to reconstruct historical concentrations of contaminants dissolved in ground water. And I'm specifying dissolved in ground water because benzene occurs in two different states, dissolved in ground water and floating above, as an LNAPL, which I'll explain a little bit later on.

In Supplement 7 we simulated benzene as it occurs as a floating product above -- primarily above the water table. And the model that was used to simulate and reconstruct concentrations for benzene occurring as an LNAPL as well as a dissolution of the LNAPL into ground water, and its impact on water supply wells.

And finally Supplement 8 provides information on field data that we collected and field tests that we conducted for the three water distribution systems for

the study areas, and also presents results of reconstructing the intermittent transfers of drinking water between Hadnot Point and Holcomb Boulevard water distribution systems for the years 1972 through 1985.

At this point I'd like to go through the water modeling, the conceptual water modeling process that we used as part of the historical reconstruction process. It's a five-step process. Each step required, obviously, the knowledge of subject matter experts. Step 1 was to identify, collect information and data. Step 2 was to build electronic databases of all the information and data. Most of the information and data were not in an electronic format or compatible forms, on paper and things like that, and so we had to key those in and set up databases. Step 3 is model development, extracting model-specific input. Data files, different models require different electronic databases and formats, and then running the models.

On step 4, we made the decision; we look at the results coming out of a particular model and look at what field data we have available and see if there's reasonable agreement. And I use that in a qualitative sense. If there is reasonable agreement, then of course, we can provide the results to the

epidemiologists conducting the health studies. If, in fact, there's not reasonable agreement, then we go into an iterative feedback loop where we may question the values of the parameters that we used: Are they correct or are there different values? Do we need to obtain more information or search the databases and information sources for additional information or different interpretations of -- or perhaps do we need to change our conceptual model? And this is a process that happens hundreds and thousands or tens of thousands of times. At this point we're at step 5, with all water modeling activities.

Now at this point I'm going to go into a general discussion of the types of models that we use. On the following slide, I will get into specificity, and also the Chapter A report, as well as the eight supplements that accompany Chapter A, had specific details on specific models that were used for specific tasks.

Basically we've got the study area here that we conceptualized underneath as a porous medium. We use a ground water flow model to determine ground water levels under non-pumping and pumping conditions for the years 1942 through 2008, and using that model, we derived ground water flow velocities. Having the ground water flow velocities for each month, we then

were able to use fate and transport, and chemical properties, put that into a fate and transport model, whether it's dissolved in ground water or an LNAPL, it's still fate and transport model, and then derive concentrations in the aquifers, the confining unit at water supply wells.

Now, at Camp Lejeune and, in particularly Hadnot Point and Holcomb Boulevard, all the supply wells mix at the water treatment plant prior to being treated and prior to being discharged out into the distribution system. Because of this fact, we were able to use a simplified flow-weighted mixing model. Mix all the wells at the treatment plant, use an algebraic model, and then determine the concentration, each month, of all the wells that were pumping at the water treatment plant. And that was the concentrations that occurred in the distribution system throughout Hadnot Point area and Holcomb Boulevard area before the Holcomb Boulevard plant came online in 1972. At that point we provided those results to the epidemiologists.

Now during the period 1972, June 1972 to be precise, and 1985, January 1985, the Holcomb Boulevard water treatment plant was operating. Because of that, we had to go to a much more sophisticated numerical

water distribution model to look at the distribution of contaminants within the Holcomb Boulevard water distribution system during periods of intermittent transfers of contaminated Hadnot Point water to the Holcomb Boulevard water distribution system. And so we used a numerical water distribution system model which allowed us to compute the varying concentrations within pressurized pipes that provided water to the different housing areas and locations at Holcomb Boulevard. Those analyses, obviously, are complete, and once we get data, we'll provide those results as well for the study epidemiologists.

And this is a list of just the computational and numerical models that we used: ground water flow, fate and transport, linear control method, LNAPL models, flow-weighted mixing model. We needed to do some probabilistic analysis for the intermittent transfer into the distribution system and the distribution system. These specific models are listed and described in the Chapter A report, in the main part, and each of the -- in the supplemental sections that support Chapter A, there are details about this, and the development used and assumptions of all these models.

At this point I wanted to go over a couple of

concepts that we had to understand and deal with, make decisions on, in order to use some of these models. And the first one is contaminant characterization: How do we characterize contaminants? If we have chlorinated alkynes, such as PCE and TCE, those are classified and characterized as dense non-aqueous phase liquids. And that's because they are denser than water, water having the density of 1.0, PCE has a density of about 1.5, 1.6. And so it sinks in its pure phase form.

Based on the field data that we had, however, the field data indicated that the concentrations were well below the solubility limit, and so we can assume that all TCE and the PCE were dissolved in ground water but they do sink well below the water table, right here, and as such, they impact pumping wells depending on the operational sequence and how these wells are pumping on and off. So you see sort of a downward migration on different PCE and TCE.

When we compare that to benzene, and this also would be used for benzene that's totally dissolved in ground water, by the way, any constituents that dissolve in ground water, this is the conceptual model that is used. On the other hand, based on data presented in the Chapter D report, which shows areas

of flowing product, of hydrocarbons, we have this model; it's an LNAPL because benzene is lighter, or hydrocarbons, are lighter than water. It's a light non-aqueous phase liquid. And so it primarily, most of the mass here floats above the water table, whereas most of the mass here is below the water table. And so because most of the mass here is above the water table, in order to obtain simulations and impacts, individual impacts at wells, we had to use a different numerical model, an LNAPL. But you see primarily it impacts areas at or above the water table and very little goes into water supply wells. And the Chapter A does present -- Chapter A and other supplements do present mass balances so you can see the relative amount of contaminant that goes up into gas, up into the air, into the wells, into the aquifer.

So those are the two different concepts that we had to use to classify the different classifications of the compounds or chemicals of concern.

MR. PARTAIN: Morris, can I ask a question at this point or you want to wait?

MR. MASLIA: I've got just a couple more slides.

MR. PARTAIN: Okay.

MR. MASLIA: Make a note and I'll answer it.

MR. PARTAIN: I want to come back to that.

MR. MASLIA: And we'll come back, okay. Another point that we had to understand and deal with, and say, an area of big uncertainty, are factors affecting water quality sampling. Of course I show the slide in our water modeling process where we run a model and then compare it to field data. Now if you're doing, say for example, remediation studies, currently, you have properly constructed monitor wells. And that's really what you want to use to sample. But you can also use water supply wells, and that's primarily what we had to rely on. Historically there were no properly constructed monitor wells prior to the 80s, mid-80s, even prior to the 90s, to be -- so we used water supply wells. Next question is what was the sampling standard methodology of protocol, if in fact, there was one? Third, if we were using water supply wells, what was the operational status? Was it on when the sample was taken or was it off? If it was off, how many well bodies were evacuated 'til a sample was taken. And all that, to be blunt, is enough information for the historical reconstruction process.

And finally are the sampling results repeatable or consistent? If you take two samples within a day or either within a month, are you having orders of magnitude difference in values, things like that. And

those are explained and discussed, both in data presentations in the various chapters and in Chapter A as well as in the limitations sections of the reports.

Finally we get to what Dr. Portier has mentioned, the exceedence of MCLs, or maximum contaminant levels, in the study areas. This is the Tarawa Terrace water modeling study period that went from January 1953 through December 1994, and the period of time that VOCs exceeded the current values of the maximum contaminant levels began in November 1957.

For the Holcomb Boulevard -- Hadnot Point, Holcomb Boulevard study area, the water modeling study period was 1942 through June 2008, and the estimated period that VOCs exceeded the current MCLs are August 1953.

MR. ENSMINGER: No earlier?

MR. MASLIA: No.

MR. ENSMINGER: Never? Never exceeded the MCL any earlier?

MR. MASLIA: I cannot say never on any of the results that I present.

MR. ENSMINGER: Okay.

MR. MASLIA: That concludes my formal presentation, and I will be happy to answer any questions that you want to ask.

MR. PARTAIN: Morris, going back with the LNAPL and the benzene.

MR. MASLIA: Let me just pull it up. Yep.

MR. PARTAIN: Okay. Are you going to put that slide back up showing the wells and everything?

MR. MASLIA: (Indiscernible).

MR. PARTAIN: Okay. I have read stuff in the documentation from Camp Lejeune about a karst. Can you explain what that is and how that would affect that model, if a karst was located near the Hadnot Point fuel farm or within the Hadnot Point fuel farm area?

MR. MASLIA: What you're referring to is the first eight pages of the site management file 1185, and that's a memorandum from a geohydrologist, I'm not sure who hired by, but to evaluate -- they were planning some work. And the whole site is calcareous limestone. It would be underlying those official aquifers.

MR. PARTAIN: What does a karst do as far as return --

MR. MASLIA: I'm getting to that.

MR. PARTAIN: Okay, I’m sorry.

MR. MASLIA: It contains fractures, faults in there. Now one of the issues you have to deal with

when an area is characterized with fractures and faults and all like that, is the scale of them. That's always been an issue in any kind of modeling. Are you just going to look at one fracture or fault or are you going to look at a certain scale where we can represent all as a porous medium? We have taken the approach in all our models, Tarawa Terrace is the same way, that we can represent at a certain scale, we don't know what that scale is and nobody knows what that scale is, but at the scale that we modeled, that these could be represented as a porous medium. So Darcy's law is obeyed in all those ground water concepts.

The other thing, when they map fractures and faults in a geophysical analysis, and this talks about it, and it's documented, they're not mapping whether there's fluid flowing through them, okay? All they're mapping are voids. And in fact they refer to losing drill bits, you know, losing a tool, two feet and so on. I've had experience in south Georgia on Colonel's Island of drilling a well in the 1980s, where we went down to the salt water interface, several thousand feet down. And we would constantly find voids of ten and 20 feet but there was no guarantee if there was fluid flowing in there. And so you cannot -- we could

not just do a fault zone or a dual porosity model where we were modeling the faults.

We made that decision early on for a number of factors, one being the field data just were not there. We were looking at a historical period. You would have to have millions and millions of dollars of data. The industry that uses that, nuclear industry uses that because to them whether the fault's carrying fluid or not is immaterial, and they spend that kind of money to determine that.

Number 2, I want to get to this, since you've referred to it, and this is in the files, proposes a conceptual model trying to explain how LNAPL can be found at depth, and that's what he was trying to explain. But the key paragraph here is the primary aspect of this model, and this is the key, which is based on conjecture. He has no data, okay, which is based on conjecture, is that water supply wells were overpumped in the system, causing dewatering of the voids. I categorically disagree with that, okay? And the reason why the system was not overpumped is the models we ran in that did not go dry. When Camp Lejeune needed more water, they drilled more wells and brought more wells online. They did not dewater the aquifer. And all our model runs from 1942 all the

way, the aquifer is not dewatered.

MR. PARTAIN: Well, one thing that -- the reason why the karsts caught my interest is there was language discussing there was a rapid recharge area of the aquifer, and that, basically the location of the karst was pretty much right within the massive, what, 1.2 million-gallon fuel plume that's at Hadnot Point.

MR. MASLIA: Our conceptual model, and this is described in Supplement 4 of the Chapter A report, ground water levels.

MR. PARTAIN: I read that.

MR. MASLIA: Not Supplement 4, Supplement 3, the water level and ground water flow conceptual model. Has the recharge occurring at the uplands area, which are towards the eastern, northeastern parts of the study area. And that ^ by karst, too, and limestone. And then coming down and moving westward and discharging out at Northeast Creek.

We're not denying that there’s limestone or karst there. What I'm telling you is we are not modeling, nor do I feel, based on available data and the objective of our studies, is there a need to do karst-specific fracture flow-specific modeling.

MR. PARTAIN: And that's getting beyond my tech grade. The thing that I'm getting at and what I'm

trying to understand is, you know, from what I've read, with the presence, if that is correct that there is some type of natural karst there or rapid recharge in the aquifer in and around the Hadnot Point fuel farm, would logic not dictate, then, that there would be a more susceptibility of mixing the fuel and the ground water going into the recharge and driving some of that contaminant deeper? Because your model there seems to suggest that the deep-water wells, and I don't know your, you know, feet there, are not capable of being exposed to benzene.

MR. MASLIA: Not from a conceptual standpoint. There could be a number of mechanisms -- you know, benzene, depending on where the supply well is located, poor casing, some of these wells are quite old, leaking down, down the casing, and then as the well turns on, it draws it down, and then it's trapped in some of the fractures. What I'm trying to tell you is, while you can't rule that out, our conceptual model is in fact that most of the benzene flows, a little of it dissolves, the LNAPL model does take into account the dissolution of the flowing product into the porous medium and gets into wells because of continued pumping action. But the models do not -- are not a conceptual model of a karstic fractured

dominated system.

MR. PARTAIN: And how did you all -- there is data out there in the sampling showing benzene in the deep aquifer. How do you all account for that or what do you do with that data?

MR. MASLIA: We did not -- we reported it and it's unexplainable, just like other -- like that 2,500 microgram per liter benzene at the treatment plant after, supposedly, all the wells were shut down for a year. We reported as we -- as it is given to us, and I think in chapter -- I'm not sure. I'll just say it's unexplained. That's one data point. If you go through the documents the Marine Corps -- I say the Marine Corps, I think -- it's their consultant or whomever that have had -- attempted several different explanations for that one data point at depth. At one point they had a hurricane coming through and depressed pressure pushing it all the way down there. And so we start getting varying explanations as to why something occurs like that, the next answer is, well, we have to go out and instrument the place completely and spend the appropriate amount of money, and then you may or may not get your answer.

MR. ENSMINGER: Well, historically now, the benzene levels in the deep aquifer have been showing

at higher levels than the shallow and intermediate aquifers of recent testing.

MR. MASLIA: Recent testing.

MR. ENSMINGER: I mean, within the last five or six years.

MR. MASLIA: That is correct.

MR. ENSMINGER: So how do you explain that?

MR. MASLIA: I don't. Again, we --

MR. ENSMINGER: I mean, these are actual analytical results.

MR. MASLIA: First of all, what I want to explain is what we're doing, okay. We're looking at a historical model, okay, based on historical water quality things like data. So while we can use some of the present day information to help guide us, and we did, that's why we took the model of 2008. We did not model the present day system in terms of -- we would have to start putting in all their remediation technology as well, all the air sparging, vapor removal and all that sort of stuff to be able to try to duplicate what the results of the present day system would -- and we did not do that. We were charged with, and we did, develop a model that went back historically, and all those mediation systems were not in place until the late 1990s, probably the

early 2000s. All I can tell you is that --

MR. ENSMINGER: They started the remediation system at the Hadnot Point fuel farm in the early 1990s.

MR. MASLIA: And it did not work properly a lot of the times.

MR. ENSMINGER: Well gee --

MR. MASLIA: Well, well. So, what I'm saying again is these are the conceptual models that we have. I've been given the data, the historical data. They are consistent, okay, for the level. Anything else, in order to go back historically, as I pointed out, we have a number of unknowns. And part of that is when leakage started we made some assumptions as to when the tank system, underground storage tank system started leaking, and all of that. There's a lot, a lot of unknowns that we dealt with that we made assumptions on based on documents, based on literature searches, and site data was not available.

MR. ENSMINGER: Throughout your data research for these water models at Camp Lejeune, did the Marine Corps ever provide you, or the Department of the Navy, ever provide you these regulations -- their own internal regulations, that have been on the books since 1962?

MR. MASLIA: Water quality?

MR. ENSMINGER: Water quality standards and testing procedures. One specifically for carbon chloroform extract, which is outlined in their NAVMED P-5010-5 dated August of 1963.

MR. MASLIA: I don't recall.

MR. ENSMINGER: And they set a standard for total organic levels in their finished drinking water at 200 parts per billion in their BUMED Instruction 6240.3B, dated a month after this document came out. In other words this document was used to discuss and outline the procedures and standards that they were coming up with, and then they put that into action in the BUMED Instruction 6240.3. So in September 1963, the Navy issued a BUMED 6240.3B, which had a standard of 200 parts per billion in total organics in the finished drinking water. Now, that belies the statement that's been made by the Department of the Navy and the Marine Corps to this day. They state that there were no regulations in place, and there is an ounce of truth in their statement, the ounce of truth being that there were no regulatory standards for those specific chemicals. However, what they’re failing to tell you is that they did have a standard in place for total organics. And every chemical that was found in our

drinking water at Camp Lejeune is an organic chemical.

So, and when I approach these regulations over the years with ATSDR, I got an answer back stating that ATSDR did not get into the legal side of these issues. And well, that's fine. But the fact that their regulations created a standard and outlined that this stuff was to be tested, so there should be analytical results available, and I would think that it would be advisable for ATSDR to write a letter citing these regulations to the Department of the Navy. I know what kind of answer you're already going to get back but, for your records, have something in writing back from them and the negative response, stating that we don't have it.

MR. MASLIA: If I could just address, and this goes to the Tarawa Terrace modeling that we did as well, the MCLs, whatever they may be, are not direct in any way used in either model concept development or running the models. We use them simply as a comparison standard.

MR. ENSMINGER: Yeah, but these would give you more data points.

MR. MASLIA: Just let me finish here. So if someone had come and said, we want you to use an MCL of 10 or 50 or one, we'd put that line on the graph.

It would not change the modeling results because that does not -- now what does affect modeling results, of course, is the detection limits on the sample, that that would take into account, things like that. The sampling protocol or frequency, things like that, that we have to do to interpret the difference between the model result and a field result. And so I just want to clarify that the MCLs, from a modeling perspective, have no impact or no influence on the modeling results themselves.

MR. ENSMINGER: Well, what I'm saying is these results would give you more data points within your model.

MR. MASLIA: Well, we have gone back, and not just the water modeling group but other groups at ATSDR, and have asked for every piece of data that they have.

MR. PARTAIN: But this is important enough 'cause if this regulation was followed and these tests were conducted, like Jerry said, these are going to be data points, and historical data point throughout the survey period. Right now the samplings --

MR. MASLIA: And they've told us, time after time again --

MR. PARTAIN: I understand.

MR. MASLIA: -- and they've gone on record as not having any, I repeat any, VOC data prior to 1982.

MR. ENSMINGER: This is not VOC data. This is organics, total organic.

MR. PARTAIN: And this is --

MR. ENSMINGER: Total PCE.

MR. PARTAIN: This is a requirement that was internal to the Marine Corps and the Navy, and is a specific testing requirement, and it should show data that is out there. And they should have been doing it 'cause this order wasn't revised until December of 1988.

MR. ENSMINGER: No, at '72 they lowered it from 200 parts per billion to 150.

MR. PARTAIN: So this is their drinking water regulation standard. And Morris, I know you want to jump in here for a second but here is the thought with this, okay? You guys have only got limited data between 1982 and 1985. Now, if the Marine Corps and the Navy had been doing their job and following their own regulations, then we would have data points dating back to 1963 for both TT and Hadnot Point and Holcomb Boulevard.

Now, I understand that they said over and over again, we've given you everything; that's a blanket

statement. Then, you know, we can have it pop up again like housing records. I would feel comfortable, as a CAP member and a representative of the community, to see a letter from ATSDR to the Department of the Navy, citing these regulations that Jerry's talking about, specifically asking for these test results. 'Cause like the Sphynx, if you don't ask the Sphynx the correct question in the correct manner and the correct gesture, you're not going to get the correct answer.

MR. MASLIA: I'll defer that decision to Dr. Sinks and Dr. Portier.

MR. PARTAIN: And I think I'll speak for the rest of the CAP that we would like to make that recommendation. And I mean, it goes along with this is the same animal we're dealing with, with the water supply logs, production logs, for the Hadnot Point wells that mysteriously disappeared. We'd been told all the data's there -- I'm sorry, all the information available is present, but specifically those well logs, which are critical to your water model 'cause they show the sequence of when the wells were operated, are missing.

And this is one of these key data points that we get to that, when it's time to, you know, to fluster

out the devil in the details, as Dr. Walters talked about earlier, those details are mysteriously missing. And this is one of them right here.

MR. MASLIA: I will say that in the data mining technical workbook, if you go through the types of data, and there's a table in there, and it's also in Chapter A by the way, the final document's on the web. We gave the dates that we needed information for and it started in 1942.

MR. PARTAIN: And this is not to say that you guys are not doing your job or anything; it's just, to me, scientifically, you want to nail things down as tight as possible, and this regulation is a huge question mark on the data.

MR. ENSMINGER: Well, I mean, and the Marine Corps and the Department of the Navy have historically played this role in this issue: Well, you didn't ask specifically for that, so we didn't give it to you.

MR. PARTAIN: And I'll give you a great --

MR. ENSMINGER: And I mean, that has been historically the answer you -- everything is legalese with those people because their butts' hanging out, okay? But this is a standard; it is a regulation and it sets the testing procedure and the testing for the ^. And those analytical results should be available.

It even has the form that they were required to use in it.

MR. PARTAIN: And to give an example of what Jerry's talking about with these questions, in the summer of 2009, Senators Burr and Hagan, both posed the question to the Department of the Navy and the Marine Corps concerning a whole host of things including the Hadnot Point fuel farm and what was leaked out there. Now while we didn't specifically ask how much fuel had leaked out or what the estimates were, the Marine Corps answered the question but never provided the information to the senators that there was around 1.2 million gallons of fuel floating in the aquifer, which you'd think that would be an important piece of information to disseminate. That was found a year later by you all and also by Jim Fontella. So you think, you know, two U.S. senators writing to the Marine Corps and the Navy a set of inquiries, that the Marine Corps would come clean and say that. That's why I'm asking for this request to be put in writing. Like Jerry is and I am too; I'm seconding it. To ask for this specifically. 'Cause I do not want to see it pop up after all your studies are done: Oh, by the way, here's some data points that we, you know, we have.

MR. ENSMINGER: The Department of the Navy Marine Corps knew the magnitude of the losses at the Hadnot Point fuel farm, documented as early as 1996. And when did ATSDR find out about it? The magnitude?

MR. MASLIA: I believe it was in March 2010.

MR. ENSMINGER: In March of 2010. They knew that they had lost in excess of 800,000 gallons, and it was cited in a technical or in a -- what was it, a working group meeting, in November of 1996. ATSDR was at Camp Lejeune working on the public health assessment. They were working on studies. They actually kicked off the water modeling. Had meetings on all this. And they didn't tell you guys that they knew how much fuel was in the ground? What the heck? I mean, that shows -- that shows. You know I went to your website the other day, which reminds me, on your website it says ATSDR's been working on the health exposures or human exposures to VOCs since 1993. Well, isn't that great? You just haven’t had any ^ in 20 years. But that date’s wrong. ATSDR has been working at Camp Lejeune since January of 1991.

MR. TOWNSEND: Jerry?

MR. STALLARD: Yeah, Tom, welcome back. Let me ask, do we have any more questions for Dr. Maslia?

MR. ENSMINGER: Doctor?

MR. TOWNSEND: Yeah, I have a comment from what Dr. Maslia was talking about.

MR. ENSMINGER: You look like a doctor.

MR. STALLARD: Well, he has shared with us an enormous amount of expertise and passion in geohydrophysics, so I thought I'd recognize that.

MR. ENSMINGER: What did Tom want?

MR. TOWNSEND: Hey, I'd like to just throw in a comment about the extent of the contamination. I was a ^ observer artillery, and was in the firing range area, and we had exercises, used to dig down about a foot and a half in the sand, and there would be an oil ^. I mean, this has been going -- and that was in 1955. This crap has been going on -- I was fortunate my family moved out of Tarawa Terrace before it became contaminated. I had the unfortunate action of being assigned to a house on ^ at Hadnot Point, which was the fire hydrant had about 300 parts per million of this crap. That was -- my family was drinking it and taking showers and washing clothes. This thing has got to come to a screeching halt.

MR. ENSMINGER: Well, I have right here, ATSDR's preliminary findings from their site visit from January of 1991, in a letter written by the Navy Environmental Health Center in September of 1992. And

ATSDR's preliminary findings were contaminants of concern on base including fuels, VOCs, solvents, metals, solvents and fuel constituents were identified in base potable supply wells. The contaminated on-base supply wells are a past completed exposure pathway.

And mysteriously, the fuel ended up being dropped from the public health assessment whenever there was a completed pathway already identified, in 1992. How'd that happen?

And, oh gee, let's not forget that none of the supporting documents for that piece of crap health assessment is available; the dog ate it. It was lost in a move. Then it was explained to us that a contractor came in and just arbitrarily went through the boxes of these documents that were sitting in the reproduction room, and took it upon himself to go through all of the files, pull all of them out of their binders and shred them. Come on.

MR. TOWNSEND: The dog ate them.

MR. STALLARD: All right, folks. We've heard this mantra before.

MR. ENSMINGER: But can I make one other point? On ATSDR’s website it also states under the Camp Lejeune thing that ATSDR cannot determine any of the

health effects of exposure to VOCs. Really? Three of the known chemicals we were exposed to at Camp Lejeune are known human carcinogens, for God's sake. And it's right there. It's right there on your website. I called Frank about it the other day. I said, what the hell's this? He said, well, it's something you need to bring up. He said, because it's wrong. I mean, you know --

MR. STALLARD: Let me say that we're here right now. I need to see if Morris can sit down.

MR. ENSMINGER: Morris?

MR. STALLARD: And then I'll turn it over to Dr. Portier to answer questions?

MR. MASLIA: Is there another question?

MR. ENSMINGER: Yes.

MR. MASLIA: Yes.

MR. ENSMINGER: On the LNAPLs. Who did the work-up on the LNAPLs?

MR. MASLIA: Who did the work-up?

MR. ENSMINGER: Yeah.

MR. MASLIA: You mean the study team of ATSDR's -- water modeling team gathered all the information, put it in, in a package. We did the concept, we plotted maps out. And then the actual model development was developed by Georgia Tech.

MR. ENSMINGER: Okay.

MR. MASLIA: They provided the results back to us, which is part of the Supplement 7.

MR. ENSMINGER: I would hope that Georgia Tech is here at the representation to explain how they did this model, whenever the Chapter A report comes out. I'd like to see them here to explain why they say that it's virtually impossible for these LNAPLs to get down that deep.

MR. MASLIA: I do.

MR. STALLARD: Want to extend the invitation?

MR. MASLIA: What? I'll defer to my superiors on that.

MR. STALLARD: Okay. All right, Mike, you had a question?

MR. PARTAIN: Jerry got most of what I was going to -- I said Jerry got most of what I was going to say. But I'll just tack on, you know, when the finished product comes out, is there going to be any type of caveat or asterisk denoting the fact that there are data points indicating benzene in the deep aquifer, for the benefit of the doubt, I mean?

MR. MASLIA: Those are, I believe, in Chapter D report.

MR. PARTAIN: Okay.

MR. MASLIA: That's already out there. And again we didn't just eliminate -- let me clarify, because I think that you bring up an important point. If there was a data point, I'll use the water treatment plant, that says it's unexplained or whatever, we provide that data point and cite the exact reference where we found the data point at, okay. And just say that -- I believe we even used in discussing in saying it's unexplained. But we're not taking data out or not providing data.

But I want to clarify one other thing. I'm not here saying that none of the supply wells in the model showed any benzene or any particular constituent. What I was trying to do with the conceptual models is show the relative difference between a DNAPL migrating through ground water and an LNAPL. And the models show that if the majority of the mass in a DNAPL is below the water table, the majority of the mass in an LNAPL is above the water table, and most importantly you have on the average, 28 wells pumping, sometimes it's higher in a period of the epi studies, sometimes as high as 35 wells, mixing at one point in time, okay.

MR. ENSMINGER: How is that?

MR. MASLIA: How is that? To get the water

supply, we have documentation on that. Go to the supplemental -- the published Supplements 1 and 2, and you will see how much water, raw water, that is total water, that we have documentation on. And a well is only capable of pumping at best what it's rated. Many of the wells as they age pump even less. And that's why they have to have 28, an average, of 28 wells mixing at any one time, obviously averaging no higher than that or lower than that. But at the Hadnot Point system -- so again, when we're doing a mixing model, you don't only mix contaminated wells, you mix, for each month, you mix all the wells that were pumping, and that is consistent with the total water, that was provided to us in documentation, raw water that was received at the water treatment plant.

MR. ENSMINGER: I thought that they could only facilitate ten wells at a time in the plant.

MR. MASLIA: No. They can do more than that. Maybe only ten, only full bore out. I don't know; I've never heard that limit. But our models -- it varies month to month, okay. And based on the work in Supplement 2 that describes the process that we used to reconstruct monthly operation of the wells, which was based on the 1998 'til 2008 daily records, and some other sporadic.

MR. PARTAIN: Now, the pumping sequence of the wells, Morris?

MR. MASLIA: Yes.

MR. PARTAIN: That was established after the contamination period, correct? As far as what we were --

MR. MASLIA: No, what we did was, and this is important to understand, is we had -- we first established the historical operation of the wells in terms of whether they were on, and Jason did this work, and when they were completely pulled out of service and/or when they were replaced by a new well. And that graph is also in several of the reports in Chapter A. And there's 97 -- there's a hundred wells but 97 water supply wells, okay, 97 wells. Once we had that, we then had information, daily information, from log sheets from 1998 through 2008 on the daily operations of all the wells.

So we used that information sort of as a training period to train the wells because typically water plant operators like to operate similar wells in similar manner. They don't all of a sudden like to go turn on a well ^ turning on. And so through a technique and procedure developed, you know, with our cooperative agreement partners and ^, who is an ^,

ORISE fellow with us, we developed a method to go back. And then on a monthly basis tell us which wells and how much they operated. So one of the assumptions is a well can't pump more than its rated capacity. If the well's rated at 150 gallons per minute, it can't pump more than 150 gallons per minute.

MR. ENSMINGER: You'd be lucky if you get anything.

MR. MASLIA: Yeah, that's the point. And we had sporadic information going through the well files at Camp Lejeune and speaking with retired operators and current operators as to how they -- if we had a question about how they would operate certain wells.

MR. PARTAIN: And that's what I'm getting at, 'cause like for example, Bert, when we talked to him and interviewed him, he indicated that prior to 1985, the operation of any specific supply well was a haphazard decision that was made by the water treatment plant operator at that time when they were in there. There was no set pattern or no set routine. Now, here's my concern, and there's a reason why I bring the point up, and I understand you have to have something to run the water model. If you're running the water model using the sequence of water wells that are being turned on and off and supplying that well,

based on 1998 forward, that is number one to me after the contamination period, the behavior has been modified because of an event, and the event being that Camp Lejeune's drinking water was poisoned in 1985, which -- and they got caught, and that changed a behavior. And yet you didn't see it in the log books in the plants how they start talking when you go into the log books. And curiously back to my original point about the well logs, supply logs, books from 1995 backwards, they're not there. So how does ATSDR address that tinge of doubt that's in there? Because, you know, correct me if I'm wrong, how the wells operated in the sequence they're operating can affect a water model. If I'm turning on one -- like for example, if I'm operating well 602 every day, or, you know, over, you know, overoperating or overpumping them, that could affect your data points, correct?

MR. MASLIA: Right. The one overriding, the major constraint, whatever we get in terms of wells operating, not necessarily operating behavior, it was a constraint that no matter what happened, no matter what they did, they had to keep every storage tank filled. They would not allow the storage tanks to drop more than a foot. We were there on base when that happened and they would turn it. And during

that, that means they would have to operate, I would kindly disagree that they could only operate ten wells at a time because we operate more than ten wells at a time. It does not dewater the aquifer. And that was -- now, which wells they cycled in and out specifically, and we say that that's an unknown. But the volume of water that the model needs for the ^ wells and all that, that I'm very confident in.

And in fact we have tried numerous simulations, in fact very recently, to see if we can vary that, and because they had to keep those tanks filled, when we tried to vary it even by five percent, it would blow up. It would not work, okay. They had to have that supplied with water. And that's really -- that was a constraint on the operators, to keep those tanks filled and once they drop like a foot, they dropped like a foot, 1.2 feet, they would immediately turn on those wells.

UNIDENTIFIED SPEAKER: Morris, also you add the well histories ^ the time a well came into existence through --

MR. TOWNSEND: Morris?

MR. MASLIA: Yes.

MR. TOWNSEND: Tom Townsend. When -- I missed something. When is this new report for Paradise Point

going to be coming public?

MR. MASLIA: Which report?

MR. TOWNSEND: For Paradise Point.

MR. MASLIA: Chapter A in the spring of 2013.

MR. ENSMINGER: This year.

MR. TOWNSEND: In the spring.

MR. MASLIA: In the spring.

MR. TOWNSEND: Yeah, well, I'll look for it in the spring, okay.

MR. MASLIA: I checked this morning and the vernal equinox does not occur until March 20th.

MR. ENSMINGER: Tom, I noticed that the maple trees are budding out already.

MR. STALLARD: Hopefully the snow will be melted by then up there and you'll have good water. Dr. Portier would like to speak.

DR. PORTIER: Yeah, I wanted to speak before I lost track of everything you guys had said as we went along. Jerry, you'll have to show me or one of my staff exactly where that wording is. It shouldn't be in there, on the website, and I'll make sure we get it clarified, whatever the wording is.

The question you had regarding the total carbon and measurements of total carbon, we'll talk about it.

MR. PARTAIN: You mean the carbon chloroform

extract?

MR. ENSMINGER: Total organics.

DR. PORTIER: Total organics, sorry, total organics. But we'll talk about it. There's two questions that have to be asked. Number one is could Morris use it if he had it; that's question number one. And question number two is: Is it likely to make any difference because of the fact that they're using different measure than what we would normally be looking for. So we'll talk about it and decide whether or not we really need to send something or not, based upon utility in characterizing the model.

Most of the things you're talking about, Mike, most of the questions you were asking, are dealt with in this whole section of uncertainty of the model or uncertainty of the predictions from the model, as Morris pointed out, in trying different scenarios under different conditions to see what would happen. So I think when you get the chapter and the supplement associated with the uncertainty part, you'll see some of these things addressed as best they could. I do know for a fact, having read this chapter enough times, that the large benzene value is indeed discussed in Chapter A and in the supplement, but clearly in Chapter A as a bearing point that we don't

know what to do with. It's one of the major uncertainties of the overall evaluation that is pointed out in Chapter A.

MR. ENSMINGER: I have a question. How many other NPL sites has ATSDR been working on for over 20 years and don't have a public health assessment?

DR. PORTIER: We can probably get you that number, but if it's more than zero, I'm going to be pretty angry with my staff.

MR. ENSMINGER: I mean, and I realize that this is not all ATSDR's fault.

DR. PORTIER: Well, I will point out, Jerry, that we work all the NPL sites, every five years we look at them, we revisit them to see if we need to do anything else. Until they come off the list they're still in our bailiwick.

MR. ENSMINGER: Yeah, but I mean, we've been working on Camp Lejeune for 20-some years without any answers, I mean, without any real answers yet. I mean, what's the reason for that? I mean, I know that's not -- it's not all ATSDR's fault. Whose fault is it that this has been drug out for so long? Or don't you want to say? I mean, is it the Department of the Navy's fault, Marine Corps?

MR. STALLARD: Jerry, we're not here for --

MR. ENSMINGER: I am.

MR. STALLARD: -- for blame right now. We're just trying to continue to advance our work as the CAP to address the studies.

DR. PORTIER: Morris is probably getting tired.

MR. STALLARD: He's got to be.

MR. MASLIA: I got here about 5:30 this morning.

MR. PARTAIN: I'm done with Morris.

MR. ENSMINGER: That bow tie will hold him up.

MR. MASLIA: Are there any other questions?

MR. PARTAIN: For Morris? No.

DR. PORTIER: Morris, I think you can answer any additional questions from your chair, if you'd like to sit down.

MR. MASLIA: Oh, sure, okay.

MR. STALLARD: Yeah, and take off that microphone before you go.

MR. MASLIA: I will.

MR. PARTAIN: Going back, Dr. Portier, to when you mentioned talking about the utility of the data and stuff. The fact that we have you said the variant data point for Hadnot Point, 2,500 parts per billion of benzene. To me the existence of that data from the Marine Corps and Navy in the form of their carbon chlorified extract testing should help -- I mean, to

me it would theoretically help nail down the possibility that would be correct anyway. And --

DR. PORTIER: What was their standard again? Was it 200 --

MR. PARTAIN: Well, it's 200 parts per billion total. 'Cause and that's in 1972 that changed 'cause, you know, reading from the carbon chlorified extract point on here, this is what the regulation's saying: The use of carbon chloroform extract as a practical measure of water quality and as a safeguard against the intrusion of excessive amounts of potentially toxic material in the water has been discussed elsewhere. It is proposed as a technical practical procedure which will afford a large measure of protection against the presence of undetected toxic materials in finished drinking water. The most desirable condition is one in which the water supply delivered to the consumer contains no organic residues. Residual organic matter in the treated water clearly represents manmade or natural pollutants which had not been removed in water treatment or materials such as lubricants inadvertently introduced by the water plant. In a view of general inability to clearly define a chemical and toxicological nature of this material, it is most desirable to limit it to the

lowest obtainable level.

Analysis of data available indicates that the water supply is containing over 200 micrograms of CCEs, slash, 1, of water represents an exceptional and unwarranted dosage of the water consumed with ill-defined chemicals. And it is recommended that 200 parts per billion be the limit in concentrations in drinking water.

MR. ENSMINGER: And those recommendation -- that document is dated August of 1963. Those recommendations were put into the regulatory standards in the BUMED Instruction 6240.3B, which was issued in September of 1963. And then it was revised again in September of 1972 and reissued as BUMED Instruction 6240.3C, where they lowered the standard from 200 parts per billion for total CCE to 150.

Now, in 1982, when they got a report back from Granger Laboratory showing 1,400 parts per billion, of just TCE alone, and their standard of 150 parts per billion, they were in violation of their own damn standards by 9.33 times.

MR. PARTAIN: And did absolutely nothing.

MR. ENSMINGER: But then you listen to them in the documentary film, and their spokespeople say, we couldn’t figure out where it was coming from. No

shit! Do the test. You had the requirements right there, and the standard. Now where are they?

And, you know, that's something that ATSDR should have learned a lesson about the Department of the Navy and these DoD sites, for in the future. You need to find out what their own regulations were before you move any further. Because these guys had regulations and they've been lying about them for all these years.

I didn't find that P-5010-5 until the spring of last year. And I still don't know where I got it but I got my hands on it. And we had the BUMEDs all these years which showed the standard MCL in their regulations, in the BUMEDs of CCE, but we didn't know what it was. 'Cause in the BUMEDs it didn’t spell it out. The only place it was spelled out was in that -- the NAVMED. And none of these directives were canceled until 1988.

MR. PARTAIN: And Dr. Portier, the reason why, you know, I ask, personally, as a former resident of Camp Lejeune, that this be put in writing to eliminate all doubt whether this data's there or not, is from a statement that the Marine Corps has made over and over again. This particular one comes from General Conway in -- Commandant of the Marine Corps in 2009. Quote: Although drinking water regulations did not regulate

the contaminants at the time, space, and would not until 1989-1992, the Marine Corps took action.

Now, the -- whether this stuff is out there as far as the Marine Corps following their regulations and doing this required testing, as a member of the community, that is vitally important to me, because, if they did do it and it does show the contaminant there, then, to me, that backs up your water model, it backs up when your water model's going to be attacked by the Marine Corps and the Navy as being junk science or whatever they want to try to say it is, and it is vitally important that that point be nailed down as firmly as possible. And the only way I know how to do that is a, as a claims adjustor, is I deal with facts. I don't deal with generalizations.

The fact is Marine Corps/Navy, here's your regulation. Do you have the analytical results for this regulatory testing? And it's either yes or no. Of course they'll come up with another answer saying, we don't have the documents. That doesn't mean that we didn't do the testing because we don't have the documents. But I want them to answer that question, just like I want them to answer where those well supply log books are. We've been told that we don't have it, but specifically they have never put it in

writing. And we disposed them. We don't have them or whatever. I actually have a well log book for one, New River, that's dated back in the 1980s.

MR. ENSMINGER: Well, another point is --

MR. PARTAIN: That was given to me by Bert.

MR. ENSMINGER: -- the fact that these standards are not done away with, these regulations were not canceled, until 1988? Gee, all that stuff that was taking place in the 1980s, which is within their document retention period of requirements for maintaining this stuff, and especially under CERCLA, then if they were doing their own testing in the 1980s? Some of those results should be in their files, right? If they were going. I guarantee you they weren't. That was just nice stuff to put on the shelf for inspections.

DR. PORTIER: Okay. I got your point. And we will look at it and consider it.

MR. STALLARD: Thank you. We made the segue, when Morris stepped away from the podium into CAP concerns. And so we have --

CAP UPDATES/COMMUNITY CONCERNS

MR. ENSMINGER: We've already heard one.

MR. STALLARD: I think we have. So we have another seven or eight minutes. Tom, on the phone or

Mary, I invite you to give us an update on things you've been working on or other concerns or issues you might have.

MR. TOWNSEND: I'm ready to speak.

MR. STALLARD: All right. Go ahead, Tom.

MR. TOWNSEND: I've claimed disability from the Veterans' Administration because as a regular officer of the Marine Corps, I cannot claim against the United States without their consent. So for seven years I've been going to the VA processors for neuropathic disability. I've been to 15 outside neurologists who gave me neuro history, neuro conductivity and all this stuff, and my feet are failing. The nerves are disconnected, and anyway, I have ^ down at Louisville, and the people there have got all my claims despite they say that nothing has occurred and that I do not have any symptoms, and that I have been examined by a doctor that I've never seen. So I just -- I'm just so tired. I mean, that's my personal thing. The fact that I lost my wife and my child to Camp Lejeune is galling. And to make matters worse, friends with a Marine, a former Marine, in Mobile that lost three children that were born at Camp Lejeune. Clearly there's something going on -- clearly there's something wrong with the system of claimants through

the VA. I mean, I want to -- they seem to want to deny everybody. I don't know how many turned-down veterans who were revealed but I imagine they're going to discount all of them. I don't know.

MR. STALLARD: Tom, were we successful in connecting with you at the break to get your claim number?

MR. TOWNSEND: Yes.

MR. STALLARD: Well, then we would hope to hear a different outcome at the next meeting in terms of however that evolves. And thank you for sharing that. I would say that what we have seen since the VA has joined the CAP is a tremendous change in the direction to address the needs of our veterans and family members. So thank you for sharing your situation with us.

MR. ENSMINGER: And I want to thank ATSDR for getting this word out to -- this information out to the Veterans' Administration so that they can proceed with these veterans' claims. These guys, like I said earlier, a lot of these folks are terminally ill. They're going to die sooner than later. A lot of them just want the peace of mind before they die that they've achieved that step, and attained their VA benefits, knowing that their surviving spouses are

going to have some of that to fall back on.

A note on that, yesterday morning at 4:00 a.m., we lost Frank Rakowits(ph). He was a metastasized kidney cancer victim. Frank died yesterday morning at 4:00 a.m. And yesterday we also lost Mary Freshwater. Mary Freshwater was featured in the documentary, and she was given testimony to the NRC committee, and she was describing the death of her two infant sons. And she held up a little blue jumper and the box of memories that she had for her children that she lost, that were conceived and born at Camp Lejeune. Mary died yesterday of AML.

This is not a pleasant job. I know you all deal with facts and figures. And I deal with the personal aspect of this. I got involved in this mainly because of my daughter, who died. She was the only one of my four children to be either carried, conceived or born at Camp Lejeune.

After my deep involvement in this and realizing how big this thing was and how many potentially exposed and affected people there were, I tell you what, this -- you get to know these people, you cry with them, and every one of them that dies you die a little bit each time. And this is not fun.

And I mean, to look at the misconduct of the

people that we served and the leadership, that the misconduct that they're demonstrating is appalling. Their lack of cooperation with investigating bodies, such as ATSDR. I mean, the track record goes on and on and on, and we got letters from ATSDR in complaint to the Department of the Navy that they weren't cooperating with ATSDR and providing them the data they need. This is repeated. This isn't just one isolated letter.

But yet these people can come out in the media and say that the health, safety and welfare of our Marines and their families are our first priority. Bullshit. And people wonder why I cuss? I mean, these people are lower than low.

But with that being said, I got a phone call right at the beginning of the meeting. It was my wife's administrative assistant, calling me from her school. My wife's father died this morning, so I've got to leave; I won't be here after lunch. I'm sorry, but I got to go.

MR. STALLARD: Thank you, Jerry. Dr. Portier?

DR. PORTIER: Yeah, two quick things. One is I also have to leave after lunch so I will not be here after lunch but Tom Sinks, my deputy, will be here to answer any questions for you. The other thing is, for

the rest of the audience, I did hand out to the CAP a letter from me to General Allison Hickey at the Department of Veterans' Affairs, and if you'd like a copy of this you are welcome. I've got four left here. If you'd like a copy, please pick it up. If not, please ask my chief of staff, Sasha, and she'll make sure she gets you a copy.

MR. ENSMINGER: General Hickey?

DR. PORTIER: Yeah, General Hickey.

MR. STALLARD: And with that, thank you very much. We're going to adjourn now for lunch. Be back in an hour, please, 1:15.

(Lunch break, 12:00 p.m. until 1:15 p.m.)

MR. STALLARD: Okay. Welcome back, please. We're going to get started. Do we have our colleagues on the phone at the moment? Tom? Sandra? Not yet, okay. I'd like to thank you all for abiding by our guiding principles that we established this morning. I think we're doing a good job in that. I would suggest that, since we're coming back from lunch, you please turn off your cell phones at this time or put them on silent.

Okay, I know some of you may need to leave earlier this afternoon as we were just notified that there is a severe weather alert from now until seven

o'clock tomorrow morning.

MR. MASLIA: It's because it's my wife's birthday. It always happens on my wife's birthday.

DR. WALTERS: Well, your wife needs to change her birthday.

MS. BRIDGES: Sandy Bridges on line now.

MR. STALLARD: Thank you. Welcome, Sandy.

MR. PARTAIN: And Chris, I --

MS. BRIDGES: We were having a problem there 'cause I couldn't get through.

MR. STALLARD: Okay, well, you're through right now. And we're about ready to resume, thank you.

MR. PARTAIN: And with that note, if we can get through -- if we get through earlier --

MS. BRIDGES: Chris, you look nice in that suit.

MR. PARTAIN: -- move quickly. If we move quickly and get done early I have no opposition 'cause I've got to --

MS. BRIDGES: You're looking older from what you did six years ago.

MR. STALLARD: Well, thank you so much. For the viewing public, please acknowledge. I had more hair then, too.

So the point is that what we'd like to do is get through this afternoon. We're not going to rush it

but if you need to leave in order to make your flights and be safe in getting to your destination, please do so. So without any further dialogue, let's move on to our afternoon presentation with Perri.

MS. RUCKART: Welcome back from lunch. Before I get started I just want to introduce to you two, okay, three ORISE fellows that we have working with us. They're going to be helping us with the health survey, entering the surveys that we received from the last batch of the registrants and also working on the male breast cancer study. I'll just introduce them -- I need you to stand up. We have Toni Lombardi and Crystal Lane and Kirsten Simmons.

MR. STALLARD: And ORISE stands for?

MS. RUCKART: Oak Ridge something.

MR. MASLIA: Oak Ridge Institute for Science and Education.

MR. STALLARD: Good. Thank you.

MS. RUCKART: So I think everyone has met them because they've been escorting everyone from the visitors' center. This is their formal introduction.

MR. STALLARD: Welcome. Thank you.

UPDATES ON HEALTH STUDIES:

BIRTH DEFECTS, CHILDHOOD CANCERS

MS. RUCKART: So just want to update you on some

things where we are with the epi studies. It's rather brief and you can ask me any questions that you have. Okay, so everyone is familiar with our study of birth defects and childhood cancers. In case there's some people who are watching us who may not be familiar, I have this slide up.

So where we are currently, the draft of the final report and results is currently undergoing CDC clearance and is on track to be released in the spring of 2013.

ADVERSE PREGNANCY OUTCOMES

Now, as you know we're also re-analyzing the 1998 study on adverse pregnancy outcome. We're re-analyzing it because, during the water modeling process, it came to our attention that births before 1972 at Holcomb Boulevard were incorrectly classified as unexposed so we're going to use the information from the water modeling to re-analyze the study, and also because now we're going to have information on the estimated levels.

So you can see here a comparison of the exposure status from the previous exposures estimate before water modeling, when there was that error, and also the current exposure assessment. And the main difference is that, based on the new exposure

information, there are almost 1,200 fewer people categorized as unexposed. So that gives us -- thank you. And that gives us over 1,300 additional people categorized as exposed to TCE, 'cause they lived at Holcomb Boulevard and received Hadnot Point water before June 1972.

The reason why I say there's almost 1,200 fewer people as unexposed and there's 1,300 more exposed is 'cause there were some differences with Tarawa Terrace as well. But the bottom line is we can now evaluate TCE more thoroughly because we have a lot more people in the exposed group, whereas before there was like 31, whereas now we have over 1,300.

So anyway we've begun the data analysis for the study. We're looking at several outcomes: preterm birth, term low birth weight, small for gestational age and mean birth weight deficit. As I said, the analyses are currently being conducted, and once we're done with the other two studies, the birth defects and the mortality study, then we'll focus more on this study. And so we expect this one to be released in summer of 2013, after the other are two, which are our main priority. Any questions about this one?

HEALTH SURVEY

Okay, just an update on the health survey. As

you know, we have about 76,000-and-change surveys completed. That's a 27 percent response rate. Well, last time we provided information on the number of conditions we're confirming. And I wanted to let you know that the numbers have changed since last meeting; they have increased. That was because it came to our attention that a few cancers were inadvertently left off of the list of diseases that we want to confirm.

So at this point we're continuing the process of confirming the self-reported cancers and other diseases by obtaining medical records and looking at cancer registries, both VA and state. So this is 22,429 conditions in 16,642 people. As you can see there that's a little over 8,100 cancers and over 14,300 other diseases.

Now since I last reported this, throat and pharyngeal and windpipe laryngeal cancers were added and prostate were added. They were inadvertently left off the list. But the list of the other diseases has not changed. And now Frank will update you on the mortality study.

MORTALITY STUDY

DR. BOVE: Okay. Right now with the mortality study, it has gone through a peer review process with peer review comments back. And I'm reviewing the peer

review comments and doing some additional analyses. And hope to finish with the peer review process either at the end of this month or probably somewhere by the middle of next month.

The size of this study is rather large. This is the number who were either at Camp Lejeune or Camp Pendleton during 1975 to '85, anytime during that period, and who started their active duty service either in '75 or later. So this is a smaller group than the entire dataset that we have. The entire dataset we have includes people who started before '75 and includes people all the way up to '87. But we focused on these people because we don't know, for those who started before '75, we don't know where they served, how long they served. And for those after '85, the exposures were kind of low. So we decided to focus on these, these cohorts.

We have 18,166 deaths among these two cohorts. These are deaths occurring from 1979 onward. Deaths occurring before 1979, we could not capture their cause of death through the National Death Index so they're not included in this study. But we do have, as I said, 18,166 deaths, 2,086 list a cancer as an underlying cause, and some of course had multiple cancers, and so we have 2,659 total cancers listed as

underlying or contributing causes. Here's a look at some of the demographics.

MR. PARTAIN: Frank, on the data for that. You may have said it when I stepped out for a phone call, but when was the last time that you all did a refresh as far as an end date for the death certificates?

DR. BOVE: Let me see, 2008.

MR. PARTAIN: 2008? Are you all planning to step back and see if there's any more data from 2009, '10, '11?

DR. BOVE: No.

MR. PARTAIN: No?

DR. BOVE: No, this study has finished its data collection quite a while ago.

MR. PARTAIN: Okay.

DR. BOVE: The only thing that we could do is probably ^. I'll explain that in the next slide. Is that this is a young cohort. As you can see, very few are over the age of 55 as of 2008, when we stopped data collection. So this study probably should be revisited in ten, 15 years, when people are older. It's something we might decide to do. Yeah.

MS. RUCKART: But the health survey goes up through whenever they filled out our health survey, 2011 or 2012, so as you know we do have next of kin

filling out surveys for people who are deceased, so we're getting some information that way. That's a little more recent.

DR. BOVE: Right. But we're talking about the mortality study that's --

MS. RUCKART: I know, but I just -- that's the general.

DR. BOVE: So. And as you can see it's almost entirely male, and it's mostly enlisted, the ^ of racial composition's not that different from the general public. And we don't have much in the way of lost to follow-up. However, I do notice, when I look through the data, that those who were killed in the Beirut bombing in 1982 were not caught up -- not found in the National Death Index. Going through the Social Security administration databases as dead; all I have is the last date of the DMDC, so that's interesting. Why that happened, I don't understand. But if they were lost to follow them, it does not mean they're out of the study. They stay in the study, contributing person years and that's what the bottom line there is, until I have the last date I know that they're alive. And that might be the last date in the DMDC data that we have, which goes up to the end of '87. So they do contribute person time for that period and then they

stop, when I have no more information on them.

Just some quick things about the study. Looking at a whole slew of cancers, although our primary focus is on those cancers that have been pretty well linked to TCE and PCE and benzene, and those include, of course, kidney cancer, hematopoietic cancers like non-Hodgkin's lymphoma, leukemia, multiple myeloma. We're also looking at liver cancer, of course, and probably for PCE there's esophageal cancer, bladder cancer. So those are the ones that we're primarily focusing on, but then we're looking at a whole slew of other cancers that have been suggested, at least, to be linked to solvents. And as well we're looking at ALS and MS. We're looking at -- we're going to try to look at Parkinson's but I have a feeling -- we have very few numbers of that. We have very few numbers of aplastic anemia in the dataset, so it's going to be difficult if not impossible to look at that. Male breast cancer, we have very few -- we'll not be able to look at that in this study. So there's some cancers we can't look at and some diseases we can't look at, because it's, again, it's a young population and there are very few of those diseases in the dataset.

The exposure assessment, first of all, the

comparisons that we're doing in this study is first comparing Camp Lejeune and Camp Pendleton and the general population. And then we're comparing Camp Lejeune to Camp Pendleton, and then we're going to do an internal analysis in Camp Lejeune itself and using the monthly estimates that Morris's team has given us.

And it's kind of a complex exposure assessment. We have to take into account whether they are married or single, whether officer or enlisted, whether female or not, and even some of the units who have moved around, and we have to take that into account. And we have some information on where units were barracked. But again that's -- a lot of that is historical recollection of retired Marines; there's no hard data. So we've been able to use that data but there is some uncertainty in the exposure sets. So that's the mortality study. There’s more to be said, I guess, about it, but if you have any questions I can go into it.

The next part of this study, which I'm just starting to really work on, is looking at the civilian workers. And preliminarily, I've looked at all the workers that are in our database from '72 to '85. But what we probably will focus on are those who started in '73 because I can determine when they started. I

can determine that they started in '73 or later. If they're in the database in '72, I don't know when they started. And so again, the fact of the situation of not knowing their history. So this'll be a smaller number.

But this is the situation right now, the number of deaths. Again, these are deaths since 1979 to 2008, using the National Death Index for the cause of death. And it's a smaller dataset but we have a lot of deaths, and the reason we have a lot more deaths than you might expect, given the previous slide, is because this is a much older group. The median age is in the 60s, a whole lot of them, most of them, are over 55. So this is a smaller population, very much smaller. It was one-tenth the person time or even less. But because they're an older population there are more deaths.

So again, these studies need to be revisited, especially the Marine study. This one, we have now an older population. This one probably will give us more interesting results probably. Let's see, is there anything else to say? Any questions about the mortality study?

MS. BLAKELY: I don't have one. You have one, Mike?

DR. SINKS: You mentioned the exposure assessment for the active military. What about for the civilians? How are you going to consider exposure?

DR. BOVE: For civilians we're assuming that all the civilians are working on main side. We have no information as to where exactly they worked. But in talking to the Marine Corps, they said that that was a -- that's a good guess. In both studies we have information on their occupation. In the mortality study I did take into account whether they were solvent exposed, whether they were hospital workers or whether they were food workers, and I will use the occupational data as well for this study.

MS. BLAKELY: There were also a lot of office workers like in the, I don't know, my mother-in-law was like a secretary in one of the offices, and my husband worked in the print shop.

DR. BOVE: Right. They're all in this study.

MS. BLAKELY: Okay.

DR. BOVE: Yeah. I'm just saying that we take that into account as additional exposures besides the drinking water. So for Jerry, in one of the meetings, was worried about the cooks, for example, in the Marine Corps, so I did look at that. I had information on whether they did food service work. I

incorporated that into the models and I'll do similar with the civilian workers.

DR. SINKS: Any other questions? Okay, Eddie.

MALE BREAST CANCER

MR. SHANLEY: Hello, my name is Eddie Shanley and I'm going to be providing an update on the male breast cancer study. Since the last CAP meeting, the protocol has been approved by ATSDR. The process involved conducting an external peer review as well as obtaining the agency clearance. The study must also be approved by the CDC and the VA Institutional Review Board. That's to maintain that we adhere to record security and protection. So approval from both IRBs is pending.

The data use agreement between the agencies. The data use agreement basically establishes the IT infrastructure and the protocols that we're going to use in order to image the data and ensure its security. So we are in the process of finalizing that document as we speak. And I am anticipating that we will have the data use agreement approved by the end of January.

Once both agencies sign off on the data use agreement, then the pending IRB approval from both CDC and the VA will be moved to approval status and we can

begin the data collection process.

So the data collection will of course involve obtaining the electronic records from the VA. It will also involve obtaining data from hard copy personnel records that are maintained at the National Personnel Record Center. Based on a preliminary assessment that I did back in May of 2012, I'm anticipating that the time it's going to take to collect the data, and that means abstracting it from the records, entering it in and cleaning it and preparing it for analysis, it's probably going to take around five months.

At which time, once all the data's been entered in electronically and been prepared for analysis, I think analysis will take about three months, at which point we'll begin writing the final report. And as you can see from the slide there, the second to last says the report will need to be peer reviewed and cleared through the agency. And right now we're on track to release the report in the spring of 2014.

MR. STALLARD: Any questions for Eddie?

MS. BLAKELY: No, but I'm sorry, Frank. I brought the rest of the infant death certificates over there, so we would like your opinion on those.

DR. BOVE: Sure.

MS. BLAKELY: Thank you.

MR. PARTAIN: Have you -- where's the number of potential male breast cancer cases you've identified to date so far? Has that changed?

MR. SHANLEY: Well, the numbers we have were provided to us by the VA, and those were the same numbers we reported at the last CAP meeting.

MR. PARTAIN: Sixty-nine, I think?

MR. SHANLEY: I think it was 61. But that's not a final as far as the number that will be included in the study based on age criteria that we'll be using. If those individuals were born after January 1st, 1969, we'll be excluding them 'cause they won't be of age and in service during the period of contamination. So again, we hopefully will be receiving that data and we'll have an update by the next CAP meeting.

MR. STALLARD: Thank you, Eddie.

OPEN DISCUSSION OF ISSUES RAISED DURING MEETING

MS. BLAKELY: Can I mention one thing? Mary Freshwater, she just passed away this morning --

MR. PARTAIN: Yesterday.

MS. BLAKELY: Oh, yeah, yesterday. She shared with me the last time I spoke with her that she also lost a set of twins. And she has two living children, and her daughter has lupus. So that water has decimated that entire family. And that's just one

family.

We deserve the truth. We don't want money. We don't want revenge. We want the truth because the truth empowers us to deal with whatever we have going on with our health and with our families.

And I love the Marine Corps and I believe in everything that my father stood for and that I grew up next door to. We just want the truth and we want to give like those infants over there some dignity and honor that they existed. They mattered.

Most of them would have grown up and become Marines. That's how it works in the Marine Corps. When your family's in the Marine Corps, your entire family grows around it and becomes Marines. I could have been one but I couldn't graduate high school, and I didn't know why. I didn't know why I couldn't until I was in my 40s. That's not right. That's not who the Marine Corps is. All we want is the truth.

MR. PARTAIN: Frank, on the death certificates there, that Mary did the research on, I mean what is some way that you guys could use that or what are some thoughts on those?

DR. BOVE: Well, when I reviewed the last group, I tried to find if there were any interesting conditions in there that I know -- I suspect might be

related to solvents such as heart defects, neural tube defects, clefts.

MR. PARTAIN: Anencephaly?

DR. BOVE: Anencephaly's mentioned.

MR. PARTAIN: 'Cause there's quite a few of those that I remember seeing.

DR. BOVE: Anencephaly would be a reason for infant death, still births. Yeah, I'm looking for that for sure. Anencephaly I'm looking for. But I'm looking for all the ^, spina bifida, anencephaly as well.

MR. PARTAIN: I guess my question would be, 'cause there's quite a few, and I --

DR. BOVE: Another thing is that, if they don't die at birth but they die within a year, let's say, then I'm interested in other things, too, any childhood cancers.

MR. PARTAIN: I think I saw one with optical cancer at one point. But as far as how -- I mean, how would ATSDR -- I'm just trying to guess or understand how data like that, where would you put that data? 'Cause it is a unique subgroup. I mean, you're dealing with people who essentially didn't get a life. They're dead before they're, you know, before anything took off. I mean, what does that -- and what does

that mean?

DR. BOVE: I'm not sure. I mean, that's what I'm saying. What I'm saying is basically the case study, looking at the kinds of diseases from the death certificate. But beyond that, I don't know. These are all the -- why don't you tell me how you came about this information. That might help.

MS. RUCKART: We were wondering if these were the original copies -- your original copies or if this was a copy for us to keep and you have your own set?

MS. BLAKELY: Well, what caused me to originally start with them was I was looking for some way I could help, because, you know, Mike and Jerry, they do like on-the-ground work. And I wanted to make a difference because I do care about this community. And my father was diagnosed with Agent Orange lung cancer, and he still lives in Jacksonville.

And he was supposed to have some testing done. And I hadn't made a return trip to Jacksonville since my mother's funeral. I believe she died because of the water. So I went back 'cause he was having some testing done.

And I made friends with Jessica Ensminger, Jerry's daughter, on FaceBook. And she shared with me that there were some infant graves in the city

cemetery there, and that they believe that those babies died because of the water. And since it's right across the street from where my mother's buried in the military cemetery, I wanted to go there and just see them. And so I did.

And there is -- there's a baby garden in ^ Cemetery. And towards the back there's some buried by what looks like a ditch, and you can see how the water rises and covers their gravestones. You can tell that they've been disturbed by the water. And Jessica shared with me that there were some other graves in a bigger cemetery in Onslow County. And she told me how to get there, and so I went there with my sister, Marie. And sure enough, they have their own baby garden. And on the headstones are the ranks of all their fathers.

And we were standing there looking at them and a caretaker drove up on his lawnmower, he was mowing the lawn, and he said what're you doing and we told him. And he said you want to see more baby graves? And I said, more baby graves? And he said yeah, they're up there towards the road, by the line at the pine trees, but you gotta really look.

And we couldn't, I mean, the way that the headstones are, they're on the ground, so we couldn't

even see that there was anything up there. He said, well, you gotta really look, and he said, get on my tractor and I'll take you up there. And so he gave us a ride up there. And he said, now, you're going to have to kick the ground and knock the grass out of the way because the markers aren't regular headstones. They're metal plaques that the funeral homes delivered the babies with. They're just there for temporary purposes. Excuse me, has anybody got a tissue? They were just placed there for temporary purposes -- thank you. Until the families could either take them back home from where they're from or move them in the cemetery and get them a headstone.

Well, those parents never came back. They either couldn't afford a headstone or to move their child or they were too heartbroken to come back and get them. And if you'll notice a lot of them don't even have names because the parents were so devastated they didn't name them.

And so I started walking up that row, and there's two rows. And sure enough, I had to kick dirt and grass out of the way but they were there, little metal plaques. And I had to be careful because some of them were broken into pieces. And you had to fit them together to read them, and some of them you can't read

at all.

And I'm a person of faith. I live my life by faith; I trust God. And so I pray when I'm in a situation like that. And I asked him if he wanted me to do anything, however little it could be, because I have -- I am not an educated person.

And I was led to go to the register of deeds in Onslow County and make copies of all the children's death certificates of children under the age of two, who had any relationship to the base. Well, I didn't know what I was taking on. I thought I could just go there and ask them to make me copies. But when I went over just to look at the death books, there were just so many children that I realized that would cost a lot of money.

And so I started trying to think of ways to make copies. And I realized there had to be some sort of scanner of some sort that I could scan them with, and then load them on the computer. And so I did that. I bought myself a hand-held scanner and I scanned.

I scanned up to from 1950 to 1963 or -4. And then I had to go home. And I decided I would be back. And I loaded them up onto my computer, a Toshiba, old one, and I was trying to organize them and clean them up to make it something that somebody could look at.

And my computer died. And so all my work was lost. So I got a Dell and loaded them on that, a brand new one. And I was trying to organize them and my computer went down again. All my work was gone. So I took it back 'cause it was brand new, and got another Dell. Loaded them up. That computer went down, software problems. All my work was gone.

Then, I realized that I wasn't going to be able to load them up on a computer and I decided to print them out. So I took them upstairs to our desktop and loaded them on that one. And I also loaded them onto a Windows like live account, trying to share them with Jerry and Mike. And my husband bought me a program like for Adobe Acrobat. I loaded it on there. I also had g-mail accounts and I tried to email them, like an idiot, unsecured. And I just couldn't figure it out; I'm not a computer literate person. So anyway I took them upstairs and loaded them on the desktop upstairs.

And then I tried to print them out with our, you know, printer. And for some reason my printer wouldn't work. And so then I started getting a little suspicious there might be something funky going on. You know, I'm not stupid, I'm just -- I just have a learning disability. And so I decided I'll just take them to a printer and print them out. And so I did.

And then I decided that I should make a copy and keep one for myself and bring one to you. And so I tried to do that. And I don't know, I'm an observant person. I just -- I don't know how to put this without sounding paranoid but I felt like I was being followed.

And so then I gave up trying to make copies, and I took what I had to my church because I was afraid to keep them in my house with my family. And my church has had them for three months, waiting for this.

MR. STALLARD: So these are the only copies.

MR. PARTAIN: One thing -- yeah those are the copies.

MR. STALLARD: Those are the copies.

MR. PARTAIN: Now one thing, Frank, to answer your question directly. A lot of this came up in 2010 as Jerry and I were talking to community members across the country. We kept hearing the same things over again about women losing their children and stillborns and things like that. And then the baby having came back again 'cause that was told to us by one of the parents. And actually Mary Freshwater was one of the first ones that told us about the graveyard. My understanding, a lot of families, like Mary was indicating here, that the Onslow County

Cemetery is not the only place where there are groups of babies buried, that some families sent them off to New Bern and some of the other surrounding cemeteries.

But, you know, the big thing comes to me as far as the death certificates and looking at this previously, you know, under an analyzed group of people who really knock out -- getting a start. And that's how this all got started.

DR. BOVE: Right. And previously, the adverse reproductive outcome study was done where we were analyzing the fetal deaths. And probably because of some problem with the health department in terms of deciding what was a fetal death and what was a stillbirth whatever, I'm not sure what the problems, but we had it under account. So we did look at it in that study. I looked at the previous batch that Mary gave me, and a lot of them are preterm. And so we are looking at preterm birth in the ^ so we can address that, and we are looking at neural tube defects and clefts and heart defects so that's, you know, I did see some heart defects in the previous batch.

MR. PARTAIN: Now, there's a lot, too, they have --

DR. BOVE: And I'm looking only actually for things like, for example choanal atresia which was

found in Woburn, three cases and none expected, so it stood out. And if I see something like that, if I see something where it's a rare defect and -- if I see choanal atresia in particular, that's something that would raise a flag for me. But that's basically what I did the previous times. I looked through them, see if there are any conditions that stood out. Get a handle on what dominant cause of death was. As I said, ^ was a major cause. But okay, at least we're looking at that in the study and the analysis.

MR. STALLARD: Tom would like to have a comment, but what is choanal atresia?

MR. PARTAIN: That's one of the outcomes.

DR. BOVE: It's a nasal defect that's related to other heart defects, major heart defects. So it was interesting when we -- we didn't see it. It was the CDC birth defects group that was involved with Massachusetts Health Department that looked at birth defects. The study was never published. There were a lot of small numbers and there were a lot of problems. But one thing that did stand out was this choanal atresia finding. And you know, again, we don't know what to make of it. It's a very rare birth defect. And as I said, if I see something like that. We were hoping to look at that in the birth defects study that

Perri discussed. It's not unusual and it's a very rare defect.

MR. STALLARD: All right. Thanks.

MR. FLOHR: Excuse me, Tom, we're going to have to make our way to the airport. Glad to be here again as usual. Glenn, you might want to mention when you get back, the latest estimate we got from the Navy/ Marine Corps of the number of servicemen who served at Camp Lejeune during that 30-year period from '57 to '87 was 630,000. We're probably going to ask them to see if they can re-compute that number based on Hadnot Point ^ 2003.

MR. PARTAIN: So you're saying that days between 1957 and what?

MR. FLOHR: Well, currently it's '57 to '87. But now Hadnot Point is August of 1953 at that time. So.

MR. MARKWITH: Yeah, I talked to them at the lunch break and gave them the heads up.

MR. FLOHR: Okay, great. Thanks.

MR. STALLARD: Great, and so I take it you're going to depart now, right?

MR. FLOHR: Yes.

MR. STALLARD: All right. Safe journeys. We hope you get home safely. All right, Tom?

DR. SINKS: Yeah, so I have four things to say.

Let me just thank our colleagues from the VA. I remember the first meeting where we had Terry and Brad here. And how beaten up they must have felt from the experience, and yet they kept coming back and they kept coming back and they kept coming back. And, you know, I would love to be able to say that every community ATSDR works in, we're in a position where we can deliver the goods. And these folks have helped, and you, have helped deliver the goods to a lot of people who are going to get medical care because of this. I just think that it's terrific the support the folks from the VA have gotten and the support from the CAP. So just a word of appreciation, and safe journey home.

MR. FLOHR: Thanks, Tom.

MR. PARTAIN: Thank you, Brad and Terry and Wendi.

DR. SINKS: So three things regarding this last discussion. Mary, first of all, thank you for sharing the story.

MS. BLAKELY: Sorry I went on.

DR. SINKS: It may have been difficult for you to describe it. I think it's really valuable at least for me and I think for others to hear the experience that you had and what you went through, and we really

appreciate it. The second one is it's not clear to me if you want us to make copies for you and provide --

MS. BLAKELY: Yeah.

DR. SINKS: -- them back so you will have them because I always worry about the dog chewing up the files.

MS. BLAKELY: Yeah, I would like copies.

DR. SINKS: -- and I would hate to see your files being chewed up.

MS. BLAKELY: Yes.

DR. SINKS: -- so if you want us to make you copies --

MS. BLAKELY: Definitely.

DR. SINKS: -- and give it back to you, we will do that.

MS. BLAKELY: Yes.

DR. SINKS: Okay, so that's a yes so that's an action item.

MR. PARTAIN: And while you're making copies, I'd like to get a formal copy, too. While you're making a copy, I would like a formal copy.

DR. SINKS: So make two sets of copies. The third thing is, I think, what I would like to propose, and these guys next to me may push on me, is that by the next CAP meeting, we will get back to you in terms

of how you might use them or how you might not use them, so at least we don't leave this as an open issue. There may be ways that we could use it in an objective way, and if we can we'll take a look at them. But I think we'll, by the next CAP meeting, we'll try to get you at least some response back about how the CAP can use these.

MS. RUCKART: Instead of copies, would you want just scanned images or you want copies?

MS. BLAKELY: Scanned.

MR. PARTAIN: If you guys are going to put it in electronic format, just put it on a DVD for us. If you guys -- whatever is convenient for you guys.

MR. STALLARD: All right. We will deliver the goods.

MR. PARTAIN: And this pivoting off of time here, when you're talking about the different agencies and stuff, you know, as a CAP member, I would very much like to see the presence on the part of the Navy and the Marine Corps here. Not to say that Glenn is not worthy of that, but an actual presence from headquarters of the Marine Corps/Navy, preferably not JAG lawyers. Just, you know, people who can answer questions and take it straight back is, with anything when you're going through note-takers and other

people, there's things that are lost in translation. And this is serious enough, the VA's got people here; they've shown their dedication. The Marine Corps needs to put some people back here, too. They've been absent too far, too long. And that's -- I'm making that as a member of the CAP request.

MR. STALLARD: Mark? Well, it appears to be that there are no more questions for the health studies, I take it?

MR. MASLIA: A request from Glenn to carry back to the Navy/Marine Corps 'cause you've been asked to look at this water supply 1963 document. Did we get the entire chapter?

MR. PARTAIN: I've got it. I'll email it to you.

MR. MASLIA: Yeah, you do? Okay.

MR. PARTAIN: If you want a copy of it before I leave --

MR. MASLIA: You have it electronically?

MR. PARTAIN: I've got electronically and on paper.

MR. MASLIA: Electronically. Thank you.

MR. PARTAIN: It goes into those things that we --

MR. MASLIA: Yeah.

MR. PARTAIN: No, I'm saying, they said in the

past they supplied all records. This is not in the CLW or CERCLA or any other database that I've found. Jerry and I, we were trying to find this on the internet about a year ago because it's referenced in BUMED. And I don't remember if Jerry found it downloaded or how we found it but, you know, we found it somewhere else. Why it's not in the Navy/Marine Corps document libraries, I have no idea. But that goes back to my point earlier about requesting things specifically in writing. Because you never know if you, you know, if you don't ask the Sphynx the correct question, what kind of answer are you going to get back?

MR. STALLARD: All right, are there any other outstanding questions, issues that come to mind?

MR. PARTAIN: I did miss the mortality study. When is the anticipated release date as far as -- I apologize.

DR. BOVE: Spring.

MR. PARTAIN: Spring of 2013?

DR. BOVE: This year.

MR. PARTAIN: This year?

DR. BOVE: What I said was that I'm addressing peer review comments and doing additional analyses. I hope to be done with that by the middle of next month

at the latest, and I hope to start clearance process for a spring release. But I'll let you know at the next CAP meeting whether we hit it or not. We can't control the clearance process once it gets to ATSDR. So there's a similar issue that might arise that's in other reports. But we're still on target as far as I know for release this spring.

MR. PARTAIN: And also, going back to -- I forgot your name, I'm sorry.

MR. SHANLEY: Eddie.

MR. PARTAIN: Eddie. I knew it was there, I just had to go to the file card to get it. Now that we have 1953 data for Hadnot Point with male breast cancer, I'm not sure if you were using '57 as the beginning point. Probably you want to go back and re-query the VA to see if they have anyone that fits into that category, for example Tom Jabrowsky (ph).

DR. BOVE: No. We have all the cases of male breast cancer --

MR. PARTAIN: Oh, you just blanket --

DR. BOVE: Yeah, we'll just delete those who are too young.

MR. PARTAIN: Okay. Perfect. Okay. Yeah, I understand the January '69 thing.

DR. BOVE: The only issue is they may have

diagnosed with male breast cancer prior to 1995 in the registry.

DR. SINKS: We'll get the service records from the data file when we abstract. We identify people on the basis of their diseases, so get the exposure information.

WRAP-UP

MR. STALLARD: All right. Well, that brings us to the part of the agenda where we talk about scheduling the next meeting, which generally is in about three months, which generally would coincide with spring and the release of potentially valuable long-awaited information. So as a CAP, rather than set a date certain, should we vote in terms of some of the things we're expecting?

MR. PARTAIN: Well, here's the problem with that. I'm going to bring this up 'cause this is a sore spot with me from the last CAP meeting.

MR. STALLARD: Okay.

MR. PARTAIN: We were told that, expecting the Hadnot Point water model in November, nothing against you guys, you know, we agreed to be flexible on the date.

MR. STALLARD: Right.

MR. PARTAIN: And then November rolls around,

Jerry and I are sending email, where in the heck's our meeting, and it just didn't materialize and now we're in January. And the last CAP meeting was in July. So it was six months in between. Don't mind being flexible for the release of the water model, 'cause frankly that's what needs to happen at the next CAP meeting, but I do want to go ahead and put a day in with the understanding that if the water model's done sooner, maybe we can move that date up or move it back. But I do not want to leave here today without a date.

Second thing, being that our next CAP meeting more than likely is going to be comprised of the release of the water model and everything else, and I know I'm beating a dead horse with this, but I would like to see some type of formal invitation to the Department of the Navy and the Marine Corps to be here with the release of that, of the water model and the first studies here. 'Cause that's -- I think it's extremely important that they're here.

DR. SINKS: Okay. I'm glad I don't have a horse since you're beating the horse. I think that I wasn't at the last CAP meeting that happened in July but I think the discussion was trying to go towards: Let's have our CAP meetings when we can provide you

informative information, because, you know, you're hearing the same presentations over and over otherwise. And I think this year would have been -- I think this is exactly where we want to be, which is to be having CAP meetings as we're rolling out this information as a way to inform you. And if we can be face-to-face, that would ideal. We can invite the Navy. I can't --

MR. PARTAIN: I know they can't make them come.

DR. SINKS: They have bigger weapons than I have. I can't --

MR. PARTAIN: I understand they can't make them come but the --

DR. SINKS: We can certainly invite them, and our roll-out plan is to inform them simultaneously or, you know, about the same time that we inform the CAP. And we will be rolling out reports to the public very shortly after we, you know, provide them to the CAP.

We are on target for, right now, three releases in the spring of 2013, and that seems to be, you know, about the right time for a CAP meeting. And if the water modeling and the case control study, you know, don't come out simultaneously, I would think we'd have two separate CAP meetings, one for each.

I agree with you, Mike, that given the confusion

from the last meeting in July, I read the texts to see why there was confusion. We do need to put an outer limit on that in case those studies don't come out on that time. So I don't know what your normal schedule is, Perri? Three to four months?

MR. STALLARD: We would be looking at --

MS. RUCKART: I mean, there is no normal schedule, you know. We don't have any hard and fast rules. What we've been doing in the most recent past is, prior to coming here today, we would have already talked about dates and had some options because, you know, there are a lot of factors at play here and there's availability of the room and all these people's schedules here, plus Dr. Portier, so I don't feel like we could leave today with a definite date. We can have a general time frame that we work from.

MR. PARTAIN: We can work with a date range. That's what we do is we'll submit the date range, and then you follow up emails to --

DR. SINKS: Well, let me suggest we use the month of April, and we identify dates in April for a meeting. And that will also help us in terms of rolling these reports out because it will put a monitor down there in terms of, you know, here's about where we would like to be.

So why don't we work with that in mind, with the goal being that the next meeting will be to release these reports to the CAP, to invite the Navy or, you know, the VA as well, you know, other stakeholders to the meeting, so they can hear this -- the results simultaneously. And we'll shoot for a date in April. And I think if they're not ready by then, we'll still try to go ahead and proceed.

MR. PARTAIN: No, we'll be asking where are the reports?

DR. BOVE: I think that it's more realistic to say late April into May because based on recent history, it's taken a while to get these reports all the way through the chain.

MR. PARTAIN: Where is the chain, by the way? Who's giving the final clearance to publish these things?

DR. SINKS: I'm going to go back. We have three different reports that are in process, and I think we're far enough along that we should be in pretty good shape sometime in April to release them.

MR. PARTAIN: Well, why don't we try for late April 'cause I'm not sure Easter's --

DR. SINKS: The mortality study -- I'm not sure that the mortality study's going to catch up to the

other two but I think we should be shooting for that. If it's the last couple weeks in April, I'm okay with that.

MS. RUCKART: You know what, though? I don't think that we can do all three in one meeting. That is a lot of information to discuss. I think it makes sense, maybe, to do water modeling and the birth defects or -- you know, I think we're going to need more than one meeting probably.

DR. SINKS: Well, let's, let's come up with a date and we'll start from there, and we'll see, you know, it would be great if we got all three out. We do have this issue that, I think once we're ready to roll these out we want to roll them out. We don't want to hold them back. So you know, we'll figure out what's on the agenda but I agree with Mike; let's go ahead and set a date and let's be looking for that.

MR. PARTAIN: Another thing, too, I would say late April, you know, that's fine. We'll just figure the dates out. One thing in between, and this was part of our issues between July and now. I understand there's a lot of irons in the fire with the studies. I would like to request, if possible and with respect, that any delays or problems or hiccups or anticipated problems be communicated down to the CAP, too, so we

don't get hit with a surprise at the last second, something's gone wrong. Because if there's -- if something's been submitted, even just letting us know where in the process the reports are. Like if it's gone to Morris's desk and your desk, and if it's gone to XYZ desk, and now it's at, you know, St. Peter's desk or something like that, it'd be nice for us to know where the reports are and, you know, if there's any hiccups or roadblocks that are preventing the progress of the report.

You know, it's, like Jerry pointed out this morning, you guys have been involved in this since 1991, 22 years. I have children that are older -- that were born about the same time, you know. It just -- I can't believe that this has gone on so long. And it needs to come to an end and the reports do represent some of the end points. So I would respectfully ask if we could be kept apprised of the progress of reports, where they are, when they were submitted, who they're going to, so, you know, we can take action if we need to.

MR. STALLARD: All right.

MR. PARTAIN: Oh, one -- I'm sorry, I'm tagging on things. One thing, too, I know we have a lot with water modeling. We did this when I first got involved

in the CAP -- actually in halfway through my involvement in this, we did this in 2009. There was a special meeting about the water modeling. And the Navy was invited and, you know, Jerry and I were invited as members of the CAP.

There's a lot with the water model for Hadnot Point, and especially Morris today, you know, going through, there's a lot of questions and Morris and I have been bantering back and forth about some of the things with the water modeling. I know Jerry and I specifically have a great deal of concern about the fuel plume. You know, the presence of 1.2-plus million gallons of fuel floating around within very close proximity, 300 feet of active, producing water wells. I want to make sure, for the benefits of the veterans and their families, that we really understand what's going on and how Morris has come to his conclusions. Not to question his work or cast doubt on it, but so we, you know, we don't get hit with an end product that we don’t understand.

I would like to submit that, bring up and have a special meeting with Morris, Frank, Jerry, myself and Dr. Aral, Bob Faye, and have a discussion about the water model. And invite the Navy, too, if they want to come -- I have no problem with that. And get, you

know, get some of these questions out that Morris, you know, can address and let us know what we have. Don't know what your thoughts on that but I would like to request that between -- before the release of the water model.

MR. MASLIA: Can I just clarify, the meeting that you're talking about in 2009 was an expert panel.

MR. PARTAIN: Yes, that's it.

MR. MASLIA: That we, ATSDR, set up to get expert input into the direction we should go and some things we need to consider. The Navy was invited both to bring -- have a person on the panel, which they did, as well as to have somebody speak on that. And I just want to make sure we're -- you're not suggesting having another expert panel meeting.

DR. SINKS: So, let me make sure I understand what you're requesting, Mike, and one of the things we need to keep in mind is our fairly aggressive attempts to make sure we maintain our timeline for producing this report in the spring of 2013. So that's one of our goals is to be able to release the water model in 2013.

MR. PARTAIN: All right. You might want to tell her that her conversation's being court recorded, too.

DR. SINKS: It doesn't bother me.

MR. PARTAIN: I'm ADHD so I'm all over the place.

DR. SINKS: I'm hard of hearing, so.

MS. BLAKELY: Yeah, so am I.

DR. SINKS: But I think what you're asking for is an informal meeting with Morris and his team that would go over the methodologic issues that we used in the water model, not the results because the results won't be --

MR. PARTAIN: Be published until --

DR. SINKS: Released until they're released. And we'll brief the CAP on the results. But to sit down with Morris and his team to better understand the methods behind what they did and what difficulties they saw. And inviting the -- you'd also welcome Department of the Navy to participate in such a meeting. Is that pretty much -- and to do that before we roll out the --

MR. PARTAIN: It would be nice to -- I mean, something like that, I think, would be, I mean, it would be valuable to the community so that way if we have questions or concerns, you know, we get them addressed. 'Cause we do.

DR. SINKS: So let me not provide an answer but let's take that under advisement and we'll have to get back to you in a short period of time.

MR. PARTAIN: Understood.

MR. MASLIA: Okay, Dr. Sinks, I would like, and I'm not speaking on the Navy, but they have gone on record, when we met with, I forget which general it was, during the data mining, and they have said to us that they will not and do not accept any of our water models. So you can invite them and I want to believe we attempted to -- we offered to get into a technical discussion with them at any point.

MR. PARTAIN: Do we have this in writing by the way?

MR. MASLIA: I know there was a conversation between me, Bob Faye, Mike Edwin (ph) and Dan Waddell, their head technical guy from NAVFAC.

MR. PARTAIN: So my understanding, if I hear you correctly, is that the Navy has already come out with the position, before your work is complete, that they will not accept your models?

DR. SINKS: Let me just -- one thing, we don't have anything in writing. You know, this is something that may have been a discussion between Morris and technical SMEs that provide information and aid. There are disagreements between the agency as to whether or not we can use, you know, data to do water modeling. And you know the NRC report has its own set

of --

MR. PARTAIN: Yeah, it's pointless.

DR. SINKS: We're moving ahead to use the water modeling. We think it's a valuable way. I think the essence of the request was, if they would like to participate, that would be okay with you. It's up to the Navy if they participate. I have no problem extending an invitation, whatever their concerns are.

We aren't always in agreement between what members of the CAP say and ourselves and we're not always in agreement with what they're saying. So I think we can always agree to disagree on certain issues. We should be open. We can extend the invitation, if we decide to have it. So I'm not going to give you any specific answer about whether we'll accommodate the request but we'll consider it and get back to you.

MR. PARTAIN: Okay. So they flat out said they're not going to accept it --

MR. MASLIA: I know who said this... data mining... they have no issue. We've done this in the past. We did this in 2008. I had them here to discuss our approaches. But what I would suggest first before we schedule such a meeting is to allow y'all, once the reports are released, to go through

the reports. Because they contain a lot of detail on approaches, the mathematics, what assumptions were made.

DR. SINKS: So let's go ahead and have that discussion internally, in terms of the request, and we'll get back to Mike fairly soon. And in terms of getting -- how we'll respond to it. It's a reasonable request.

MR. PARTAIN: And the things that are being cleared, and not results, but like for example some of the findings that were released for the VA and stuff, if anything that comes up in the interim between now and the next CAP meeting that's being released, if we could get the CAP to get a copy of it, I would approximate it.

DR. SINKS: Right. We won't release anything publicly that we wouldn't be providing to the CAP or other stakeholders. That's what we did today.

MR. PARTAIN: Okay. And out of curiosity, Morris, did the Navy express similar concerns about your Tarawa Terrace water model? A refusal?

MR. MASLIA: They basically are in agreement, except the NRC report which obviously we have not only disagreed with verbally but we have published --

MR. PARTAIN: Well, they paid for it, so...

MR. MASLIA: -- a journal article stating, it appeared in a journal stating our approach and our disagreement with that.

MR. PARTAIN: But the Navy --

MR. MASLIA: But we did -- they were here for a meeting. They were here basically for a similar meeting that you're asking for, for us to explain. And they brought Navy personnel, Marine Corps and some people from USGS as well who provided them with some advice, and we explained what we did on the Tarawa Terrace model. And to my knowledge, at least, to me anyway, nothing was ever sent back, either orally or verbally, disagreeing with what we did at Tarawa Terrace.

MR. PARTAIN: Okay.

MR. STALLARD: Okay. And thus concludes our meeting for today, I would say. We're going to have -- we’re looking for late April to schedule the next CAP, bearing in mind that spring goes until June 20th, right?

MR. MASLIA: It starts March 20th.

MR. STALLARD: Okay. So that's the time frame we're working with. Any administrative stuff? Vouchers submitted on time. Do what you need to do. Please travel safely on your way home or wherever

you're going. Thank you very much, and those on the phone, we're done for today, Tom and Sandra and everyone else. Thank you.

(Whereupon, the meeting was adjourned, 2:23 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 January 17, 2013; 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 17th day of February, 2013.

_____

STEVEN RAY GREEN, CCR, CVR-CM, PNSC

CERTIFIED MERIT COURT REPORTER

CERTIFICATE NUMBER: A-2102