THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

EIGHTEENTH MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

DECEMBER 9, 2010

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 Dec. 9, 2010.

STEVEN RAY GREEN AND ASSOCIATES
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C O N T E N T S

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

(alphabetically)

BOVE, FRANK, ATSDR
BRIDGES, SANDRA, COMMUNITY MEMBER (via telephone)
BYRON, JEFF, COMMUNITY MEMBER
CLAPP, RICHARD, SCD, MPH, PROFESSOR
ENSMINGER, JERRY, COMMUNITY MEMBER
FLOHR, BRADLEY, VA
FONTELLA, JIM, COMMUNITY MEMBER
KAPIL, VIK, NCEH/ATSDR
MASLIA, MORRIS, ATSDR
MENARD, ALLEN, COMMUNITY MEMBER (via telephone)
PARTAIN, MIKE, COMMUNITY MEMBER
PORTIER, DR. CHRISTOPHER, DIRECTOR NCEH/ATSDR
RODENBECK, SVEN, ATSDR
RUCKART, PERRI, ATSDR
SIMMONS, MARY ANN, NAVY AND MARINE CORPS PUBLIC HEALTH CENTER
SINKS, DR. TOM, NCEH/ATSDR
TOWNSEND, TOM (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 to those on the phone. You all should have gotten an agenda so what I'm going to do to start this off is first of all go over our operating guidelines and then we'll do brief introductions so everyone knows who's in the room.

Our operating principles unless they've changed, please be sure that you sign in. If you have cell phones, that's for the audience and those here gathered, please have them on off or silent stun. The audience as you recall are here to listen. This is an open meeting.

We're live streaming and that's archived. The audience may be invited by the CAP members to participate if there's someone in the audience you wish to refer to. We ask that the audience not participate unless you're invited to do so.

As you know we're talking some time now on these issues, and we all represent different agencies so this is not a time for personal attacks. Along with that, one speaker at a time, please respect the speaker. Let's not speak over. It

makes it very hard for Ray to understand who's saying what if there are multiple people talking at the same time. That impedes effective listening and communication. Along with that then we ask that sidebars be kept to a minimum.

We will take a break. If you have some important business to discuss with someone, that will be the appropriate time to do it. And respect the process and the progress that we make in these meetings.

So with that what I'd like to do is we're going to go briefly around the room for introductions meaning just your name and your organizational affiliation. And then we'll move into an update after that.

So I'm Christopher Stallard with the Center for Global Health. I'm your facilitator today.

MR. FONTELLA: Jim Fontella. I'm a member of the CAP.

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

DR. PORTIER: This is Chris Portier, technically challenged Director of National Center for Environmental Health and the Agency for Toxic Substances and Disease Registry.

MS. RUCKART: Perri Ruckart, ATSDR.

DR. BOVE: Frank Bove, ATSDR.

MR. FLOHR: I'm Brad Flohr with the Department of Veterans Affairs in Washington.

MR. STALLARD: Welcome.

MR. BYRON: Hi, this is Jeff Byron with the CAP.

MS. SIMMONS: Hi, Mary Ann Simmons, Navy/Marine Corps Public Health Center.

MR. ENSMINGER: Jerry Ensminger, Camp Lejeune CAP.

MR. PARTAIN: Mike Partain, Camp Lejeune CAP.

MR. STALLARD: Before we go into CAP updates, Dr. Chris Portier has asked for some remarks, and so we'll use this time for that.

MR. TOWNSEND (by Telephone): Tom Townsend, CAP.

MR. STALLARD: Pardon me. Yes, thank you. Tom Townsend, welcome.

And who else do we have on the phone?

(no response)

MR. ENSMINGER: Allen was there.

MR. STALLARD: He was?

All right, please proceed.

WELCOME FROM DIRECTOR NCEH/ATSDR

DR. PORTIER: Good morning, everyone, and welcome to Atlanta. I just wanted to take a moment to tell you a little bit about what's happened in the four months that I've been here, and you'll get a lot

more update today from the rest of the crew that works here.

First, I thought I'd tell you that from my perspective it looks like we're on target for everything we said we would do. You've gotten all the publications, I hope, that have come out recently. I think the water modeling staff has done a great job, great staff appears to be really on top of planning and setting up the health studies that will be coming along in time. So I'm really pleased with their work.

As many of you know we recently had, like two weeks after I got here, we had a Congressional hearing which I think went fairly well looking into a number of issues related to Camp Lejeune.

In addition, as I promised some of you in discussions, we have clarified the issue about what ATSDR thinks about the National Academy of Sciences report and exactly what parts of it we agree with and disagree with it. And if you haven't gotten a copy of that we will get you a copy of that letter now.

So I think we're doing quite well on this particular project. We're moving forward. The annual plan of work is in place for 2011, and so I

think we're going to get everything done in time as we said we would.

One thing I'd like to bring up with the CAP was the question of venue. I know you've had some discussions about the difficulties of getting into CDC and how hard that is, and I can sympathize with you on that. So this morning I thought I would offer you a change of venue. There's no reason why we can't hold this in a local hotel and rent a room there.

It'll cost us. There's no doubt about it, and the money we would spend elsewhere, but nonetheless, we can do that. The downside of that, and nothing comes cheap. The downside of that is we won't be able to broadcast the meeting on video if we do that. We're going to lose that capability.

That capability resides here, and it's unclear we can get that capability in a local hotel and have it done at a reasonable cost and have it work well. So that's what you have to think about, and whatever you decide as a group we will certainly try to honor that decision.

Jerry.

MR. ENSMINGER: Yes, I have some suggestions for this alternative venue idea. And I think the

streaming video could be facilitated if we made arrangements and set the meeting up at like UNCW, University of North Carolina Wilmington, or the Coastal Carolina Community College in Jacksonville.

MR. BYRON: We've done that before, right?

MR. ENSMINGER: Well, the Commandant's, quote-unquote, blue ribbon panel back in 2004, which was a joke -- but we won't go there now, they had a meeting, and they had all the bells and whistles at that meeting.

MR. STALLARD: Okay, so may I suggest that by the end of the day we'll list some potential sites and our needs and then that will be an agenda item to see if that's even possible for us to do.

MR. BYRON: And even the US –- this is Jeff Byron – even the USO is a good spot in Jacksonville at the time if you're talking about for streaming any information.

MR. ENSMINGER: Yeah, you're not going to have that there. I mean, that's World War II vintage.

MR. PARTAIN: And I think the point of doing a meeting off campus is not necessarily 'cause of inconvenience of coming here. Just coming here one was the issue of allowing media in. The other is if we want to get, do some meetings in the community to

where other people get access to it, and Jacksonville was one of the suggestions that we do a meeting there.

DR. PORTIER: Well, as I said, we'll consider it. We have to look, I was thinking offsite in Atlanta because if we go offsite out of Atlanta it's going to cost us a fair amount of money because then I have to not only, I have to transport staff to such a meeting. And that, of course, carries a cost with it. So we'll have to look at that issue carefully.

Again, I'd like to have you discuss it and give us some options. And we'll look at them and see what we can do.

MR. ENSMINGER: Well, Morris and his crowd love Jacksonville. They're up there all the time.

MR. STALLARD: He's known by name there.

MR. MASLIA: I can tell you the best places to eat.

MR. **STALLARD**: Would you like to introduce Vik Kapil?

DR. PORTIER: Yes, thanks for reminding me. I'm going to be coming and going today, and I won't be here for the whole meeting, but I'll try to come down as often as I possibly can.

I'd like to introduce to you my Chief Medical Officer, Vik Kapil. Vik just joined NCEH-ATSDR, and

he will be my representative at this meeting all day today. So I'm going to change my name to Vik Kapil, and I'm actually going to sit in the audience and let him come up here. Thank you very much.

MR. STALLARD: Thank you.

MR. ENSMINGER: Your letter that you wrote regarding the NRC report, remember I asked if the VA was going to be addressed with that letter. Did the VA get that letter eventually?

DR. PORTIER: Yes, they got a copy of the letter.

MR. ENSMINGER: Because I didn't know. Nobody --

DR. PORTIER: Thank you for reminding me. It was always intended they would get a CC on the letter, and we just, I hadn't communicated it well to my secretary.

MR. STALLARD: Thank you. Thank you.

CAP UPDATES/COMMUNITY CONCERNS

So now what I'd like for us to do is to go around and update each other on what has transpired relative to the CAP since the last meeting; what have you accomplished, challenges, issues and CAP update. So we'll start with Jim.

MR. FONTELLA: Jim Fontella. I sent, with the help of Dr. Clapp, I sent out letters to the AOEC Clinics around the country. They're in 28 states. There's

about 50 or 60 of them, 12 in New York alone. Some states have one. Some states have two, three. Mostly they're in colleges. In regards to a place where a person can get medically serviced and at the same time where the doctors are MPHs as well where they'd be familiar with environmental exposures which would help them in the long run end up with a medical evaluation if they were going to file a claim with the VA for a, you know, a nexus linking their exposures to their illnesses.

I've got like seven responses and just to put it in a nutshell, the responses that I've gotten, some aren't taking patients. Some feel that they can't do anything. And the responses which were helpful were basically saying that they needed to, they need more information on the exposures and the studies that are going and all the different things on the chemicals. And they'd probably have to wait until the ATSDR studies.

And then we're finished, and then there would be no really guarantees that they could link that illness. This is kind of the same story we're getting everywhere else. But anyway that's what I've worked on with several other things.

MR. STALLARD: Thank you, Jim.

MR. FONTELLA: Thank you.

DR. CLAPP: This is Dick Clapp. I basically just worked with Jim since the last meeting. That was my input and I helped draft the letter that Jim sent around.

MR. STALLARD: Thank you and welcome.

DR. KAPIL: Thank you very much. It's a pleasure to be here. I've met a number of you in the past when I was at ATSDR before. It's a pleasure to be back, and I look forward to working with all of you.

For those of you that don't know me, my background is in emergency medicine and also in occupational environmental medicine so those are my specialties. I've been in, been doing environmental health the vast majority of my career so look forward to working with all of you. Thank you.

MR. STALLARD: And you were the former branch chief.

DR. KAPIL: That's right. I was previously the Branch Chief of the Surveillance and Registries Branch at ATSDR.

MR. ENSMINGER: Where did you go?

DR. KAPIL: I went to the Injury Center here at CDC and now with the Division of Injury Response in the Injury Center for the last several years.

MR. ENSMINGER: And you came back?

DR. KAPIL: I'm back.

MR. STALLARD: Thanks and welcome.

Brad Flohr.

MR. FLOHR: I have some things I want to say during my time at eleven o'clock, but basically we have been very busy on this issue. We've spent a lot of time meeting with Senator Burr's staff. We had a meeting with DOD on Monday, Mary Ann was at and myself, on all the exposures that are being tracked by DOD and the VA, one of those being Camp Lejeune's whose issues are right up there in the forefront.

MR. STALLARD: Jeff.

MR. BYRON: This is Jeff Byron, and the ATSDR asked the CAP to ask the community through The Few, The Proud, the Forgotten website to give us their unit information where they were barracked and so forth. We got about 25 responses we'll give to Frank before today is over. I left our computer outside. Had to put it down on a disk for him.

MR. STALLARD: Jerry.

MR. ENSMINGER: Just keep digging.

MR. STALLARD: A deeper hole or what?

MR. ENSMINGER: Looking for more information.

MR. STALLARD: Digging for information. All right, thank you.

MR. PARTAIN: Pretty much the same thing, just research reading, updated my glasses prescription.

MR. STALLARD: So will you be able, have you, in data discovery and digging are you coming across other sources and more information?

MR. ENSMINGER: Once you get to a point in a situation like where we've gotten thus far with this thing, way down the road, and then you look back at some of the stuff that was there glaring you in the face before, you see some, I mean, just some blasphemous documents, statements that were made in the past.

I'll give you a prime one right now is the public health assessment, the draft public health assessment. When they were discussing the Holcomb Boulevard drinking water system, in the text it said when the fuel contamination was discovered in January of 1985 in the Holcomb Boulevard water distribution system, it was immediately shut down and their water was replaced with the known contaminated water from the Hadnot Point drinking water system. That was the draft.

When the final came out, it said the Holcomb Boulevard water distribution plant was immediately shut down, and it was replaced by water from the

Hadnot Point water distribution plant for which the contamination had not yet been discovered.

I mean, when you look back historically at some of this stuff and how it morphed and changed, somebody was making deals. I mean, there's no way other, I mean, look at the rifle range. Nineteen-eighty, the Marine Corps and Department of the Navy were out there stirring around at the rifle range because there was an EPA-registered and state-registered chemical dump out there.

They were out there testing wells, testing the finished drinking water from the Hadnot Point, or from the rifle range water distribution plant. Sent a letter to the commanding general Camp Lejeune telling them not to use a certain well because they found two parts per billion of the damn trichloroethylene in it, in the raw water well.

But yet when they show up with 1,400 parts per billion in the finished water at the main water distribution plant at Hadnot Point and 200-some parts per billion in Tarawa Terrace's finished drinking water, they don't do shit. Excuse my mouth. I mean, it's blasphemy. And then they try to sit there and give out these statements of how much they care about their people. Give me a break.

Makes me sick.

MR. BYRON: Or how much they knew at the time. That makes me sicker. They act like they were ignorant about the facts of what was going on in these wells, and that's not true at all.

MR. STALLARD: Thank you. And we're moving forward based on the facts that to a large degree you all have helped to uncover.

MR. ENSMINGER: It's all been a big team effort. I mean, I truly appreciate everything that Morris and Bob Faye and Professor Aral and all their crew, Dr. Bove, have done, and Perri. Our problem with ATSDR has not been the people that are actually down here doing the work. It's their people up above them that have been the problem in the past.

MR. STALLARD: In the past.

MR. ENSMINGER: Now I must say that Dr. Portier is a breath of fresh air. There's been one hell of a change here. And I don't want to sound completely negative, but I mean, we finally got the public health assessment taken down, which was a joke in reality. I mean, whenever you can't produce the source documents for which a document, official document, was created, how the hell can you stand behind the document like that?

But by the same token the people who were responsible for these changes, if you go back and look at that public health assessment and how it morphed over time, somebody needs to be held accountable for that. The people responsible for that public health assessment and those changes, they knew. They knew that water was contaminated. They had it right the first time then they changed it. Why?

People like that need to be sought out and dealt with. I know that some of them are GS employees. I know you have to kill a GS employee to fire him, okay? But they don't need to be in a position where they're writing or have anything to do with public health assessments that are taking place now at current NPL sites or future NPL sites based upon what they have done in the past and shown that they were making deals with people to change the facts. They need to be axed.

MR. STALLARD: Thank you.

MR. PARTAIN: Just one quick observation. Just out of curiosity, in the audience I see one captain back there, but who is here from the Marine Corps today?

(inaudible response)

MR. PARTAIN: I'm sorry. What was your last name,

Captain?

CAPTAIN MILLER: Captain Miller.

MR. PARTAIN: Captain Miller.

CAPTAIN MILLER: You met me last meeting.

MR. PARTAIN: Yes, I remember. I just couldn't remember the name. Sorry about that.

Anyways just wanted to point out that since, what, January was the last time that we had the representatives from Marine Corps, the people with the knowledge of what went on at the base, the documents and everything, they're conspicuously absent and continue to be absent from these meetings.

In April the Marine Corps stated that they felt they were a distraction, which I disagreed with. Their absence here is noted and I guess that's how the Marine Corps shows their concern for their families and the Marines.

MR. STALLARD: Thank you, Mike.

Tom, are you still on the phone?

MR. TOWNSEND (by Telephone): I certainly am.

MR. STALLARD: Well, good. Would you like to update us on maybe briefly some of your activities?

MR. TOWNSEND (by Telephone): Well, my activities on the Camp Lejeune document searches and stuff like

that have sort of come to a halt. I picked up all the pieces of the glass in the cathedral that was blown out and tried to put it back together again.

No, I'm just following along and I'm focusing on the Veterans Administration and what they're doing. I'm most anxious to hear about the Veterans Administration and their handling of the claims of the veterans. I've slowed down on discovery. That's about where I'm at, and I'm up to my butt in snowdrifts right now.

MR. STALLARD: Okay, well, stay warm and stay tuned because I believe around eleven o'clock we'll have some updates from the Veterans Administration.

MR. ENSMINGER: Hey, Tom, why don't you give us an update on your love life, man?

MR. TOWNSEND (by Telephone): No, no, this is very upright. I was remarried on 30 November to a lady that I used to go with in high school in 1947. I lost my first wife to the Camp Lejeune fiasco.

MR. STALLARD: I think there's a story there to be told.

Is Allen on the phone?

MR. MENARD (by Telephone): Yes, I am.

MR. STALLARD: Welcome.

MR. MENARD (by Telephone): I've basically been

networking, talking with other veterans trying to get the word out and that and helping them with their claims is what I've been doing.

MR. STALLARD: Thank you.

And is Sandra on the phone?

(no response)

MR. PARTAIN: Chris, I got an e-mail from somebody saying they're having difficulty getting online with the streaming for the CAP today. So I don't know if there's something we could check on.

MR. MENARD (by Telephone): I'm looking at the streaming right now. I have it up, and I have no problem with it. This is Allen.

MR. STALLARD: Thank you.

Just one quick update from you, Mike. What's the number of male breast cancer folks that have been identified in your effort?

MR. PARTAIN: Well, we're currently at 66. There is a 67th. When I was down at the Moffitt Cancer Center last month doing some follow ups, the physician who appeared in the CNN story informed me that he is in contact, actually had another gentleman who was diagnosed with male breast cancer from Camp Lejeune. They couldn't divulge the information, but he was at Camp Lejeune.

Matter of fact, Dr. Kiluk informed me that he routinely asks any new male breast cancer patient that he comes across whether they were a Marine at Camp Lejeune. It's a standard question he follows up on. The gentleman's undergoing treatment so once he comes out of that he's going to try to get him in touch with us or have him contact me. And he'll be 67.

MR. STALLARD: Thank you.

MR. FLOHR: Hey, Mike, is that just, is it Marines or is that dependents or a combination?

MR. PARTAIN: It's a common, most of the lion's share are Marines. They're roughly about I want to say six to ten, six to eight dependents, but the rest are all Marines.

MR. ENSMINGER: Or sailors.

MR. PARTAIN: Or sailors. Sorry, Jerry. We have a few Navy corpsmen that are in our group, too.

DR. BOVE: What's the total?

MR. PARTAIN: Sixty-six and there's one pending.

MR. STALLARD: And so this one doctor is making it part of his protocol to ask any male breast cancer patients about a Camp Lejeune connection?

MR. PARTAIN: Yes. And he is a breast cancer surgeon.

MR. STALLARD: Okay. I think at some point maybe in your efforts all male breast cancer patients have been asked that question.

MR. MENARD (by Telephone): Christopher, can I ask a question of Mary, please?

MR. STALLARD: Yes, please.

MR. MENARD (by Telephone): Mary, has the Marine Corps been doing any outreach as far as trying to get the word out about the contamination at Camp Lejeune lately?

MS. SIMMONS: They continue to do the outreach for the survey and the registry, so yes, and I have an update for that, too.

MR. STALLARD: Thanks.

MR. PARTAIN: Chris, one thing on the male breast cancers, I know according to that article that Frank was quoting at the last CAP meeting was 640-something male breast cancer patients identified within the VA system. It would be very interesting to have the VA go back and identify these people and find out how many of these guys were Marines at Camp Lejeune.

DR. BOVE: Later in the meeting we’re talking about possible options, and that’s one.

MR. STALLARD: Thanks.

Perri, our update, please.

RECAP OF PREVIOUS CAP MEETING

MS. RUCKART: Well, I'd just like to start off our current meeting by summarizing what happened at the last meeting, and some of what I wanted to mention was already discussed during the updates. So thank you.

As was mentioned, Dr. Portier told the CAP that he was looking to communicate our position on the NRC report to the VA. And as he stated we drafted a letter and sent a letter to the DOD. It was shared with the VA. We provided a copy.

And just to further update you, ATSDR has a meeting planned with the VA in February to further discuss ways to facilitate dialogue between them and us and the CAP and to answer any questions the VA has about our scientific work at Camp Lejeune. So we're continuing to develop that relationship.

As mentioned there were questions last time about media filming the CAP meetings and what types of exemptions and exceptions we could get for that. One option could be to possibly have a meeting offsite as Dr. Portier had mentioned. Also, it's my understanding that there's no blanket policy to prohibit cameras from coming in. It's just approved

on a case-by-case basis.

MR. PARTAIN: So is that the official stance that on a case-by-case basis because --

MS. RUCKART: I'm getting the nod, yes. There were no requests for this meeting by the way.

MR. PARTAIN: Okay.

MS. RUCKART: As Jim and Dr. Clapp mentioned, they were working on getting assistance for vets who were preparing claims packets and nexus letters. They already discussed that.

MR. FONTELLA: Some of the questions I asked them also were what the fees they would charge, if they did any pro bono work or what would be involved in contacting them and getting medical assistance of some sort. And again, I didn't get a lot of positive reaction.

MR. STALLARD: Who were you asking these questions?

MR. FONTELLA: To -- in a letter I sent to the Association for Environmental and Occupational Clinics. There are 28 states and there's, the exact count I'm not sure of how many letters we sent out, somewhere between 50 or 60, and I received seven replies.

The only positive thing is it lets us know where they're at or what they need, information they

need before they can help the veterans. But other than that there's not really much they can do or guarantee that they could even give a medical evaluation or a nexus. They would have to know all the exposures and what they were exposed to and the doses and things like that that probably the veteran would not know until they finish the studies here.

MR. BYRON: Jim, this is Jeff. Is this strictly for veterans, or does this group also deal with civilians?

MR. FONTELLA: They deal with civilians, work with --

MR. BYRON: Workers' comp?

MR. FONTELLA: Yeah, things like that. But they're MPHs as well as MDs, so they're familiar with exposures which is very important which again we'll talk later on with Brad with the VA with what's going on there. But that's what the issue was there. I don't have the letter with me. I probably should have brought it to give you a better description of it.

MR. BYRON: One other thing real quick, and I just want to mention this so that we can, maybe the ATSDR can expound on. I guess some of the people who are streaming and watching this and keeping up with the

CAP, because there's been so much VA involvement in the last year, and because we're talking about the health survey and the mortality studies, it seems like some of the people feel as though we've lost sight of the original in utero study.

I'd like somebody from the ATSDR to expound on the fact that, no, what we're doing is that the water modeling and so forth has to be completed for that portion of the study. And what we're doing is we're concentrating on that still, or you are, but you're also concentrating on the veteran end of this issue, too. Thank you.

MS. RUCKART: I think you just summed it up perfectly; what you said is the case so I don't know how much more we can add. That's where we are. We haven't forgotten about it, and it's pending completion of the water modeling. We're still committed to completing that.

DR. BOVE: And completing it as quickly as possible once we get data from Morris.

MR. BYRON: Thank you. I just wanted the reassurance to the crowd.

MS. RUCKART: Last time we discussed the CAP governance, items were clarified and the CAP members provided their reaction. And at that time CAP

members said if they had any additional comment they would provide them in writing and no additional comments were received.

Last time the CAP mentioned they would like to discuss vapor intrusion as a pathway. ATSDR DHAC, which is where Morris is, they are working through the redacted UST files to determine what, if any, impact it will have on the water modeling. And there was a question about how many draft reports or documents do not become final. And Morris said he would try to look into having a summary for this meeting, but that is still in progress.

And at the last meeting Morris provided a water modeling update that included the status of data extraction, UST file reviews, mass computations, water supply well operations and chronology for water flow, water development and a water distribution system monitoring for the Hadnot Point-Holcomb Boulevard interconnection. He also let you know that Chapter C would be coming out in October, and he will provide a further update later today.

And it was discussed that the CAP would provide Morris with a water treatment plant operator’s contact information to get more insight into water usage for the golf courses and Mike did e-mail that

information to Morris.

Morris asked the DOD to make copies of the UST DVDs available to the public because its too resource intensive for ATSDR to handle the request. And since the meeting the DOD responded that anyone who wants a copy of these files needs to submit a FOIA request, two weeks.

And at the last meeting Brad Flohr gave his update. He said about 200 claims have been filed based on exposure at Camp Lejeune and about 20 have been granted. The VA is working on developing a claim label to be able to electronically track things related to Camp Lejeune and their outcome.

And he said he would follow up on the CAP request that the VA eliminate mentioning the NRC report in the training letter that's sent to their regional offices and others. And he can provide a further update later this morning.

Terry Walters of the VA mentioned that the VA does have a task force reviewing the Camp Lejeune situation and the NRC report and they're producing a report for the Secretary. She also mentioned that the VA has an Environmental Agents Coordinator in each VA medical center. And the VA is considering how to make this person available to Camp Lejeune

veterans to get an evaluation. I don't know if you or she will be providing an update on that.

Tom Sinks suggested that the VA get the CAP's input on communication related to Camp Lejeune before materials are sent out.

Sven gave an update on the data mining technical workgroup activities. Most of the work was expected to be completed by the end of October. The closeout report will have all the indices from the various repositories that the workgroup looked at. And Sven will also be here later today to provide another update on their activities.

The CAP requested to see the USMC versions of the pre-notice and survey invitation letters. I want to share with you that the USMC stated they would rather not release the unsigned draft letters because they don't release documents until they are final as a matter of practice. They had hoped to have these letters available prior to the CAP meeting so they could be shared, but that has not occurred.

There is a deadline, a hard deadline though of December 15th, to get these letters finalized. They are aware of this and are working toward that deadline. This is the deadline so we can have the

materials to our contractor for the health surveys. But we can begin and stick to our schedule. And we'll be providing a further update about the health survey later this afternoon.

Last time it was mentioned that CAP members are concerned that once the surveys are starting to be mailed out, additional people may want to register to receive surveys, and the CAP wants to make sure that we can include these later registrants.

So we discussed this with our contractor, and they'll be getting two data files from the Marines with the registry contact information, one at the beginning of the survey mail-out, and one towards the end so that we can account for any late registrants and include as many as possible.

As Jeff mentioned, we were wanting to work through him to get information on where units were barracked, and he said he posted that out on the website and has some information to share with us, so thank you for that.

Also, we discussed with the CAP members how they could help us with the health survey, and they could do that by encouraging everyone who gets a survey to respond and to respond quickly and not to share their unique PIN because that could create

confusion and problems among who's actually answering the survey.

I also want to let you know when you do all that, please also remind the participants to sign the inform consent and medical record release forms and return them with the survey. Of course, that will be highlighted and mentioned in the materials you get, but that's very important that when completed surveys are returned they do have these other forms with it.

The CAP asked if the ATSDR could include dependents from the 1999-to-2002 ATSDR telephone survey in the mortality study. So for the mortality study we need to determine the vital status and cause of death, and we're relying on social security number information for that.

And we have the social security number for the active duty and civilian workers from the DMDC database. We don't have the social security number for most of the dependents, and for this reason it's not possible to include them in the mortality study. But as you know they are a part of the health survey.

It was mentioned last time the CAP wanted to know who made the decision to have armed guards in

106 for the April meeting. Caroline McDonald, our former deputy director, was present at the meeting and said she would follow up on that. I know that she did follow up on that but was not given a clear response.

David Williamson, our division director, would like to respond to that. Thank you.

DR. WILLIAMSON: Yeah, Caroline did follow up on that with the Office of Safety and Health at CDC. We were told by them that armed guards at CDC locations is nothing new. They have always been here. They may have been more visible that particular day.

I know I talked with Jerry and a couple of other folks and they said they were extremely visible that day. Also Safety and Health did not respond to that, but they did say that this is not unlikely or unusual for us to have armed guards at all of our facilities and most of the time. Whether or not they were visible, I'm not sure what the response is to that.

MR. ENSMINGER: That's bull.

MR. STALLARD: Thank you, Perri.

MS. RUCKART: Thank you.

And then last time it was discussed, and

there's a request if we could provide a mechanism for the community to provide input to and raise questions and concerns with the CAP members during the CAP meeting.

We don't have a mechanism to respond real-time during the CAP meetings; however, I want to remind everybody or let people know if they're unaware that we have the ATSDR Camp Lejeune e-mail address. We respond personally to every request that we get.

So if there are questions we definitely give everybody a personal response. If any issues are brought to our attention through e-mails that we receive that would be beneficial for everyone to know about, we do share those during CAP meetings.

That's all I have.

MR. ENSMINGER: I have one thing, and I know this is going to come up later, but something for you to be thinking about between now and your time. This is one of the questions you're going to face during your period coming up at eleven.

MR. STALLARD: We don't need armed guards for that one.

MR. ENSMINGER: No, especially DeKalb County Sheriff's Department. I've only ever seen them here once and that was for that meeting, okay?

Somebody’s filling you full of crap.

MR. STALLARD: Go ahead.

MR. ENSMINGER: Has the VA distributed Dr. Portier’s letter concerning the NRC report to your regional offices?

MR. FLOHR: To our regional offices? No.

MR. ENSMINGER: Why not?

MR. FLOHR: That’s --

MR. ENSMINGER: And the same thing goes for the Marine Corps. Dr. Portier is the director of a government agency that’s responsible, was created and mandated by Congress for these types of situations, superfund sites, NPL sites. Dr. Portier put a letter out that conflicted with the NRC report. Why hasn’t the Marine Corps distributed that letter to all their registrants? Just something for you guys to keep in mind.

MR. PARTAIN: This is Mike Partain. I want to add two things in here. One, tagging on to what Jerry just said about the Marine Corps registry. One thing with the registry, I wonder, and I do not know if they’re collecting social security numbers when they’re calling in stuff because when you’re making the comment about the in utero study I find it incredibly lack of foresight that that information

wasn’t collected.

I work as in insurance adjuster, and I handle personal injury claims and things like that on a daily basis and that’s one of the key criteria that we get when we’re collecting information. I think it is a huge mistake that the in utero population is being left out of the mortality study. I understand why, but I just want to go on record that I think it’s a mistake.

And the other point I want to bring up about the Marine Corps registry. If people do call in and the Marine Corps controls the registry information as the primary responsible party, and last July the Marine Corps printed this booklet which was given to every member of Congress shortly before the hearing. And we understand from our community that people were getting this booklet despite the fact there were some errors in it.

And it was addressed in the hearing and this book was nothing more than propaganda on the Marine Corps’ behalf. Again, as Jerry just pointed out, Dr. Portier offered a letter in October addressing some of the very things that were talked about in here. This booklet talks about the NRC report and how unfortunately couldn’t give conclusive answers

and basically said that we'll never get it.

And yet Dr. Portier's letter addressed some of the failings of the NRC report, and that letter has yet to be distributed to the families. It seems the Marine Corps is abusing their responsibility and authority with the registry or custodianship of the registry.

And they need to disseminate any and all information about Camp Lejeune including Dr. Portier's letter, including the President's cancer panel report released in May, and give this out to the community so they can make informed decisions and the Marine Corps can fulfill their pledge to keep the families and Marines informed.

MR. STALLARD: Thank you, Mike.

MR. BYRON: This is Jeff Byron. One last thing on notification, I did want to mention that we had a recent member of the website just found out about the contamination at Camp Lejeune. And the way that they found out about the contamination is the woman and her husband went to a VA facility in Virginia and saw a posting on the board there about Camp Lejeune. So they were clearly not notified by the Marine Corps.

They were there – what years, the '70s? So

they were there in the ‘70s so they fall in the time frame. She’s had, I believe, it’s non-Hodgkins lymphoma. Her husband recently passed away from heart troubles. And like I said the way she found out about it, she only lives ten miles from where I live.

Again, it’s been in the news normally later on in the evening, but they never received notification and she found out through a posting on a board at the VA.

MR. FLOHR: I’m glad to see it is at the VA, and I hope that they’re all at one of the VA medical centers. Do you know which one, Mary?

MR. BYRON: But it’s in Virginia. I guess he went there for care and that’s how they saw it.

MR. STALLARD: Is that widespread, Brad, they’ve been directed to have that posting throughout?

MR. FLOHR: I have no idea.

MR. BYRON: That’s all the information I have.

MR. MENARD (by Telephone): This is Allen. I’ve got a question for Mary. Do you know why the Marine Corps has not sent out the responses by the ATSDR and also the President’s cancer panel? Can you answer that question that Mike had?

MS. SIMMONS: This is Mary Ann. No, I don’t know,

don’t know, but I’ll be glad to get a response for that and send it back to the CAP.

MR. MENARD (by Telephone): Thank you.

MS. SIMMONS: You’re welcome. Also, I just wanted to say about the VA, that’s part of the outreach process that the Marines are trying to do to locate people, so actually that’s a success story. I hope she registered.

MR. STALLARD: Thank you.

Frank, are you good or are we going to move on?

DR. BOVE: We’ll deal with that question. Why don’t you bring that up later?

MR. STALLARD: Okay, great.

MR. PARTAIN: What, the infant mortality? Okay.

MR. STALLARD: Well then thank you for the updates --

MR. BYRON: I do want to ask Mary Ann one last thing. This is Jeff Byron. You know we’re talking about this notification at the VA. How about notification to all the American Legions that are listed in the country and the VFWs? Do they all get one?

MR. ENSMINGER: The Marine Corps League.

MR. BYRON: The Marine Corps League?

MS. SIMMONS: I believe they did, but I’m not sure.

I don’t have the list with me of who they sent out information, but I can find out and let you know. There’s a whole list of people; I think they did but I’m not sure.

MR. BYRON: I’m just concerned that they would send to the national office and then it would never be received in the regional areas.

MS. SIMMONS: Let me follow up on that.

MR. STALLARD: Have we ever had an update on the extent of the outreach activities?

MS. RUCKART: Not for a while, I don’t think.

MR. STALLARD: Maybe that’s something we might like to consider as an agenda item at another meeting.

All right. Let’s move on to Morris and our water modeling.

WATER MODELING UPDATE

MR. MASLIA: I’ll just speak from up here. Is this mike on?

MR. BYRON: So real quick. Just so everyone who’s listening knows that this is the portion that concerns the in utero study if I’m not mistaken as well as others. But this is the effort that’s going forward with the in utero children.

MR. STALLARD: And our presenter is Dr. (sic) Morris Maslia.

MR. MASLIA: I wanted to try to update you on some reports first and then get into a little more technical issues. As you know Chapter C was released via our website in October. We said we would. And then just this latest week we received in the hard copies of the Chapter C report, they're identical to what's on the website.

I brought some down on the table here. We've mailed copies to the Navy and Marine Corps, and we will get with Frank and Perri to mail hard copies to the CAP members if they so desire, just if you'll let Perri or Frank know, so we'll do that.

We also printed just some extra packets of the map of Plate 1 and a CD containing the report itself of the map. So for those who do not have a large format printer to print out the map, there's some extra maps.

I received yesterday a draft of the Chapter B report. That's the geohydrologic framework. I will be reviewing it the remainder of this month, and then sending it out for external colleague review or technical review, whatever term you wish to have, and providing it obviously to our stakeholders like the CAP, EPA, and Region Four as we did with Chapter C. Navy, Marine Corps points of contact. I have

requested in our monthly phone conference and if the Navy or Marine Corps have any expert in particular in this geohydrologic framework that they would like to review that report for them or review it, to let me know and we will be happy to send them a copy, an official review, in other words with a cover letter and expect an official response back.

MR. STALLARD: For comment.

MR. MASLIA: For comment, yes, technical comment on Chapter B. We're asking everyone who gets the report to return it within 30 days so we can reconcile comments and then it will go through ATSDR clearance process.

And we are just starting to work on information on Chapter D, which is the above-ground and under-ground storage tanks report, so I cannot give you any dates of draft or anything on that.

That's where we stand with respect to reports. Are there any questions with respect to the reports? But I did want to introduce –- forgive me, an oversight, the authors of Chapter C, took a lot of work. And that is Bob Faye is here and I don't see my other coauthors, but Barbara Anderson and Rene Suarez and Elliott Jones came on late and worked on maps and stuff like that. And as you well know

going through all these historical documents and trying to make some of those chronological and technical order out of them is not an easy undertaking and really just wanted to give my thanks to Bob and his coauthors on that report.

So with that, I wanted to update you on our water modeling activities. Again, the goal is to be able to provide monthly concentrations of various constituents from the time the plant started operating, water started being delivered, to the time of, to the health study time.

For modeling purposes, because of both hydraulic and fate and transport requirements, we are modeling a very large time frame beginning basically January 1941 going through December 2008, that's on monthly. And we're doing that on calendar month what we call stress periods when we turn on these wells.

We have developed, and this is the map I've shown you out here, this is the active model area for flow for hydraulic considerations. On the west is bordered by a water boundary, Northeast Creek, and which is a hydraulic boundary. And then to the east we go to the ^ divide. That is a modeling requirement. It makes it at least about 50-to-80

times larger than Tarawa Terrace.

So this is what we call the active model area. Within this area we will compute water levels and then within the smaller red areas in here, in here and in here, we will compute fate and transport properties and concentrations. The actual grid for determining water levels and simulating historical water levels, we use a 300-by-300 foot grid. I'll load that up in a minute. I'll need to see if it'll allow me to blow that up some. Okay, here we go.

And that basically results in a model that's 172 rows by 152 columns. It's actually smaller from a computational standpoint than the Tarawa Terrace model. And that's sufficiently refined for water levels, for pumping if we were not concerned with transport. If all we wanted to do is find out what water levels were historically or present day, this is fine, and in fact, this is the grid that we're using for our predevelopment prior to when pumping starts which we have to get a starting water level. And it's also good for pumping, for just general water level considerations.

And we have calibrated our 95 percent calibrated with the predevelopment model. It'll stay at 95 percent because as, if you remember from

the Tarawa Terrace approach, we use an iterative process to calibrate. We get a model to the extent that we believe it's calibrated and then move on. In this case move on to the transient, introduce pumping and fate and transport.

And if things don't match or we find out information from the model that seems at odds to either field data or what we think that should be happening, we may go back and have to refine something in the predevelopment panel. So that's why I'm not going to tell you it will be a hundred percent calibrated when we publish the report.

But for all intents and purposes it's calibrated enough for us to move on to introduce pumping. That's a major step forward, especially recalling that out in this eastern area, way out here there is really very little information at all, field data.

With that said, the actual transport model requirements to do fate and transport requirements because of numerical and aquifer requirements cannot be any larger than what we used at Tarawa Terrace, which is a 50-by-50 grid, which means it's 36 times bigger model size computationally otherwise.

And this is that grid. You can't see it

because it’s so refined, okay, I’ll have to zoom in. The blue areas are the streams and stuff like that, but those are individual blocks. They’re not colored in; it is so refined.

I’m going to zoom in on this area right here, that’s industrial area, and now you see the 50-by-50 foot cells in there. And that is strictly required to honor numerical requirements for fate and transport modeling for these types of numerical models.

With all that said, the run a complete simulation to test out from 1941 to 2008, 816 stress periods, putting in about ten example wells with this 50-by-50 foot grid. That grid is basically -- you’re using a model consisting of over seven million nodes per solution locations, and it runs between four and five hours, which is unbelievably fast for a model that size.

So it can be done. We’re doing it, and obviously the transport will be in the smaller areas so it won’t take quite as long as that, but even at four or five hours per run that’s very doable.

So where we are currently just to summarize, we have basically, we’re satisfied with the predevelopment calibration, 95 percent calibrated

and will remain that way. We are beginning to input the pumping information. We do have it on a monthly basis through our work with Georgia Tech to synthesize operations on a monthly basis for the transient, that is the water supply well operations as they were introduced, turned on, turned off on a monthly basis in the model, and then we will proceed with the fate and transport.

And I believe that is all I have to add. We have everybody working, fully working, on the modeling and on data analyses as needed for the modeling and on the reports at the same time. So I'll be happy to answer any questions. If I've left out anything, somebody just yell out and I'll try to address it.

MR. ENSMINGER: Morris.

MR. MASLIA: Yes.

MR. ENSMINGER: In the earlier conversation that we had about CLW-1406, where the 2,500 parts per billion of benzene was shown in the water in November of 1985, 38 parts per billion in December of 1985, you had mentioned that there was some question as to whether this was finished water or whether it was raw water before it was treated. The letter says finished water.

MR. MASLIA: Right, that was not, actually the question is not whether, the question is, and it's footnoted in Chapter C in the table is, it says the treatment status is unknown, okay? And there's a difference. We're not questioning that the sample was taken some place at the treatment plant, but where in the process of the treatment, in other words, raw water comes in, mixes in a raw water tank and then you can take a sample.

You can take it somewhere in the treatment process, and you can take it, like at TT, there's a sample location which we know the identity of at Building 38, which was on the delivery side of that. And so that's what we don't know about, and that is an important piece of information.

MR. ENSMINGER: Yeah, but it says finished water. I mean, you got to go with what it says, finished.

MR. MASLIA: But it doesn't say where. Finished water could be any place and once it's mixed and they start treating it, it could be in the tank, it could be on the side of the building. I don't know where they took the sample. We've asked that question directly to the chemist who wrote that, and her answer is she does not know. And I think it's important to footnote that, and we did in Chapter C.

MR. STALLARD: So are you assuming that finished means at the point of drinkable?

MR. ENSMINGER: Yes, I mean, finished is finished.

MR. PARTAIN: I mean, Morris, is that the uncertainty is whether this is pretreated water or drinkable water or --

MR. MASLIA: I would like to know where in the treatment process the sample was taken. What I'm saying is, and I've used Tarawa Terrace as an example because I know exactly where the treatment process, those samples were taken because I knew the location of the sampling.

MR. PARTAIN: So is the dispute whether or not this was water that was ready to be consumed or --

MR. MASLIA: Yes.

MR. PARTAIN: -- water that was in the process of being treated for consumption?

MR. MASLIA: Yes, yes.

MR. PARTAIN: Because –- and I've seen this term used –- but in the enclosures to the document it says chemical analysis results at Hadnot Point finished water. And I've seen the word finished water appear in other documents relating to water that was post-treated. It was ready for consumption and distribution. So, I mean, that would --

MR. MASLIA: Again, we are not in our analysis doing any treatment analyses. In other words we're not analyzing the water as it travels through the plant. It's either raw or it's treated, finished, the water's finished. The whole point was we wanted to be as clear as we could.

MR. PARTAIN: Well I think we have, while we're working, I'll go look for the documents for the JTC lab reports for the other months that weren't showing anything, I believe they were taken in Building 20, and I'll go find that.

But you mentioned that the 2,500 parts per billion, that's the point that's in question because that's an extreme hit for benzene in the finished water.

MR. MASLIA: Yes.

MR. PARTAIN: What other things have you done to verify that because all we have is this chart. We don't actually have any other --

MR. MASLIA: We had a telephone conference, unofficial, with the chemist, Ms. Betz, who's now with EPA, and asked her a series of questions about that. That was on October 13th, representatives from the Marine Corps, ATSDR, were on the phone as well, and we specifically asked her what she intended or

what she meant by her remark, I believe it says --

MR. PARTAIN: Non-representative.

MR. MASLIA: -- and her answer was basically that because she saw benzene concentrations, constituent concentrations, jumping around. You know, the high hit of 2500 down to 38 and all that over a period, she said that meant that that was just not a representative concentration. She was not questioning the QA/QC on the sample analysis or the result itself.

MR. ENSMINGER: So they're valid?

MR. MASLIA: That was her answer, and we --

MR. PARTAIN: Well, going into that, and here's a concern here, the document that this letter's attached to is signed by Jullian Wooten. It says enclosures one and two indicate no immediate concern over the quality of water in the two systems at Tarawa Terrace and Hadnot Point. While periodic readings of benzene are felt to be a quality control problem -– which we've heard many times before when there's a problem –- and sampling and/or laboratory analysis. Supplies for each raw water well for Hadnot Point were taken by N Read last week. Results are anticipated in early February.

Two things, one they're saying we've got the

boogey man quality control problem which whenever there's an issue that's the terminology that comes out from the Marine Corps.

MR. ENSMINGER: An anomaly.

MR. PARTAIN: So they're saying that there, but that's just saying that was a valid reading, is that correct?

MR. MASLIA: That's correct. I asked her, I repeated a question in a slightly different manner I believe. Bob can correct me. He was on the phone too. I mean, I went back after she gave me her initial answer and followed up with a follow-up just to make sure I was, I clearly understood.

MR. PARTAIN: Are there plans to get this in writing because, as you know, verbal things change over time and what have you. But this is something important. Like I said, 2500 parts per billion is an extreme amount of benzene in the finished water.

MR. MASLIA: Yes, there are plans to get that, and actually that falls under the data discovery and mining activities work group. Sven Rodenbeck can actually give you specifics. The plans are in progress to actually have an attributable statement from Ms. Betz in writing.

MR. ENSMINGER: Another thing, another thing in that

letter is this is the samples taken from all the Hadnot Point wells and the results were expected in early February. And we can't find those, and I've asked Morris.

You can't find those analytical results for those raw water wells, and they were talking about doing the Tarawa Terrace wells right after that.

MR. MASLIA: We continue to ask the Marines, and they know our position, for any and all information that they have.

MR. ENSMINGER: You know, I find this so convenient that out of a whole year's worth of water samples from two water distribution systems, Tarawa Terrace and Hadnot Point, a whole year's worth, we found every laboratory analytical result sheet in the files except for the two that showed benzene. Those are missing. Gee, go figure.

Now, November of 1985 is a year past the point where they said they took all the benzene contaminated wells offline. The two wells that showed benzene in 1984 were taken offline in November and December of 1984. Where in the hell did this slug come from? There wasn't any operating wells even close to any of the points where benzene fuel contamination was operating. There weren't any

more wells operating even close to those areas. Where does this slug come from?

MR. MASLIA: It's one of these of a model as a tool that can let you look at --

MR. ENSMINGER: Did they turn one of those wells back on?

MR. MASLIA: At this point I don't want to answer that because we haven't looked at that, but we have looked at similar, not with benzene, but similar well operation issues at Tarawa Terrace. And the model gave us some insights into that, and that is one of the uses of a model as a tool is to look at plausible operational scenarios when, in fact, we have limited or missing information.

MR. STALLARD: Anything else for Morris because we're right at a break?

MR. PARTAIN: One thing real quick. When you're talking about the samples I'm looking at one of the documents of the JTC Labs which comprise the chart that's put together, and it's saying the sample points need to be 20, and, I guess, they've got the time, 1405, June 24th, 1985. So, I mean, like I say, going back to, they're taking, this is a sample taken from the finished water at Building 20.

MR. MASLIA: Right. I did ask during our

conversation with Ms. Betz, I addressed that issue of where in Building 20, up in Building 20, and there are lots of places you can take samples from.

MR. ENSMINGER: They have a sink in there.

MR. MASLIA: Well, I'm saying, that's, and so I wanted to know if she recalled or had documented where precisely --

MR. ENSMINGER: They might have dipped it out of the toilet.

MR. MASLIA: -- they had taken the samples, and she did not recall. She did not have that information.

MR. PARTAIN: But if I heard you correctly earlier though, the point is, the concern is finished water meaning this is drinkable, serviceable water.

MR. MASLIA: Right, right.

MR. PARTAIN: And that's what you need to know.

MR. MASLIA: Yes, yes.

MR. PARTAIN: And from the indications in the document it says it's finished water so logically this is finished water, not raw water but pretreated water?

MR. MASLIA: (no response)

MR. PARTAIN: Yes?

MR. MASLIA: Yes, yes, yes.

MR. BYRON: This is Jeff Byron. Since this

individual works for the EPA and I suspect that there's a possibility we could have her in here at a meeting to answer some questions. She's a government official. Is that correct?

MR. MASLIA: Ms. Betz, I'm not sure I'm the one to tell you how to go about doing it.

MR. BYRON: I'm not too sure she'd want to show up here. She could answer some questions in front of the CAP.

MR. MASLIA: In her defense she was very cooperative and answered every question we had. Bob could attest to that as well. We gave her an opportunity to say anything she wanted to say, and when we asked her to refine or expound on something, she did. So there was no issue there. But that gets into administrative legal issues, and that's well beyond my expertise or desire to be involved with, and so I will have to defer to someone else to address that issue.

MR. BYRON: This is Jeff again. I wasn't really meaning as far as legal issues, but she has knowledge of the water system. She's involved in this all along. I mean, if she was here in the meeting, I think she could clear up a lot of things personally right here.

MR. PARTAIN: I think as a CAP we should extend an invitation for Ms. Betz to come. Whether she accepts it or not that's up to her or what have you, but we can at least have ATSDR make that request.

MR. BYRON: And I second the motion.

MR. STALLARD: Okay. Well, I mean, you clearly expressed an interest in hearing from her, those involved.

MR. BYRON: Actually, we're talking about that, even those who were running the lab. I mean, why can't they be here if they're doing government work and getting paid by the taxpayer?

MR. STALLARD: Thank you.

All right, let me just make a point before we break. Our staff at ATSDR working with these individuals, if there's value added I'm sure that it would be a worthwhile pursuit because the staff here is working closely with them to get that information.

So let's take a 15-minute break, those on the phone. We will please be seated ready to resume at 10:35.

(Whereupon, the meeting was adjourned to resume at 10:35 a.m.)

MR. STALLARD: Before we start, I have two things.

I'd like to welcome Sven Rodenbeck who's here at the table with us and Ms. Terry Walters. Welcome.

And Morris would like to clarify something.

MR. MASLIA: Let me just clarify during our discussion prior to the break, came upon the routine reading at the Hadnot Point treatment plant, Building 20, that was taken in December of 19 --

MR. PARTAIN: 'Eighty-five.

MR. MASLIA: -- 'Eighty-five, of 2500 parts per billion. And, of course, we note in Chapter C that the treatment status is unknown. We reference Document 1406, which is on the DVDs that were released with the Tarawa Terrace Chapter A report. That's what we're referring to.

And, in fact, reading carefully and clearly it does say finished water, chemical analysis results for Hadnot Point finished water. That would indicate that in fact that sample would not be fit but would be part of the finished water delivered for drinking.

MR. PARTAIN: Thank you.

MR. MASLIA: I just wanted to clarify that up. Again, we have not begun modeling the Hadnot Point system in earnest for finished water so that is consistent. But we'll model it consistently as we

did with Tarawa Terrace where we modeled finished water.

MR. PARTAIN: So a couple quick follow ups on that, Morris. Number one, so for modeling purposes this is a valid data point of an exposure of 2500 parts per billion?

MR. MASLIA: It's a valid concentration, the sample that we will compare results against.

MR. PARTAIN: Okay, now the, would this –- and this is something that I know Jerry and I have been working over the past couple months trying, or the past couple years since we found this trying to figure out where this came from. Do you have any explanation of why this suddenly popped up, the 2500 parts per billion?

MR. MASLIA: No. Obviously, the record, when I say record, the documents that we have indicated wells were taken offline. Again, we don't have complete sets of record so we can't say necessarily if a well was needed to be turned on or turned off. We saw that happening in Tarawa Terrace based on model results. That's where the model comes in handy is looking at different operational scenarios which we will be looking at and seeing if those scenarios present plausible methods of operation.

I can't tell you at this point. We had a sample, and that's a piece of data. Our approach has always been not to exclude data just because on seeing it it looks out of the ordinary in other words. That's why it's in Chapter C. We've asked Ms. Betz about it. We will be -- soon we'll address this, we will be getting her responses officially, so to speak, in writing at some point.

MR. PARTAIN: Have you identified any wells that were turned off within a year of that sample point that were contaminated with benzene?

MR. MASLIA: The two wells that come to mind are obviously 602 and --

MR. ENSMINGER: Six fifty.

MR. MASLIA: No, there was one other one that had a low --

MR. PARTAIN: Six forty-five was part of the Holcomb system, right?

MR. FAYE: So 645 is part of the Holcomb Boulevard system.

MR. PARTAIN: That wouldn't show up in the finished sample that we have for Hadnot Point unless --

MR. MASLIA: No, no. But as far as our well operations, we've got well operations for every well by every month.

MR. FAYE: Well, in November and December of ’84 there were two wells showed hits of benzene. The worst one was 602. I think 660 showed a small amount of benzene as well.

MR. MASLIA: 608.

MR. FAYE: And both of those were supposedly taken offline.

MR. PARTAIN: So we’ve been looking for evidence of another well that may have been popped up contaminated and shut down. But from what I’ve seen, I don’t see any other wells that were shut down on the Hadnot Point system after that November-December ’85 reading so something’s going on here.

We do know that there was a sample point, a raw water well sampling completed in February of ’86, but there’s no analytical data sheets for that. And I’m assuming you guys are looking for it. Have you made a request in writing for those sheets based on this document, CLW-1406?

MR. MASLIA: Again, we have our --

MR. FAYE: Those samples are –- I have to go back and check my notes again, but I believe that those analyses that you’re talking about are the ones that are published in Chapter C under January 16th of 1985.

MR. PARTAIN: ‘Eighty-five or ’86?

MR. FAYE: ‘Eighty-five. Oh, you’re talking about ’86?

MR. PARTAIN: Yeah, well, see CLW-1406 references a sampling event that took place as a result of these readings. The date of the letter is January of 1986, and that the wells on the Hadnot Point system weren’t going to be re-sampled between January and February of ’86.

MR. FAYE: No, they were sampled already. They were waiting for the results.

MR. PARTAIN: Okay. So and we haven’t seen any sample results. Specifically what the document says, if I can find it here. (Reading) Samples of each active raw water well for the Hadnot Point system was taken by N Read and BMO last week. The date of the letter is January 24th, 1986, so this would have been taking place mid-January of ’86, the sampling. And they say the results are anticipated in early February of 1986. I have yet to see --

MR. FAYE: I’m guessing, but I’m thinking those samples probably were just for THM --

MR. PARTAIN: No, no, they were referring to --

MR. ENSMINGER: -- the raw wells.

MR. PARTAIN: Here’s exactly what it says.

(Reading) Closures one and two indicate no immediate concern over the quality of water in the systems at Tarawa Terrace and Hadnot Point. While periodic readings of benzene are felt to be a quality control problem in sampling and/or laboratory analysis, samples of each water well for Hadnot Point was taken by N Read and BMO last week.

Reading that, they're going back and sampling each and every individual water well for Hadnot Point, and they're talking about benzene. So logic says that they should be looking for benzene.

We have yet to see the sample results. I don't know where they're at. I have not seen them in the documents. And that's something you guys, I mean, to me if there's a rogue well floating out there with benzene in it, it should have showed up here.

MR. FAYE: If it's not published in Chapter C, then we haven't seen them either.

MR. PARTAIN: Okay, that's something that we probably I guess would recommend you guys put in writing to the Marine Corps and ask where these sample results are.

MR. MASLIA: We have, and I'll defer to Sven Rodenbeck, but through the data discovery it's clear to everyone that we want any and all information

whatever it is. We'll determine the relevancy of it, okay? And that's been the mission or the mission statement of that. It's clear. It's been signed off at the highest levels. There is no question that we want everything. I mean, that's clear.

MR. STALLARD: Thank you, Morris.

MR. PARTAIN: To me, you know, without another well with benzene they had, if there's not another well out there that had benzene in it, then logically the only thing they could have done is turn on or reactivate a contaminated well.

MR. STALLARD: That's a perfect segue for us to move into the Data Mining Workgroup.

DATA MINING WORKGROUP

Sven.

MR. RODENBECK: Yes, good morning, everybody. Since the last CAP meeting, the Camp Lejeune Data Mining and Technical Workgroup has met twice on October 4th and 18th, and the summaries of those conference calls are on the web page, the ATSDR web page. The slow posting of the October 18th meeting summary was strictly my slip up. There was no real delay or anything on that. It just, I didn't get around to it, folks. I'm sorry.

Since the October meeting we've been continuing activities, and some of those activities –- this is not a comprehensive list –- include that a few more of water treatment plant logs have been found, a few months' worth, from the '50s and also the '70s. Those have been given to ATSDR, and we are currently, Morris's staff is currently evaluating them to see how they can best be used.

More than likely that will mean that Action Item Number 19 has been completed. Of course, action items will not be officially stated completed until the next workgroup meeting, and there's consensus on every one that it is completed, but that's my anticipation.

Department of the Navy has completed the listing of, well, has almost completed the listing of former contractors. And this has to do directly with the subject that you were just discussing. We intend to take that list of former contractors and specifically at this time focus in on laboratories or people who may have done data, analytical results, drinking water-type things, and send them a joint letter, ATSDR and the Navy, requesting that they look into their individual files to see if by chance they still have some information regarding

those sampling events. We'll see what happens. So that's a to-do item, and that's related to Action Item Number 26.

ATSDR and Navy staff visited the North Carolina State Archives. This is related to Action Item Number 32. This is a re-visit. ATSDR staff and also Navy staff separately have been there already. The very limited information that they found there was copied and shared with both parties. So that will probably complete Action Item Number 32.

The other thing I want to bring to your attention is the Department of Navy has completed reconciling, using the North Carolina Department of Environmental and Natural Resources underground storage tank files related to Camp Lejeune with what the Navy has on their portal. Basically no significant difference was found.

The only differences were there were a bunch of transmittal letters and memos that weren't in the Navy archives at that point. Of course, that information if needed we will take a look at data transmission, but they're probably the typical here's report number bum-bum-bum-bum-type transmission thing. More than likely that means Action Item 38 is completed.

Workgroup activities will be primarily focusing on ATSDR's final review of the Consolidated Repository there at Camp Lejeune. Unfortunately, given the time of the year and other activities just trying to schedule enough staff to do that has been an issue on our end. And that's my summary. I'd be more than happy to answer any questions you may have.

MR. ENSMINGER: There was a time when, Morris, you and Bob went to the state archives. This is a couple years ago.

MR. MASLIA: March, 2004.

MR. ENSMINGER: Yeah, yeah, more than a couple. And there was a period of time in those files where everything was there, the permits and all that stuff was there and then you came across a folder where everything was gone. Remember that?

MR. MASLIA: Yes.

MR. ENSMINGER: And it was a period of time in the '80s when all this contamination was identified and was there anything back in that folder whenever he went back up this time? Did anybody locate the stuff that was missing out of that folder?

MR. MASLIA: No, no. They, a colleague, Chris Fletcher, I forget who from the Marine Corps, Scott?

MR. FAYE: I believe it was Scott.

MR. MASLIA: Scott Williams accompanied them, and they went back into the historical archives, and there was still not anything from that period. I think if I recall correctly it was from about late-, middle-, late-1960s through ’89 there were no historical documents in the State of North Carolina Archives.

MR. ENSMINGER: But the folder was there.

MR. MASLIA: The folder with the year or decade --

MR. ENSMINGER: The period.

MR. MASLIA: Yeah, we found some records from the ‘40s and ‘50s and ‘90s and stuff like that. So we specifically asked as part of the Data Mining Workgroup to go back into the state archives to see if, in fact, we had missed something or what and that period they still did not find anything.

MR. ENSMINGER: They’re there somewhere. Somebody probably took the stuff out of there and stuck it in a folder somewhere else.

MR. STALLARD: Are there any other questions for Sven?

MR. BYRON: Yes, this is Jeff Byron. I am wondering as far as what falls under CERCLA. There are document retention, I guess, for an aerospace

manufacturer? If I manufacture a part, and it rotates in the engine, I have to keep all the documentation for 30 years. If it's a non-critical part, it might be 15 or seven years. But any rotation part where someone could lose their life is 30. So who can tell me here what the document retention is for issues concerning environmental concerns?

MR. FAYE: I think CERCLA requirements, I think they vary, but for IRP sites, I think it's 50 years.

MR. BYRON: So then how did these guys lose those documents and who's culpable? And maybe they should be up here and invited to the meetings.

MR. FAYE: It's an archive. You know, an archive is only –- only contains documents that a particular agency from the state would provide it. So the archive I don't think would be responsible for the retention of the documents. It would be the EPA surrogate agency in the state which I believe is NCDNR that would be responsible for retaining the documents.

MR. FONTELLA: And we need to be clear here that Camp Lejeune being a federal facility, the EPA more than likely would have maintained control over that. They would not have given that over to the state.

MR. BYRON: So is there a chance then that the EPA has a database of these documents?

MR. ENSMINGER: No, the EPA doesn't have anything.

MR. RODENBECK: The workgroup looked at that issue. Basically, for the CERCLA, CERCLA activities, not the underground storage tanks, not the drinking water or anything, that's strictly CERCLA its responsibility from what we've been told from the Navy to maintain the CERCLA files. And that is maintained on their portal and stuff like that. So when we're talking about like these drinking water samples, that is non-CERCLA.

MR. ENSMINGER: Then let me ask you this. When you went back up to the archives, what is their procedures for signing people in and out of there? Do they have a logbook where you can see who would have been there and who would have, when they had been there, what time they left?

MR. MASLIA: I did not make that trip. Chris Fletcher from our staff did and Scott Williams did so I can't answer what it was this time. But I can tell you there was significant discussions or e-mails that it was significantly different than when Bob and I went in 2004.

When Bob and I went in 2004, I believe we

signed in with a card. There was a guy at a grey metal government desk sitting there. We said Camp Lejeune, and he headed out the door. No. Pleased to see us. But all we did was sign a card and then we went up the stairs and told what we were looking for, and we were, and whatever files we wanted to see or look at. We were given carte blanche to look at those files.

MR. ENSMINGER: So you did sign in?

MR. MASLIA: We signed, Bob and I did. I don't know what their, I have not seen their protocol. But I can tell you this time around I know it was significantly different.

MR. ENSMINGER: What was significantly different?

MR. MASLIA: I believe more formal requests were needed.

MR. ENSMINGER: Oh, so they're learning. Is that what you're saying? Some changes have been made?

MR. MASLIA: Definite changes have been made.

MR. ENSMINGER: Well, that's one accomplishment.

MR. STALLARD: For the security of the information and the data.

MR. MASLIA: Again, for all CAP members I want to make it clear when Bob and I went up in 2004 we were not going to the archives expecting this is where

all the historical documents related on water modeling would be. We were looking for any ancillary documents because we had visited the state health department earlier that morning, gotten water use, water supply, USGS and all that.

We just wanted to sort of cover the entire territory so to speak. And we came upon this, and we did find some documents, as I said, in the ‘40s and ‘50s and ‘90s. And so we thought, I still think, that obviously whoever made the decision to archive certain documents did that, and we noted that there were empty folders from the ‘60s through the end of the ‘80s in this archive.

MR. STALLARD: Thank you, Morris.

Are there any other questions for Sven?

MR. PARTAIN: Yes, Sven, you mentioned you found some water treatment plant logbooks in the ‘50s and the ‘70s. Have they been scanned?

MR. RODENBECK: ATSDR has them.

MR. PARTAIN: Okay, and I’d like to make a request to get a copy of those as far as an electronic copy of those.

MR. RODENBECK: Make a request, absolutely. Be aware those are Navy documents so the request may need to go to the Navy.

MR. PARTAIN: Okay, I mean, last time when we had the Navy-UST we met as a CAP, you could request to get the documents. I mean, hopefully, there won't be a problem and ordeal like the last time with the UST files, but these are the water treatment plant logbooks, and we had seen previously on the CLW documents. I mean, I don't see why there should be a problem. But as a CAP member I'd like to see if we can get copies of those documents electronically.

MR. MASLIA: Let me clarify something because don't confuse what we have just received from the data mining thing to be the equivalent of the water plant logbooks that we have for like Tarawa Terrace and from the Navy in the '90s. These were a few months of some water use, of water delivery, some information.

MR. PARTAIN: Well, you said water treatment logbooks.

MR. MASLIA: So they're not –- I want to clarify that –- they are not logbooks. There may be a sheet here, a sheet there, and just so you understand the difference between the two.

MR. PARTAIN: I understand. I just heard water treatment plant logbook and piqued some interest there.

MR. STALLARD: Any other questions about the Data Mining Workgroup?

(no response)

MR. STALLARD: All right, well, excellent, back on schedule. Here we are.

Thank you very much for coming here. Thanks for the update.

MR. RODENBECK: My pleasure.

Q&A SESSION WITH THE VA

MR. STALLARD: All right. Now is the portion in our agenda where we're going to have I think a discussion from our Veterans colleagues.

So, Brad, would you take that away for us?

MR. FLOHR: Yes, thanks very much. I'm going to give you an update of what we're doing in terms of the benefits side of the issue at Camp Lejeune. Dr. Walters is here. We've been working together on a lot of these issues surrounding Camp Lejeune.

We had the hearing. We have subsequently met with Senator Burr's staff on several occasions discussing Camp Lejeune and particularly claims processing. We've briefed our leadership on the issue of Camp Lejeune in our meetings with Senator Burr's staff.

And our leadership right now including myself

are concerned with consistency of decision making, particularly in the interim while we're waiting for ATSDR to finish their studies on water modeling and the other studies that they're doing.

Consistency's an issue that is of great concern to a lot of our stakeholders. We want to be able to have a veteran who files a claim in the state of North Carolina and a veteran who files a claim in the state of Wyoming who have pretty much the same back pattern to get the same decision.

In an effort to do that we've decided to consolidate all of our claims processing of Camp Lejeune to one regional office that is going to be in Louisville. Louisville was selected because it is one of our highest performing and highest quality of decision-making offices.

To do that we're developing procedures for other regional offices to send their pending claims to Louisville. Some of them have been sent already. Some of them will be sent shortly. And I am trying to find time to go to Louisville myself and provide some training for the rating specialists that will be making the decisions.

I hope to go next week. I told Senator Burr's staff that we would be doing this before Christmas.

I plan to do that; if I can't make it next week, hopefully the week after which is the week of Christmas. I'm going to go there to give them training on not so much on how to adjudicate claims because they know that.

As I advised you when I first was here earlier this year, the claims process, the three requirements for a, for favorable determination is that there was an event, which is exposure at Camp Lejeune in this case. There's a current disease diagnosed or disability, and there's medical evidence associating the current claim condition with exposure to the contaminated drinking water. So that's for every case the VA processes.

So we provided some updated training to those people. Also though my main purpose of going there will be to sensitize those people to the issue. To let them know how significant it is, the concerns that you all have, to provide them, for example, you mentioned the ATSDR response to the NRC report. We'll discuss that.

We'll talk about the NRC report was flawed. We recognize that, but it was not completely flawed. They did have a list of 13 conditions that showed evidence suggested on this. We'll provide that

guidance, but it's going to be of utmost importance that the people who process the claims are going to be able to know what evidence is needed and how to assist a veteran in getting it.

So that's where we are with claims. We're going to do that, like I said, either next week or the week after, and we're going to proceed from there. We have placed an electronic flash in our development system, electronic development systems. Every claim that's received based on Camp Lejeune will be flashed in our development system, and that's currently in place.

In February we have an update to our rating automation system. We're going to put in a decision indicator for Camp Lejeune so the one who makes the decision for an indicator to grant or deny, whatever, we could be able to track all the cases. Starting in February we'll have tracking from every case that is done. And, of course, having them all in one office will make it a lot easier to track. So that's where we are now in the VA.

And Dr. Walters may have an update?

MR. ENSMINGER: I have a question. What about all the denials, the denied claims that have taken place prior to this consolidation? What are your efforts

going to be on those?

MR. FLOHR: Well, we're not looking at trying to re-adjudicate them because they've all been, we have been able to identify claims that were denied and claims that were granted, and we got them together and we looked at them. The overwhelming majority of claims is -- the reason for the denial is the lack of medical evidence providing a link between the claim for the disability and exposure to the contaminants.

That won't change if we go back and review them again. What is needed in those cases is new evidence, and any veteran's claim who's been denied –- and that's where the CAP can help folks 'cause you're in contact with these people and can always re-open a claim by submitting new evidence.

MR. ENSMINGER: Well, we've been in contact with a lot of our members, a lot of victims of Camp Lejeune, former Camp Lejeune Marines and sailors, and there appears to be absolutely no continuity in the decision-making process and why they were either granted or denied their benefits.

And Jim Fontella has put together a package on one specific claimant that's very detailed, and he went through all the case law on that claim. And

this man met every hurdle that was put in front of him, that his family did, and he's still being denied. And Jim just laid the case there by you.

But we've seen quite a few of those types of cases and to take these people that have been denied and leave them basically in the dust at the mercy of the people who previously denied them, I think is a great mistake. If you're going to educate these people in Louisville on these, on the subject and on this issue, I think that those people that have been previously denied should have the right to have this specialized team take a look at their case again at least.

MR. FLOHR: Well, again, you know, the claims decisions we make are legal decisions, and they're based on evidence, based on evidence we receive. And we have not, of course, because we had no way to identify every case, like one case we did see was from 1997. It's one of the oldest we've been able to identify, but I'm certain that the ones we have identified are not all the claims that have been filed. But, again, looking at denied cases, the decision wouldn't be changed if there was insufficient evidence, medical evidence, to associate what they had with exposure.

MR. ENSMINGER: Well, some of the denials, Jim's own personal denial, they said it were organo --

MR. FONTELLA: Jim Fontella. I brought five claims with me. One here I'm giving you I went into detail. In my own novice way I don't know much about VA law, but I was able to put together, based on your past history, VA past-case laws, why and how they denied this man is really is a travesty.

I brought another. This is a well-grounded claim who was denied and then he went into the DRO hearing, offered new evidence which was a medical evaluation, and the evaluation itself wasn't even in the denial. And as a matter of fact, they changed the denial, I mean his medical evaluation, they had it listed in the certified list of evidence, but they don't list it as a medical evaluation. It says -- I can go into it right now. It's on the first page of the statement of the claim, and it's listed --

MR. FLOHR: Is that this case here, Jim?

MR. FONTELLA: Yeah, right there. If you'll look at the supplemental statement of the claim it's listed as a report from Dr. Butler dated March 2010 providing medical evaluations for veterans filing for benefits. And the nexus is in that packet as

well.

You can see that by the nexus and the -- and it clearly states that it's a medical evaluation. And he searched all his medical history, that he's investigated the Camp Lejeune water, that he's 30 years Board certified in autoimmune diseases and so on and so forth, and was completely ignored in the whole thing. And he was denied again. Let me see. We'd have to read it together actually.

But in the other case they're changing, what I've seen in the denials that we're receiving because after the last CAP meeting we sent out a message to our membership. I want all the denials and the ones that were granted. And from what I've seen what the ROs are doing is they're changing the evidence, the claims.

They're either saying that there's no, the studies have not been completed on the water, that the -– let's see, it's presumptive to say that benzene was in the water. There's a –- what else is, oh, yeah. If you stated that you were exposed to TCE/PCE they might say change it to organophosphates, which is pesticides. There's organochlorines. Now these are terms I never heard of.

Just to give you an example, I'm a male breast cancer survivor. I've built three claims just with, not with their medical evidence, but with the evidence, because I have all the disks with the evidence of the contamination, and I've searched out all the clinical studies. Now I probably don't have them all, but I've given to four. One was approved, that was the one in Boston a couple of months ago, I guess, in August. One was denied, and the other two are still pending.

MR. ENSMINGER: And there's another one approved in New Jersey.

MR. FONTELLA: Well, that was, yeah, but I'm talking about what I had to do with. I didn't have anything to do with that one.

Okay, it says here in this one claim it says it changed the chemicals from benzene-bound chloride TCE and PCE to organochlorines, pesticides, DDT and PCBs, which I never gave that information. They just changed it on their own. Okay, this was a CNP examiner, and a VA physician also stated that there was, they are not associated with breast cancer as per large studies.

Well, after that I went into the Google again, and I –- originally I gave this guy ten studies, six

linking benzene to breast cancer, four studies linking PCE and TCE to breast cancer. Since then I went into Google, and I found eight studies linking DDT, DDE –- I brought them with me –- PCBs and dioxins to breast cancer or organochlorines. These are organochlorines.

So what he was stating wasn't even factual. What he was stating was he not only did change the evidence, but he based his evidence saying that it's less likely than not that organochlorines caused his breast cancer. Organochlorines was never mentioned in any of the evidence I gave this person. It was strictly on TCE, PCE and benzene.

Two on renal cell cancer. One of them said that it was more likely that his cancer was caused from smoking because he smoked for 11 years, and that there were, again, no studies connecting renal cancer to -– I mean, in all these there's a statement from the CMP examiner, every one of these claims that I brought, that says exactly that. There are no studies connecting –- I mean, I don't know what these guys are getting paid for.

I mean, they're not doing anything. How are they examining them? Are they looking for studies? All you have to do is hit Google and they'll come

up. So I'm just, that's what I'm talking about. I mean, and the rest of them, I mean, I've got a bunch of them. I've got about two dozen. But at the same time I wouldn't bring them because no medical evaluation, you know, just what you were saying. So I don't want to bring that up to you, but I just wanted to bring the ones that I saw that were flawed.

Now if you go into the one where I built his appeal for him, and I just sent it to his wife, and she is going to take it to the VA, but I found all the mistakes that he made, and I found case law that says that they have to reverse that decision based on the fact that they changed his evidence in the certified list of evidence, and they ignored the fact that he had a medical evaluation through the entire decision. And that was based on new evidence after he was denied going before the DRO.

MR. FLOHR: Jim, obviously I can't comment on it.

MR. FONTELLA: No, I understand exactly, but I'm just bringing this up to you to show you what we're up --

MR. FLOHR: Okay, and that's what we hope to do by getting all the claims worked into one office for consistent decisions.

MR. PARTAIN: We're going back to these denials and stuff. To cast a blanket we're not going to go back and look at these because of most of them have no medical --

MR. FLOHR: We've looked at the ones we've been able to identify already.

MR. PARTAIN: But looking at the one that Jim handed to you for the gentleman in Iowa. I mean, he has a six-page medical letter from a doctor connecting his disease to the exposures at Camp Lejeune. The effect of benzene, everything's in there. And then we look at the evidence like Jim was saying, the letter's not addressed as a medical report. It's just, it's basic a medical letter, nexus letter.

It's addressed as a report and basically dismissed. They don't even talk about it. So without going back and look at these people to make sure that this isn't repeated over and over and cast a blanket statement, you're doing an injustice to a lot of people out there.

MR. ENSMINGER: And the stuff on renal cell carcinoma, I thought that, isn't that why the EPA's going to be here shortly classifying TCE as a known human carcinogen based upon renal cell carcinoma, right?

MR. FONTELLA: Well, I checked up on the studies for renal cell carcinoma connected to TCE and from the National Academy's and ATSDR, CDC, NIOSH, they all show studies connecting central nervous system --

MR. ENSMINGER: The NRC report even linked it.

MR. FONTELLA: Well, what I'm saying is for them to say there's no studies, I mean, and when these veterans get these replies back, they're confused. They're misleading. They don't know how to file their appeal or what, I mean, they get all, I mean it's really perplexing.

MR. FLOHR: I agree. It's a complex issue and hopefully we can get a better --

MR. FONTELLA: I think it's a good idea really if that happens. I mean, I am all for it. I'm all for it.

MR. ENSMINGER: I would hope that you would take that file and personally look at it.

MR. FONTELLA: Everything's in there, and it's all, like I said, I'm an amateur. I don't know much about VA law and I don't want to get into that. But you'll see just by me looking back through the DAD (sic) citations, the court citations, and finding the mistakes they made that that's really terrible.

MR. FLOHR: Yeah, I'll look at this and if I think

there's something questionable about it, we can always recall the file into my office and look at it.

MR. STALLARD: Wait a minute, it's not just about the file though, it's about the standardization of the process and the appeals to go back. What is the threshold of evidence and can they go back to this centralized place I guess is the question.

MR. BYRON: This is Jeff Byron. As a matter of fact all those that filed claims prior to even the BTEX being found, that's a reason right there to go back and look. That is new evidence. Just the fact that the benzene exposure was there presents new evidence for cases that might have filed prior to that anyway.

The other question I have for you, is there a chance that I'd be able to attend that meeting in Louisville, because I live an hour and a half away? Thank you.

MR. FLOHR: That I don't know.

MR. TOWNSEND (by Telephone): I have a question. Tom Townsend here.

MR. STALLARD: Tom, yes.

MR. TOWNSEND (by Telephone): Hello?

MR. STALLARD: Hello, Tom. We can hear you.

MR. TOWNSEND (by Telephone): I'd like to get into this conversation.

MR. STALLARD: Okay, what would you like to say, Tom?

MR. TOWNSEND (by Telephone): I'd like to talk to the Veterans Administration. My claim has been filed for three years, and I'm currently waiting for, I'm on the docket for the Board of Veterans Appeals. Now, how do I know that my case has been transferred to Louisville?

MR. FLOHR: If you have an appeal pending at the Board of Veterans Appeals, that will not go to Louisville. That will remain with the Board who has jurisdiction. They will make the decision based on the appeal that you filed.

MR. TOWNSEND (by Telephone): The court will?

MR. FLOHR: No, the Board of Veterans Appeals will.

MR. TOWNSEND (by Telephone): Well, I mean the Board of Veterans Appeals. I would like, I mean, that puts me to a great deal of effort to go to the Board of Veterans Appeals when it could be handled at a lower level.

MR. FLOHR: Well, it can't. Once a decision's been made with which a veteran disagrees and files a formal notice of disagreement, and then gives the

statement of the case, and you've filed Form Nine which is the substantive appeal to the Board, the Board then has jurisdiction of that case, and they take it. The file is with the Board of Veterans Appeals, and they are required by law to make a decision on your appeal.

MR. ENSMINGER: This is Jerry. This is exactly why I asked about Dr. Portier's letter and being disseminated to everybody and anybody that's making these decisions. I mean, that letter disputes a lot of what was said in that NRC report. And a lot of your people are still operating off of that thing and making decisions because of that. And until they have that other information in their hands, they're going to continue making those decisions based upon that flawed NRC report.

MR. FLOHR: Well, that will be something I take with me to Louisville next week --

MR. ENSMINGER: I mean, in Tom's case and other guys, other veterans' cases that have been denied, that basically they are left to the, their cases are being left back there wherever their denial was made. And without this newer information refuting that stuff, what chance do they have of getting their appeals approved if they don't have all the

information?

They need that letter. Everybody needs that letter. I mean, the VA came out with a training letter that they sent around to all their regional offices based on the flawed NRC report. I think that same thing needs to be done with Dr. Portier's letter so that they are armed with all the information so that they can make educated decisions.

MR. FLOHR: As I said, I will discuss that with the people in Louisville.

MR. TOWNSEND (by Telephone): Wait, wait, wait a minute.

MR. STALLARD: Yeah, Tom's on here. Go ahead.

MR. TOWNSEND (by Telephone): I've been waiting, I have been continually going through the process of providing data from physicians, from neurologists, on my condition. The number of volatile organic compounds that have been determined since I filed my claim have gone from three to nine. How can I possibly keep up with the change?

If it's taking so long for this thing to grind through the process, how can I possibly keep up with the findings of wrongdoing on the part of the government? It's impossible. I'm sort of

discouraged that my claim is languishing as science and the work of ATSDR is passing me by.

MR. BYRON: Well, I hate to say this -– this is Jeff –- but in all honesty it's passing us all by. My kids aren't getting any younger waiting for, so you know, for the finish of these studies. I mean, we're all in that boat.

MR. TOWNSEND (by Telephone): Well, I'd like at some point in time, I'm probably the oldest of this mob, I'll be 80 in about a month, and I'm not looking for the finality or compensation particularly, but I'd like to have the Veterans Administration hear me and have all the knowledge that has been developed since I started my claim. Why do I have to deal with the Board of Veterans Appeals when other people can go get simply shifted off to Louisville ^?

MR. FLOHR: I don't understand your concern there. Just because all the claims are going to be processed in Louisville in no way means they're all going to be granted, sir. It all depends on the evidence of each individual case. In your case --

MR. TOWNSEND/MR. FLOHR: (Indiscernible).

MR. FLOHR: Excuse me, sir. Let me finish. Let me finish, Tom. In your case if you have additional evidence that you can submit, you can do that at any

time. You can submit it to the Board of Veterans Appeals. You can submit it to the regional office. And what the Board can do when they're looking at your appeal, they're looking at what was in your claims file at the time the decision was made. And if you have new evidence that you can submit in support of your claim, then it perhaps would be remanded back to the regional office for them to consider that new evidence such as what you're talking about.

MR. TOWNSEND (by Telephone): In the last three years there has been a considerable amount of new evidence. I mean, I submitted a long time ago when this thing first came up on the screen. And when we've gone from three VOCs identified to about ten. BTEX wasn't even a matter of issue at one point in time. I find myself, I find that in Idaho I feel like I'm being left out of the scrutiny that's being afforded to the people that are being shifted to Louisville.

MR. STALLARD: So, Tom, this is Christopher. So your claim has been there and let's say it's been going on for three years and you haven't had an opportunity to add new information. Is that basically it?

MR. TOWNSEND (by Telephone): No. I had --

MR. STALLARD: Hold on.

Sandra, can you please turn your phone on mute or something? Thank you.

Go ahead.

MR. TOWNSEND (by Telephone): I have new data, neurological exams by a neurologist, and I add, and hopefully it's being added. I go to the VA because I'm a 50 percent disabled veteran. All that stuff should be in the pot.

MR. STALLARD: Okay, so I'm trying to summarize what I think your message is, and I think that we're hearing it loud and clear is that there's a certain disadvantage to those who might already be in the appeals process or claims process. That they don't have the information that may be pertinent to their case to strengthen it based on new information such as Dr. Portier's letter. And that there's a concern that the caregivers in this case, whether it's VA or whomever is seeing you, also doesn't have that information. Is that the bottom line?

MR. ENSMINGER: Tom, this is Jerry. Did you take Dr. Portier's letter and submit it as part of your appeal?

MR. TOWNSEND (by Telephone): No.

MR. ENSMINGER: Well, you need to.

MR. TOWNSEND (by Telephone): I figured if it went through the VA system, that the VA would know about it.

MR. ENSMINGER: Well, I mean, you're taking something for granted. You know how these bureaucracies work. I think you ought to take Dr. Portier's letter and submit it as part of your package. It would greatly benefit you to do that.

MR. TOWNSEND (by Telephone): Yeah. Well, I will try to do that, Jerry, if I have to. I'll find the letter, and I guess I better talk to the VA administrator in Idaho and get them online of what's going on.

MR. ENSMINGER: Well, I'll get Mike to send that letter to your e-mail right now so you don't have to search around for it. We've got it on file here.

MR. TOWNSEND (by Telephone): Okay.

MR. ENSMINGER: And, you know, that letter says a lot.

MR. STALLARD: It's on the website.

All right, Tom, I have Jim here who is next in the queue for a question.

MR. FONTELLA: Yeah, Brad, at the last CAP meeting we talked at length about the NRC educational letter

with the NRC. Is there any question that any of the ROs know that there was benzene in the water? They should not be saying that it's presumptive that benzene was in the water. Am I correct? Why would they --

MULTIPLE SPEAKERS: (Indiscernible).

MR. FONTELLA: -- from the medical, from the doctor, they said that the doctor was being presumptive. So what I'm saying is you could have a nexus, you could have a well-grounded claim and still be denied. You can meet all the criteria, and this is what you're up against. I think the education of the ROs, I think there needs to be something done there, that they need –- I'm just reading the evidence.

I mean, if your claim is set up where you have, you meet all the criteria for what the VA says, I mean, I don't know where they come up with all this stuff. It almost makes it look like they change this stuff and the evidence on purpose, the chemicals, on purpose.

As an avenue -- I understand why you shake your head, no. But where is it anywhere that anybody in all these, and they're coming up in a lot of claims. They're changing the chemicals from TCE, PCE and benzene to pesticides, herbicides and none of it was

submitted.

MR. PARTAIN: And one of the recent denial letters was --

MR. FONTELLA: I mean, it is crazy. It's crazy.

MR. STALLARD: One at a time. One at a time.

MR. PARTAIN: In fact, one of the recent denial letters said that because you worked around benzene doesn't mean you were exposed. It's presumptive that you were exposed, and that was a recent denial. And, I mean, ignoring the fact that it was in the drinking water. You would think if you're drinking, you're exposed. But the denial letter said just because you were working there doesn't mean you were exposed.

MR. FONTELLA: And the CMP examiners, you know, when they say that there's no clinical studies that they could find, I mean, that opens the door for the RO to take a look at that and say, well --

MR. FLOHR: You have to understand the decisions that the RO makes based on the medical opinions that we receive and any other studies that are available.

MR. PARTAIN: Well, what professional --

MR. FLOHR: We can't, in other words, our decision makers can't use their own unsubstantiated medical opinions as the court has called it to make a

decision. Even if they're doctors they can't. That's a conflict of evidence.

MR. FONTELLA: Yeah, but what I'm saying is these clinical studies were submitted. Do you understand what I'm saying? These clinical studies were submitted with the claim like the renal cell carcinoma and the male breast cancer. I mean, I've looked them up myself and sent them. I'm the one sending them to these people.

MR. FLOHR: You know, Jim, Mike, you have your comments about various claims. I can't address those. I haven't seen the files.

MR. PARTAIN: I understand that, Brad, but the thing is also speaking in blanket terms, I mean, we can't look at it because there's no connection. Without getting specifics you're not going to get the answers you're looking for. We're giving you some specifics.

There's one right in front of you now where you have a specific claim. Granted you haven't seen it and you can look over, but it's clearly that, I mean, there's a nexus letter. The nexus letter was minimized in the claim.

Like there's a recent denial. In the denial it said, well, just because you're working around

benzene you weren't exposed. And here's another one here from Florida that I talked to. I don't know if the gentleman is still with us because at the time I talked to him six months ago, he was terminal diagnosed with kidney and bladder cancer.

He's a Camp Lejeune vet, also a Viet Nam vet. His bladder cancer dated back to 2000, I believe 2000. And one of his appeals here, with regard to your letter dated May 11th, 2010, you state that I previously was denied on October 22nd, 2001, for my claim for bladder cancer.

At that time the claim was based on medically-accepted profile that this cancer is an environmental cancer and that I'd been exposed to a very toxic chemical to something with Agent Orange. At that time I was not aware of any exposed at Camp Lejeune. Well, basically the VA came back and said you're denied for your, Agent Orange is not connected.

Then he found out about Camp Lejeune, resubmitted the claim, it says, oh, you passed your appeal period. Sorry, have a nice day. Go die. And that's essentially what's happening here. He's been denied. Now, the last I talked to him he had gotten 30 percent, I believe, for the bladder

cancer, but he was subsequently diagnosed with kidney cancer five years later which is terminal.

Like I say I haven't been able to get a hold of him for the past couple weeks. I don't know if he's still here or not. But --

MR. FLOHR: Once again, gentlemen, you cannot possibly expect me to comment on these individual cases.

MR. PARTAIN: I know that, but these are trends. Like I said, these are newer cases.

MR. FLOHR: So if you want me to take a look at it, let me know, send me an e-mail. I can't comment on them.

MR. FONTELLA: No. Brad, I'm not even asking you to comment on the cases. Just so you know, I'm just trying to bring it to your attention. Maybe I haven't made myself clear about what we're faced with. This is what, these are the mistakes that the VA is making and what we have to deal with after the fact.

MR. FLOHR: And I can't even say they're mistakes because I have not had an option to look at them.

MR. PARTAIN: Okay, well, we're making you aware so you can. That's the whole point of this. We don't expect you to analyze someone's individual claim

here. It's not fair to you or the VA or anything else.

MULTIPLE SPEAKERS: (Unintelligible).

MR. FONTELLA: Maybe I'm not coming across the same way, but just to let you know what is happening to us. And we're the ones at the other end of it. You know, this guy goes to work every day at the RO, and he's just doing his job, and we're the ones who takes two more years and three more years and whatever it takes. We have to, like Tom has to go through the system now because he was denied. It goes on and on.

But I mean, these are things that should be, these guys should know their own laws. They should know what they're supposed to do. We shouldn't have to tell them. We shouldn't even be here right now. You know, this thing should have been done, over and done with years and year ago. This is a, it's an ordeal for everybody.

MR. BYRON: This is Jeff Byron again. Did I understand you, Brad, when you said that there is going to be a meeting of the ROs and like an educational process concerning Camp Lejeune or was I mistaken?

MR. FLOHR: For all the ROs?

MR. BYRON: So how do we resolve this and make sure that everybody's looking at apples and apples.

MR. FLOHR: Like I said, Jeff, all the claims will be consolidated to Louisville. I think I said that earlier.

MR. TOWNSEND (by Telephone): Well, the claims aren't all going to be collected at Louisville.

MR. FLOHR: Pending claims. An appeal is not a pending claim.

MR. PARTAIN: In the absence of ATSDR's work and what have you, what type of professional advice have you all relied on in the decision process? I mean, we're waiting for the water model. We're waiting for the health effects and everything, and there's stuff all over the world besides. So are you guys looking to any particular, how are you getting the information to make your decisions?

MR. FLOHR: Again, for the more than once already today, I told you what is required for a favorable decision. It's medical evidence, a link between exposure and the ground contamination. That's really the key. It's up to the adjudicator. If there is negative evidence to the claim, which might be a report or something, they have to evaluate that evidence and decide which is more credible, which is

more probative which is proves the claim and make a decision and write up why they made their decision. And they have to discuss all the evidence that's available.

MR. ENSMINGER: This VA task force that you've talked about and the report that they're issuing to the Secretary, I'm thinking that this whole task force investigations and their report would have to have been based upon the NRC report.

MR. FLOHR: Not at all.

DR. WALTERS: I can address that. The task force report has been going on. It predated my time coming to the VA. Looked at the NRC report or the National Research Council report and recognized pretty early on that it did not address BTEX. So the toxicologist who was on the report looked at daily search investigation, looked at the articles in the professional literature that talked about BTEX, and incorporated that in the task force report.

Now what's lately thrown the task force report into a bit of a problem is Dr. Portier's letter which again provided new information. So we thought we had the right information but again now we're still waiting for more information. So that has

necessarily delayed the task force report.

But part of what the VA's response has been in the interim while we're waiting to come to resolution on what is the actual evidence out there -- because we want to lean forward. We want to be veteran-centic –- is to recognize that there are variations in claims and so that's why VBA –- and I represent VHA, two different parts of the VA -– VBA has gone ahead and decided to consolidate the claims to make them more the same.

Now speaking as a clinician, when you have a patient come in to you, let's say with kidney cancer, you look at the whole patient. We say, okay, you were at Camp Lejeune. How long were you at Camp Lejeune? There is a significant difference between someone who, say, was there for a month versus an east coast Marine who was there for three or four tours and spent many years at Camp Lejeune.

There's also when you make your decision as to what is causing this cancer, you need to recognize that most cancers with the exception of some lung cancers and some other occupationally-exposed cancers, we really don't know the cause. Where we have lots of people who come up with kidney cancer or leukemias, and you don't know the cause.

Most cancers we do not know the cause. And if you'll remember, tobacco companies for years fought as tobacco smoke as a cause of lung cancer. And look at Diana Reeves. She never smoked in her life. She died of lung cancer. So, you know, just exposure to a chemical, whether it be tobacco, benzene, TCE does not necessarily mean that it is causative of a cancer.

You have to put the whole picture together. So if I have this patient who was at Camp Lejeune for a month drinking the water, has a 50-pack year smoking history, and has a family history of polycystic kidney disease, my clinical judgment may be that the family history and the tobacco smoking were the causes, or the most likely causes, which I can't prove, of his kidney cancer. Let me finish.

Whereas if this east coast Marine, no history of smoking, only history is the exposure to Camp Lejeune water of a long duration, my clinical judgment is going to go much more towards the water at Camp Lejeune being somehow involved in causing his kidney cancer. So every case is different and one-time exposure or a short exposure is less likely to be a factor in a disease than a long term.

So if someone says I only smoked a year and

they come up with lung cancer, they're either very, very unfortunate or there may be some other cause like they were exposed to asbestos. So this is not a one-time hit of BTEX leads all way to a cancer. So there is many, many factors that play into a medical judgment. It isn't just exposure, cancer. There has to be a medical nexus. And I think that's what you're running into with physicians saying I don't see, I can't think that there's a medical nexus.

MR. ENSMINGER: In the case of Camp Lejeune you've got people that are subjected to scrutiny of, well, how long were you there? You know, were you there for one month, one week, one year, two years, three years, multiple tours? But yet with Agent Orange all you have to do is prove that you stepped foot in country, one day.

DR. WALTERS: Yeah, and I know that.

MR. ENSMINGER: We already know that the contaminants at Camp Lejeune were in the water.

DR. WALTERS: Let me explain the Agent Orange. For years the DOD and VA tried to figure out exposure models. And because there were poor recordkeeping on the part of DOD, and in an effort to be absolutely fair to all veterans, they basically said

if you're in the country for one day, yes, indeed you were exposed to Agent Orange. That has had a number of effects. So if you're a veteran who were cleaning out the barrels of Agent Orange, and you come down with chloracne, which is absolutely causative, and some of the other nasty things that are causative, being caused by Agent Orange, and you're 100 percent disabled, and your buddy over here, he visited –- real case –- visited the airport, is now getting a $600,000 check because he visited the airport once and now has ischemic heart disease because he smoked and drank and never missed a cheeseburger, would you feel somewhat cheated?

MR. ENSMINGER: Yeah.

DR. WALTERS: Absolutely.

MR. ENSMINGER: But I mean, that's what's going on with Agent Orange.

DR. WALTERS: Yes, indeed and --

MR. ENSMINGER: I mean, how did that get to that point?

DR. WALTERS: Because of poor recordkeeping.

MR. FLOHR: To get to the point because there was so much, as Dr. Walters said, there was so much controversy and disagreement between competing scientists and DOD and VA that Congress stepped in

at some point in 1991, they passed the Agent Orange Act and said, look, because of all the controversy and because we don't know, because we have no exact records of where people in Viet Nam were at the time of the use of Agent Orange --

DR. WALTERS: And most people were there for a year.

MR. FLOHR: -- anyone who was there was presumed to have been exposed.

DR. WALTERS: And most people, the majority of people exposed were there for a year. The guy in the airport is an exception. And most laws are made for the majority of people, not the exceptions. So that's the reason for the Agent Orange issue.

MR. TOWNSEND (by Telephone): Mr. Townsend here.

MR. STALLARD: Yeah, go ahead, Tom.

MR. TOWNSEND (by Telephone): I looked at, I was interested in the lady from the VA speaking about talking about the family history that goes along with this. I have lost a son that died at Camp Lejeune, and I have lost a wife whose death was attributed to the --

MR. STALLARD: Tom, I think we missed you. We just lost you. We cannot hear you.

Okay, folks, we're getting a little, just agenda-wise let's check in --

MR. TOWNSEND (by Telephone): Now, well, I guess I'm at home. I'll call my state VA director and see what he knows about this because I've been sitting in the system for three or four years. I've waited for the Board of Veterans Appeals, and all this stuff is new. Everything, when I started it was very, there was only a couple of components, now it's BTEX and about ten other things. I keep up with the VA. I send them stuff. I go to their physicians, and it just seems to be all screwed up. End of statement.

MR. FLOHR: Let me just say that I appreciate your concerns. I appreciate your bringing these examples of these cases that you have. I understand what you're feeling and what is going on. If I didn't, I wouldn't be here. I would not come here --

MR. TOWNSEND (by Telephone): I sent a whole history of myself to you. I sent you my VA number, and you were supposed to get back to me.

MR. FLOHR: Tom, what was your last name?

MR. TOWNSEND (by Telephone): Townsend, T-O-W-N-S-E-N-D, Thomas A.

MR. FLOHR: All right. Let me check when I get back.

MR. TOWNSEND (by Telephone): Thank you.

MR. FLOHR: But hopefully going forward we'll be able to do a better job, like I say, of tracking these cases and making decisions on them, of the claims. They won't be decisions that have been made and are final. It's going to be, what's going to Louisville are claims that are currently pending or have not yet gotten to the Board that are in some appellate status. So we'll work from there.

MR. PARTAIN: Hey, Brad, I have a question for you. The veterans who are treating with the VA system now and have had this come up a couple times for other problems and they have cancer or something that's tied back to Camp Lejeune and the VA doctors treat it, VA medical doctors treat it, and they've asked the VA doctor for a nexus letter, are the doctors permitted to write a veteran a nexus letter for the VA, a VA doctor?

DR. WALTERS: Yeah, they do all the time.

MR. FLOHR: Absolutely.

MR. PARTAIN: Because I've gotten feedback to where they've been told, no, we won't do it.

MR. FONTELLA: Jim Fontella. I've looked through a lot of VA past VA claims on appeal, and I have seen many, I have seen many nexus medical opinions that were done by VA doctors. But I also know of one

personally, that was myself, who my doctor said that he would lose his job. He was interested in keeping his job.

And I just think he kind of punked out really. I mean, that's what happens to a lot even with civilian doctors. I think that they just do that. They just don't want to get involved with something like that and put their name on something because they have no clue.

MR. FLOHR: Well, you know, in the past at least I know that VA physicians, treating physicians, were discouraged from providing a medical opinion unless it was asked for by the regional office. One of the reasons being that the physicians would be concerned that they might get sued if they wrote an opinion and it was negative because that's possible.

DR. WALTERS: And there's always a tension between, and that's why CMP examiners are not treating examiners. There's always a tension between someone who treats the patient and someone who is involved in evaluation for a financial claim.

Sometimes there's a conflict of interest there, and as a treating clinician, you have to be totally focused on your patient. So there is a professional tension there, and that's why the VA does separate

out CMP versus treating physicians. But there is no prohibitation (sic) from treating physicians writing a letter saying this is related to this exposure.

MR. STALLARD: Yes, Dr. Clapp.

DR. CLAPP: A brief addendum to Brad for your training. I spoke with Dr. Kate Guyton at the EPA about their designation of TCE as a carcinogen, and she said that she thought it would be posted this month. But Jerry mentioned this earlier that that's coming any minute now. So please keep your ears open to that.

MR. FLOHR: That will be actually more useful for Dr. Walters and the physicians.

DR. CLAPP: So it's different from what the National Research Council report said; it's taking it a step forward.

MR. FLOHR: Well, again, before we break for lunch I just want to say I've got an early flight so I'm going to leave after lunch here, but I will take back what I've heard, and I will follow up with you on anything you want me to follow up on.

Yes?

DR. KAPIL: Can I just say one thing before we break for lunch?

MR. STALLARD: Yes, please do.

DR. KAPIL: I've just been listening to this conversation, and I wanted to just weigh in as an individual. Like Dr. Walters who has had many, many years of experience doing occupational environmental medicine in clinical settings, before I came to CDC. And I pretty much fully agree with her comments on the challenges of evaluating these types of cases.

So I wanted to just reiterate that it is really extraordinarily difficult for physicians, even those who are specialists in occupational environmental health who do this day in, day out to evaluate these types of cases under these types of circumstances.

It's not unusual for us to have to deal in circumstances in which there are knowledge gaps, significant knowledge gaps, and there are difficulties with the availability of easy answers. I mean, in fact, it's probably more of a rule rather than the exception --

DR. WALTERS: Medicine is a probability game.

DR. KAPIL: -- so having said that it therefore becomes extremely, extremely critically important who is doing those evaluations and their training, their expertise, their judgment. All of those kinds of things come into play. So both sides it's a challenge.

Whether that evaluation is being done on behalf of the patient by their physician, it's an unfortunate reality that in this country the vast majority of clinicians that are in practice really know very little about environmental health or occupational health. So sometimes they find themselves struggling when they encounter patients with these types of histories.

And similarly on the other side of the coin the situation is also true. Physicians who are doing these examinations on behalf of employers, for example, also often lack the expertise and training and experience to be making these decisions which sometimes are really very, very subtle kinds of differences between individual patients.

So I just wanted to put that issue on the table that what we're struggling with here, and what I'm sure that these folks struggle with every day, we all struggle with, is how you make good, sound, evidence and science-based decisions when you have all these challenges. So I just wanted to make that comment.

MR. STALLARD: Thank you.

MR. BYRON: Real quick, this is Jeff Byron. If you think it's difficult through the VA to get a nexus

letter, try to get it through the civilian world with children that are suffering from issues.

MR. FONTELLA: And I believe it's also important that the VA more likely or as likely as not the weight of the evidence, the 50 percent. One thing, too, with TCE, I mean, I know we talked about this before, but Camp Lejeune -- if I recall I think Dr. Clapp was the one who may have said this, or Frank -- is the worst documented TCE-PCE contamination in a public drinking water system that we know of.

DR. BOVE: TCE, yes.

MR. FONTELLA: TCE.

DR. BOVE: TCE not PCE.

MR. FONTELLA: Not PCE but TCE. And the science is not quite out there looking at long-term exposures or even just chronic exposures because even if you're there a month, you're drinking this seven days a week the entire time you're there, and you're exposed to it constantly.

Now with the EPA coming out stating that this is going to be a known human carcinogen, I mean, like you said, it's incredibly bad luck, but I mean, how many times do you have to flip the coin drinking water every day, 24 hours a day, seven days a week that you do your chance comes up.

DR. WALTERS: Well, what people do, what studies do is they use occupationally exposed workers, such as dry cleaners who were exposed to this stuff a lot, and see at what point, how long is the average time before they develop cancers or adverse health effects. Same with benzene. Same with any toxic chemical.

So we assume that those who work and are occupationally, not epidemiologically exposed, get higher doses. So the classic one is the tire workers who work putting tires together, they're exposed to benzene a great deal, and that's where a lot of literature will come from. But translating that occupational exposure to epidemiological exposure is very difficult because you're sometimes comparing apples to oranges.

MR. ENSMINGER: I understand that the information from the studies in China on benzene --

DR. WALTERS: The Harvard?

MR. ENSMINGER: -- are in, and I understand they're terrifying. But by the same token when you talk about occupational exposures and adult exposures, look at the kids that were carried in utero at Camp Lejeune. ATSDR automatically eliminated the people that lived at the air station. They eliminated

people that didn't live on the base.

However, every mother prior to the new hospital being opened, we don't know what the water, how often they were opening and closing those inter-tie valves yet. But how many exposures to say 2500 parts per billion of benzene or 1,400 parts per billion of TCE that were in the Hadnot Point system, because every mother had to go to the Naval hospital.

How many slugs of that crap did it take to affect a fetus? One? I mean, every one of those kids whether they lived on base or not was exposed when their parents, and all the main services at Camp Lejeune were provided at Hadnot Point. The hospital was on Hadnot Point water, the old hospital.

If you wanted to go to the main exchange, you went to Hadnot Point. If you wanted legal services, you went to Hadnot Point. If you wanted to use special services, you went to Hadnot Point. These dependent kids were all exposed, every one of them, if they were carried in utero in the womb. If you wanted to go bowling, you had to go to Hadnot Point, everything.

MR. BYRON: Not to mention that if you were living

in base housing, I think that the comparison, occupational exposures compared to ingestion, there's no comparison unless you have information that would tell me differently. Because I've worked in front of these chemicals in the aerospace industry, okay? I know what precautions had to be taken --

DR. WALTERS: All I'm saying is that's where the information comes from.

MR. BYRON: Yes, yes, I understand that, but occupational exposure usually is going to be in the form of vapor or it's going to be your hands are in it, but you're not going to be drinking it as an employee. We were drinking it. Our children drank it. Our wives who were pregnant drank it.

Like Jerry says, if you went on base there's a real good possibility if you drank at the water fountain, you're in your first trimester, you were exposed. I mean, the whole base is listed in this study. There's not an area that's not and that's the real sadness of it, I think.

MR. ENSMINGER: Well, look at ATSDR's public health assessment, their exposure data for that assessment which, thank God, has been pulled. They had us using two liters of water in a day. My god, I

couldn’t wash my feet with two liters of water each day.

But I mean, nobody took under consideration the fact that you got up in the morning. You PT’d. If you went back to the barracks if you didn’t take a shower after PT you were a crud. Somebody’s going to end up giving you a GI shower. You took a shower. You went to work. Whatever your job was you worked around this crap all day, in the water, you were drinking water. It was, if you were on squad tactics in the regimental area in the rear or whether you were out in the field. You were still drinking a lot of water. I mean, that place is a hundred degrees down there. And the exposures you got during the day if you had your work whether it was in a shop or an office or whatever. Look at the cooks. They worked in a gas chamber.

MR. BYRON: This is Jeff again. Then the other thing that concerns me is confounders. You brought it up with veterans. Well, as a father and as a parent, yeah, I smoke. Where does the confounder end when it’s my children who are sick and not me? I know I’m asking hypotheticals, but to me, this confounder thing, sure, it plays a big part if you have lung cancer, and you’re the smoker. But if

your kid comes down with a cancer, they're not the smoker. But yet all these studies will, all those confounders to a degree --

DR. WALTERS: There's confounders in every study.

MR. BYRON: -- to everything. I agree. I just want to bring that up. My children didn't smoke and drink.

MR. ENSMINGER: Not to mention that the government provided you cigarettes in your C rations.

MR. STALLARD: We're not providing lunch though, but we're getting ready to break for it. So wrapping up and breaking for lunch here in just a moment --

Tom, are you ready to break for lunch because we are anyway.

I'd like to thank Brad and Dr. Walters. It's real important that you all are here and it really makes a big difference in the CAP, and so we greatly appreciate your participation.

So I do have a short announcement. Frank and I have been talking about the fact that there's not really a lot of published literature on the operation and design of a CAP, and we're interested in exploring sort of that idea of maybe writing an article on how this CAP operates, its structure and stuff like that. So if you'd like to join in,

participate in this discussion with us over lunch, that'd be great.

We're breaking now and we'll resume our video streaming at one o'clock.

(Whereupon, the meeting adjourned for lunch from noon till 1:05 p.m.)

MR. STALLARD: We got a little bit off the agenda this morning, but I think it was a good use of time with our VA representatives. So we're going to pick up now and we're going to move into Frank and Perri giving us an update on the studies, the mortality and health survey and any other studies.

Ready for that?

UPDATES ON STUDIES: MORTALITY STUDY, HEALTH SURVEY

MS. RUCKART: Well, I just want to start off with the mortality study just to let you know the progress since our last meeting. The contractor, Westat, is continuing to work with the Social Security Administration to identify the vital status of the Marines and civilian employees in the DMDC database.

Results of the search we categorized into four categories. There's a match between the two databases, the subject is alive. There's a match, the person is deceased. There's a match and a

status unknown whether they're alive or deceased and there's no match.

So an initial review of the results showed an unexpected large number of those in the DMDC database with unknown status in the Social Security Administration database, about 60,000. So that's a lot larger than what we would expect. They would expect just a couple thousand. So that's significantly larger.

And in addition an unusually high number whose status is unknown had social security numbers that were issued in Texas. So that's kind of an odd finding.

So why we're concerned about the high number of subjects whose vital status is unknown is that in addition to those who we know are deceased that we're going to send to the NDI to obtain their cause of death, the contractor is planning to send all those with unknown status to the NDI. Not to mention we thought that would be a couple thousand.

There's a cost involved here. So since there's 60-some thousand that greatly increases the cost. It's very, very expensive to do that. So to reduce the number whose vital status is unknown, the contractor is going to send a sample of the unknowns

to a locator firm to see if their vital status can be determined.

That would be one of these firms that does tracing of people and see if they can find some sort of record that they've paid some tax recently or they're in some kind of payroll data. Something or not to prove if they're alive or dead just to get them out of that unknown category to definitively say they're alive or dead.

Also, the Social Security Administration agreed to review a sample of the unknowns to see if more information can be found. And I just found out yesterday they did that, but I don't think they've got any more information. So we really are relying on the results of the locator firm to help with that.

And the contractor's also going to explore getting the next-of-kin information on those who are deceased from the locator firm that this will be most useful for the health survey.

Do you have anything?

DR. BOVE: Well, a couple things, the 60,000 is because, actually they have, if they look at one of the Social Security Administration databases, these people apparently are dead from one database. But

if they try an exact match on the entire social security number, the person's full name and date, that's when they start having problems.

If they allow for some errors in the name spelling, I think that that itself will whittle down the 60,000. So saying that 60,000 are unknown is a first cut. I expect it to come down on the second cut. I also expect it to come down with this locator's firm search.

Although that's important to do, we're still relying on the Social Security Administration's databases because that is the, first of all, the appropriate way to go. It's what mortality studies do. And it's likely that we'll be able to solve the problem. But going to a locator firm as well is good because that'll confirm what we think is that there are just these slight problems with the spelling of the names and we'll be able to clear up most of these unknowns that way.

Also, we have to go to a locator firm anyway for the survey. So I guess it's a segue. But there was a question about, that Mike raised earlier that I want to discuss maybe after we go through the survey.

MS. RUCKART: So as for the health survey we did

receive OMB approval on November 22nd so that's a milestone there, and we're working with the contractor to finalize all of the materials for the mailings, just final formatting and we're going to be working with that.

We're working with the Marine Corps to be able to use a Marine Corps watermark logo on the survey mailing envelope to encourage participants to actually open the envelope instead of throwing it out as junk mail. We've also set December 15th as the deadline, they're aware of this, in terms of can we use one, which one can we use and getting that determined.

MR. PARTAIN: Just to interject here on your comment about the throwing out. One of my concerns, and I brought this up kind of earlier, this informational booklet is being distributed to the registrants on the Marine Corps' registration for Camp Lejeune. In it here's a quote out of there.

(Reading) The 2009 NRC report concluded that adverse effects were unlikely but could not be ruled out completely and additional health studies are unlikely to provide more definitive results. This is going out to everybody on the Marine Corps' registry.

Now let me ask you, with epidemiological studies, if your study group is getting literature saying, well, there's no conclusive proof. Any further study is going to be inconclusive or unlikely to produce results. Why would they want to participate in your health study?

MS. RUCKART: Well, I mean, we can't control what has happened in the past or change that.

MR. PARTAIN: No, this is ongoing and my point is with this I think, and going back to Dr. Portier's letter of October of this year, the Marine Corps has access to these people, and the purpose of the registry is to keep people informed and also provide a database for you guys to do your work.

I think there should be a request from ATSDR in writing to the Marine Corps to disseminate Dr. Portier's letter to every member on registration because his letter contradicts this booklet.

And the Marine Corps, Captain Miller back there, Mary Ann, y'all need to stop distributing this. This was addressed in the hearing.

MS. RUCKART: Well, let me tell you, I mean, as you know the Marine Corps is committed to exploring if they're going to sign a pre-notice and the survey invitation letter so hopefully that would allay some

of your concerns because that would be a formal statement of them saying we do want you to participate in this survey.

MR. PARTAIN: Well, once again the literature that's going out and saying science is not going to give you an answer. So I'm sitting here, Joe Marine, with my family. I get a health survey after getting this nice little booklet the Marine Corps all over it from Headquarters Marine Corps saying that science is basically going to be useless. Why would I want to take the time to fill out the survey? It's a de-motivator for the survey.

And as a CAP member I think we should move to ask ATSDR to send an official letter to the Marine Corps to disseminate Dr. Portier's letter. And if they choose not to do it, then we'll take it up in Congress.

DR. BOVE: I do think that's a good idea.

MS. RUCKART: And so we're also working with the Marine Corps to decide how we're going to reference the survey in all the mailings, the URL for the website and the caller ID, for example, the ATSDR-USMC Health Survey. That would be what the official title is. That would show up on the caller ID and guess hopefully in making reminder phone calls and

the URL.

As mentioned we're waiting to get the signed pre-notice of the survey and the invitation letters from the Marine Corps. They have expressed, the Marine Corps has expressed, some interest in possibly wanting their leadership to also sign the thank you and reminder postcard and the second survey mailing letter again. All of this will be fully fleshed out by December 15th.

We're planning to mail out the surveys starting in March 2011. The mailings will occur in waves from March through July so that responses can be more easily managed by the contractor. If they sent out 300,000, it would be very hard for them to track and make sure they weren't sending out a second survey before they were able to process that a first one had been received. So they're going to occur in waves so they can properly manage that.

We're working with a contractor to set up the first expert panel meeting that's scheduled for January 10th. Just to remind everybody, the expert panel will develop criteria for evaluating the quality and validity of the survey information including criteria to address participation rate, statistical power. And they will later on meet to

evaluate if the survey has successfully met these criteria and make recommendations to the Agency concerning whether to proceed with confirming the self-reported diseases.

MR. ENSMINGER: Who's on this expert panel? Where are they meeting?

MS. RUCKART: Well, the meeting's going to be here in Atlanta, in our building, January 10th. The Navy and Marine Corps nominated Doug Myers from Duke. He's a DOD representative. Tom Mangione was recommended by Dick Clapp so I believe he is your representative.

And then Westat put forth two panel members to us that are very acceptable to us, Jolene Smyth. She actually worked under Dillman, who -- and that's the method that we're using for sending out the surveys for the repeat mailing. And Elizabeth Delzell , she is an epidemiologist who worked with us previously in our 2008 panel to talk about the health survey and mortality studies. She's at UAB.

MR. ENSMINGER: I'd like to get their name.

MS. RUCKART: Elizabeth Delzell, Jolene Smyth and Doug Myers and Tom Mangione.

MR. ENSMINGER: I'd like to be at that meeting.

DR. BOVE: We'd have to discuss that with, yeah.

The purpose of the meeting is to come up with criteria for what might be considered a successful survey. I think the idea was that somewhere out there there were hard and fast criteria for when the survey participation rate was acceptable or a certain statistical power was acceptable or whatever. And so the idea was to have this expert panel come up with whatever criteria that we would then apply as the results came in as we saw how the participation was occurring.

So it's an expert panel. You have a representative. We'll have to see. This was a panel that was recommended by --

MR. STALLARD: Hey, Tom, can you put your phone on mute, please?

DR. BOVE: -- well, to make a long story short, we'll bring it up.

MS. RUCKART: One thing I do want to mention though is that Ray is going to be there. He's going to produce summary minutes, not as detailed as we have today, but summary, detail but not to this level of who exactly said what verbatim, but summary minutes of what was said. And so definitely those can be shared, but we can bring this other issue back to our management and discuss that.

Also as a reminder then once the panel gives us their recommendations, the Agency will consider those as well as the results of the survey and by results of the survey I mean the participation rate, the power calculations, issues of selection bias and make the decision about obtaining medical records to confirm the self-reported diseases. And if we do decide to move forward with the medical records confirmation, that will only be sought for those survey participants who were included in the morbidity study. So just to remind you that the overall effort is the health survey. We're sending out the health surveys to those in the DMDC database who were identified as being on base from 1975 and slightly earlier than that for disability --

MR. STALLARD: Can you hold on?

Hey Tom, can you hear those of us in the room speaking?

(no response)

MR. STALLARD: Tom. Thank you for putting your phone on mute. Thank you.

MS. BRIDGES (by Telephone): I was just trying to call him but he doesn't answer.

MR. ENSMINGER: No, he's on the phone.

MS. BRIDGES (by Telephone): Well, I have his cell

phone number but it won't answer either.

MR. STALLARD: Well, thanks for trying.

MS. RUCKART: So just reminding everybody that the health survey kind of has these two parts. The larger effort is the health survey that will be mailed to everyone who registered with the Marine Corps as well as those who we've identified from the DMDC database as having been stationed or employed at Lejeune from '75 for the active duty, about '72 for the civilian employees. We're also mailing surveys out to those from our 1999-to-2002 ATSDR survey.

But as far as the morbidity study that's where we're going with the unbiased sample so that would be the DMDC database cohort and the 1999-2002 ATSDR survey cohort. So if we do decide to confirm the self-reported diseases we'll be focusing on those groups only.

So the registrants only people who are identified solely because they registered with the Marine Corps will not receive the medical records confirmation, and they're only going to get a pre-notice letter and one mailing of the survey. They're not going to get any of the full Dillman method of the repeated mailings because they're a

potential bias sample.

We still have a lot of people, a lot of numbers, a lot of power to work with in just the DMDC database and the previous ATSDR telephone survey.

MS. SIMMONS: This is Mary Ann. I have a question. Were you guys planning on how you're going to distribute the survey through March, through July? Is that what you said? Do you ever worry about people who like say Jeff got his survey in March and then say I was on the list and I didn't get mine until like months later, people calling and being upset like where's my survey?

MS. RUCKART: You know that's a possibility.

MS. SIMMONS: I would think that once you got, I mean aren't you sending out two pre-notices? Is that right?

MS. RUCKART: No, there's one pre-notice letter, but let's say if Jeff was going to get his in March. He would get his pre-notice letter in March. His clock would start ticking, and then everything would happen from the date he has his pre-notice letter. If you were scheduled to get yours in May, you would get your pre-notice letter in May. You wouldn't get it in March.

MS. SIMMONS: So you're not sending out the whole --
MS. RUCKART: Yeah, in waves --
DR. BOVE: It's because it's so large that the contractor just felt it would be more efficient and they could handle it better if they did it in waves.
MS. SIMMONS: Well, they just put it all in a box. They don't have to look at it all at once.
MS. RUCKART: Well, no, because they would have to process it to determine do you need the second survey. So they don't want to be sending you out a second survey if you've already completed the first survey, and they need to go through the whole process to check it and put it into their system.

So in terms of your question that is true, but if you know each other, and you're in the third wave and you're in the first wave, you may let her know, hey, I got mine. You should be getting yours. Then two months go by and you haven't gotten yours, that's a possibility.

The health survey will have its own special help line that Westat will be staffing and they'll be able to address that, let you know, unfortunately, we have to do waves because of the large number. And they could probably tell you if you're on the list to receive one. So we will be

able to address that.

MR. BYRON: So this is Jeff. I guess you know for members of the CAP we have a website. We can list the, you know, it's going to be sent out in groups, but what we need to know is if you haven't received one by this date then it hasn't been sent to you, and you need to contact someone right away. I mean, that's important.

I think the Marine Corps should also put on its website that it's going to come out. The survey groups and ATSDR also so as long as they're looking at one of the three websites, hopefully they'll understand that, okay, Jeff might have got his but mine will be here in July or by July. And if it's not, then I know I need to call someone.

MR. PARTAIN: Let me clarify, Jeff. What the Marine Corps does put on the website preferably would not be in the lower, right-hand corner at the very bottom. On the front page of the website so people can see it.

MS. SIMMONS: When you send these out in waves, are you doing it like alphabetically, like A-B-C go?

MS. RUCKART: I'm not sure how they've determined their waves. We can ask but I'm sure it probably was random.

DR. BOVE: Likely not the alphabet. Likely some kind of random process. They haven't discussed that with us and there's still some details that we need to work out with them. Remember, this is a long process. You get this pre-notice letter. Then you get the mailing. You don't respond, you get a postcard.

Even if you do respond you get a postcard anyway, a reminder or a thank you. And then if you haven't responded you get a second mailing, you get another postcard, and then there's the telephone reminder. So there's several sequences that take probably almost six weeks, three months.

MS. RUCKART: About ten weeks.

DR. BOVE: So that whole wave and then the second wave the same thing, six-to-ten full week process. So that's the Dillman method of repeated contacts to get you to participate.

So is that all clear to you though about the difference between -– because I think we've been over this before, but I want to make sure that it's crystal clear –- that we have those that we identified a priori, beforehand, of the DMDC data and from our survey. So that is the study population. That's the population that we're going

to use the Dillman method with. If we decide to continue with the study, those are the people we'll confirm the diagnosis.

Then there's another group over here that, as Perri said, would just come to us from the registration. Remember, how did people get registered in the first place or even know about the registry? A lot of those people were contacted using DMDC data and our survey so some of the same people are in both. So that's fine. As long as they're in here, as long as they're in this study group, they get the full treatment.

But those people who just heard from media or some other pathway, that we can't handle because it gets into biased samples. So when we send them a survey, we're going to have to keep them separate from the study population just to maintain the validity of the study. So that's the situation.

We also want our contractor to put all their effort on these people because this is the valid study.

MR. PARTAIN: Frank, when you're talking about the ones from DMDC, we'd mentioned before that the in utero population was going to be included in the health survey, correct?

DR. BOVE: The 1999-2002 survey, and it segues into your point earlier so let's go over what's in that survey. In that survey there's some 12,500 births plus 12,500 parents. So multiplied by three you have something like 39,000. So that's what this database has. That's part of the study population. So the parents of the child are part of the study population.

What we collected during the survey was we collected a name, date of birth. We asked the parents, to some extent we've looked at women who lived on base and how long they were on base, but that data is not great. We also asked if the child had a birth defect, of course that was the whole purpose of the survey, had a birth defect or childhood cancer, a cancer diagnosed before the age of 20. And then we ask if the child has died.

So if the child was born sometime before '86 and we asked in 1999-2002 if the child was still living. At the time the survey was done, which again was 1999-2002, 332 children had died. And I looked up during one of the breaks just to get a handle on how many died and see what else we could get just from the survey. And so out of the 332 deaths, there were 21 cancers that were reported.

And of those 21 cancers, 12 were leukemia and non-Hodgkins lymphoma.

MS. RUCKART: (Inaudible).

DR. BOVE: No, some are and some aren't. I didn't go that far. So we have 21 cancers on those who died that were reported by the parents. Nine of them are something other than leukemia or non-Hodgkin's lymphoma, so that's what we have.

I also found out the dates. We have year of death for each one of them except for two. And about 43 percent died before '79. 'Seventy-nine is important because 1979 is when the National Death Index starts. That's going to be the way we determine cause of death.

Some studies, some mortality studies actually use the NDI for everything to find out who died, period. That's expensive so we didn't do that. We're going to Social Security to find out if they have died or not. And then sending those who died or those we're not sure about to the National Death Index.

So from 1979 onward we can get information on cause of death. Before '79 we can't get it from the NDI. The only way to get death information for those before '79 is to go to the state and get the

death certificate.

We have a situation with the mortality study. By the way, the mortality study was always started as an adult mortality study. It was answering a different question. We were hammered rightfully, correctly, that we hadn't looked at adults, and the mortality study was an effort to do that.

And we looked at what kind of data we needed to do, a mortality study where we could follow people over time and be pretty confident that we could do that. And the way we could do that is to have a social security number on these people, that name and date of birth although useful are not sufficient. You really do need social security numbers. And even with name, date of birth and social security number, we're still having unknown problems. But we would be lost without the social security number.

So that's why the mortality study, very clean, has social security numbers of everybody identified. Most people we have names. A lot of studies we don't have names for some ridiculous reason I'll never understand. They didn't collect the full name for civilians until late in the day, late in the, it was sometime in the '80s, early '80s. But we do

have their social security number and date of birth and that should be sufficient, we hope, for this study. What we're trying to do is follow everybody and capture all the deaths.

So we can't do that for the dependents because all we have from the survey is the name and date of birth. So we can't follow these people over time. The only way we can, now, we can use the locating firm's information and hopefully that will tell us whether they died or not. If they died, we can get next-of-kin information. And we can do all this through the health survey mechanism.

MR. PARTAIN: Now when you say health survey, you indicated there were basically two branches on the health survey. You got the group, the DMDC group that's going to get the full-blown survey --

DR. BOVE: And, and the survey, too.

MS. RUCKART: The previous survey.

MR. PARTAIN: The previous survey.

DR. BOVE: We did that because we wanted to have dependents covered in one of these two studies, and that was the only study that made sense to us.

MR. PARTAIN: So then the in utero population's going to be included in that group.

DR. BOVE: In the health survey, the full blown.

MR. PARTAIN: The full-blown health study.

MS. RUCKART: The morbidity, the morbidity --

DR. BOVE: All right. Let's put it this way --

MR. PARTAIN: The reason why I'm concerned is like the in utero study is only addressing the kids up until age 19 and we don't know what happens to the kids after 19, for example, me. I'm 39 with breast cancer. So we need to make sure we're capturing that data.

DR. BOVE: Then you wouldn't be in the mortality study, yeah.

MR. PARTAIN: Yeah, I'm not dead, knock on wood.

DR. BOVE: And that was the other issue is that, you know, how many deaths will occur in the younger population. So that was yet another concern. We were concerned about the adult population being pretty young. They're all younger than me, most of them. So that we were concerned about how many deaths you have there. The good news is that not many will die. The bad news is that we have such a large population that we'll still have large numbers of deaths.

I've been thinking about what can we do, if we were concerned about deaths among the in utero population, what would be the best way to handle it

especially since you raised it this morning. I was trying to think if the health survey was the only approach and whether it made sense to even think about other approaches.

And I'm not sure because, as I said, the survey can't tell me anything. It tells me there's 300-some cases died; probably a lot of them died because they may have been pre-term or small for gestational age, and they died of that basically or they may have died from other causes. But the survey won't tell me. All the survey will tell me is how many died of cancer. I just told you there were 20-something.

MS. RUCKART: The previous.

DR. BOVE: Yeah, the previous survey. So I think the way we're handling the dependents is probably the best thing we can do for now. And we can revisit it once we see what the results are of the health survey and the morbidity study.

MR. BYRON: This is Jeff. And you even said as far as in the health survey you're going to ask questions about other family members where they can list what other illnesses or --

MS. RUCKART: No, no, the health survey you'll be answering just for yourself or if you're getting it

as next-of-kin for a deceased family member you'll be answering just for that specific individual. There will be a question, we're asking about several specific conditions.

I think what you're talking about is we do have a question where they can report another disease that was not specifically asked about but for yourself or the person who was the subject of the health survey. Each family member would need to fill out their own survey on their own behalf.

DR. BOVE: The list of conditions we're asking about, actually I think the NRC had published it in the report. I think they listed them somewhere. If they didn't, they're on the feasibility assessment that we have up on our website that went through the cancers and other diseases we thought there was some evidence of a link.

MR. BYRON: They listed like 13 or something.

DR. BOVE: They had a pretty long list actually. We're going to be asking about all these diseases. But as Perri said, we'll leave it open for diseases we didn't, because we didn't think of it or there hasn't been any studies done of certain illnesses some people might have so we wanted to leave it open so the people could report it.

MS. RUCKART: However, just to address your question though about diseases in others, for women who were pregnant, they will be able to report about the pregnancy. So otherwise this really just really is you and your diseases. Your family members would have their own separate survey.

MR. ENSMINGER: We have a question in the audience.

MR. STALLARD: We have a question from the audience.

MS. BLAKELY: I'm Mary Blakely. I was wondering if neurological effects would be included as part of your conditions and would that also include people that have like a mental disability that wouldn't be able to do a survey on their own?

Like my sister, she's illiterate. She can't read and write. Her granddaughter has to read. She lives in Ohio. She lives far away from us. She would not be able to do it.

MS. RUCKART: Yes, there is a place on the survey for someone to indicate that they're filling it out on behalf of some incapacitated family member. And then they would indicate their name and their relationship to the subject, you know, the person of interest to us. And then they would fill it out on behalf of the person who the survey was addressed to.

MS. BLAKELY: And also what about giving notice to all the people that have some sort of mental disability that the survey's coming out in a way that they can understand? Because she doesn't read, so she doesn't read magazines, and she just has limited skills as far as her ability to understand things.

MS. RUCKART: Well, you know, everyone's getting the pre-notice letter. Does she have someone who's opening her mail?

MS. BLAKELY: No, no. I'm the person who told her about this and got her registered with the Marine Corps, and I had to help her with that step-by-step so everything –- and I live in a different state than her. She lives in Ohio. I live in North Carolina.

MR. BYRON: What part of Ohio?

MS. BLAKELY: Cincinnati.

MR. BYRON: I live in Cincinnati so you just give me her contact information, have her let us know, or you let me know when a survey comes in, and we'll help her out.

MS. BLAKELY: Thank you. But what about all the other people that don't have somebody?

MR. STALLARD: More broadly the question is for

those who are unable or don't read, how do we reach them? So thank you for bringing that up for the CAP to consider.

Is that it on the studies? Any other questions?

DR. BOVE: Mike, did you have any other questions or issues that you wanted to raise about what you raised this morning?

MR. PARTAIN: About the children mortality?

DR. BOVE: Yes.

MR. PARTAIN: I'm still very concerned that the, we're leaving out a big picture in not identifying the mortality of the children born at Camp Lejeune. I mean, because that's one of the big gaps that science has is what type of effect did these chemicals have on the in utero population. So a lot of the science out there is looking adult exposures. We don't know what it does to children and we need to answer that question.

I understand the concerns about not having social security numbers, but we should try to find some way around that. When you explain this, some would work around, but that the deaths for the children are up to, recorded up to about 2000, 2001 when the survey's complete, correct? So any deaths

that occurred in the past ten years for all intents and purposes --

DR. BOVE: Obviously weren't in the 1999-2002 survey, but again what we have to do is send all these names and information to a locator to get current address. I'm talking about the health survey now. So that would include the dependents in that 1999-2002 survey. So when that goes out we're hoping that the locator firm has enough information to tell us that the child, now adult, died. And if they died and we get the year of death, then we could, depending on how many there are, we could go to the NDI with those.

We haven't thought about that. We've been talking all along about confirming diagnoses. If the expert panel, it sets the criteria, and the Agency feels that it's met that criteria, then we would confirm self-reported diagnoses with medical records.

I'm thinking about those who died. We get the next-of-kin information, but the next-of-kin doesn't participate so they're not part of the health survey. But we still have information on date of death for that person. It might be worthwhile for us to go to NDI. It really depends on how many

there are.

So it would first depend on how the participation is in general for the survey because we won't even move to the second part of the survey unless the participation rate is deemed high enough. I don't know what that high enough, I don't know what that bar is. Apparently there is no such bar, but we'll come up with one. That's what this expert panel, I guess, is going to come up with, but there is no bar.

But suppose the Agency decides to continue and do the second part of the study which is confirming diagnoses. Of course, we would try to confirm any of the diagnoses of those who participated in the survey including next-of-kin. For those who haven't, from those people we wouldn't even know if they had a health problem except for the people who died if we got that information from the locator.

I haven't thought about exactly what to do about that and so I'll try to... Again, I don't know how many there will be. If it's a small number, it won't make any difference. If there's a large number, then we'll have to think about that because you may be right. There may be something going on here that we can capture.

So really there's a lot of factors in other words here. I'm sort of thinking as I'm talking here trying to think of the best strategy here. So I'd have to say we have to wait and see, first of all, if we're going to go to part two with this study and actually confirm diagnoses. That's the first issue but assuming that things go well with the survey.

And there's the second issue of with those deaths where the next-of-kin didn't participate, what do we do about them. Because the people who do participate we're going to try to get confirmation. The people who don't participate obviously we wouldn't know anything about them anyway except if they died. So I have to think about that.

MR. PARTAIN: Just for future --

DR. BOVE: I don't know if I'm confusing you or not.

MR. PARTAIN: Oh, no, like I said, the most vulnerable population at Camp Lejeune that was exposed --

DR. BOVE: I agree with you.

MR. PARTAIN: -- it's something to consider for future, I'm sure there's going to be other contamination sites, what have you, to come up and something as simple as getting a social security

number when you did the original survey --

DR. BOVE: We did. We got the social security number. Remember now, we had the social security number for the respondent, for most of the respondents, two-thirds of them. The respondent could have been the mother, could have been the father or could have been some other relative. That's only the person we got the social security number for.

MR. PARTAIN: Well, if you do have that then, if you do have a social security number for somebody in the household for the in utero population. I mean, maybe you can take a tailored letter outside the survey, but you have somebody you can contact that has a direct relation to the person that we're looking at.

DR. BOVE: Well, the health survey's going to ask for the social security number. We'll get the social security number then. They have to participate though.

MR. STALLARD: So did I capture that up here? That is the NDI and the non-participants of next-of-kin, capture it?

DR. BOVE: Yeah, because those who died before '79, well again, if the next-of-kin participates, we

would try to confirm it whatever diagnosis was reported to us. If it's the cause of death, it's reported, so we would try to confirm that, too. The way to do that would be to get death certificates.

So NDI's not the issue so much as the issue is for those who don't participate, the next-of-kin doesn't participate. Obviously, the child who died can't participate. But the next-of-kin, if they don't participate but we know that the child died at some point, as an adult let's say, what do we do with that? That's a different situation than anything else. So let me think about that.

But also again, it wouldn't be worth doing anything with it unless there were a sufficient number of who had died because otherwise it's not going to say much.

MS. RUCKART: One thing also is it may be difficult to locate the current contact information or even the vital status of those from the previous health survey, but we don't have social security numbers for them because their name might be sort of common or if they're people who got married since then, so that's a little bit tricky.

MR. BYRON: You're going to have that.

DR. BOVE: Yes, I think we'll be trying, you know,

think about this. I mean, we first, I mean, I went down to –- I forget the name of the base and I should know the name –- Fort Benning -– I'm blanking on the name –- Fort Benning to look at and see what school records there were. I really wanted to look at dependents, and those records were a mess. I mean, we couldn't read the tapes, and so we were out of luck there. The only dependent information we have is from that 1999-2002 survey. So we're using it, but we understand that we may have difficulty getting current addresses on a lot of these people.

MR. STALLARD: What about yearbooks?

MS. RUCKART: No, we explored that as well. I mean, before we went down to Fort Benning, we contacted Camp Lejeune and the alumni association and the person who's in charge of the school system. And they don't really have --

MR. BYRON: Deteriorated microfiche.

MR. STALLARD: We're in the age of FaceBook.

DR. BOVE: Not back then, no.

MR. STALLARD: Before we move on to the discussion of the web page, Morris has asked for a few moments of your time to clarify some issues.

So, Morris, come on back up if you would.

MR. PARTAIN: Frank, I wanted to ask one quick

question before Morris gets on, about the health survey. And I think I heard something about this in February, but granted that the VA is getting claims in from Camp Lejeune veterans and their reported health conditions and what have you, is there any information sharing going on between the VA and ATSDR for the purposes of your health survey? Because to me that's a gold-mine database there, and there should be some type of communication going back saying, hey, VA, we've got X-amount of claims here with these health conditions. Here they are and share them with you. What can be done with that? Because, I mean, that's --

MS. RUCKART: These people on the DMDC database ^ are people not in our database ^ leverage use that information to contact those people in the health survey. That's what you're saying?

MR. PARTAIN: For example, the veteran here in Orlando. He had bladder cancer, kidney cancer, was treating with VA. Thought it was Agent Orange, had no idea about Camp Lejeune until recently, and say, he never found, he didn't hear about it in the paper. He saw a local paper in Florida. Can that information be captured through a social security number because I'm sure his social's there.

MS. RUCKART: (Inaudible).

MR. PARTAIN: Yes, because sick people, sick vets are going to go treat at the VA.

MR. BYRON: Well, we know there's 200 of them that you could get names on.

MR. PARTAIN: And I did pose that to Brad before he left, but --

MS. RUCKART: In a sense that's biased because those people are only diseased people.

MR. BYRON: Yeah, but biased or not, they still should get a health survey. I mean, if they didn't register with the Marine Corps or you but they were at the VA, then I think they should still get a health survey if they're saying they were sick from Camp Lejeune. Then you've got to determine, like you said, verification.

MS. RUCKART: Well, one thing I'm thinking is, I mean, we could see when we have our meeting with the VA and talk about disclosing of the dialog and all that is to ask them to encourage people they see to register and then they get the survey because they register.

MR. PARTAIN: Yeah, but we all know how that works and how miscommunications can spread about and stuff. But if the database is there, and these

people that they track through social security numbers, that they treat through VA, I mean, the database is there. There should be some sharing going on between ATSDR and the VA. You need that data --

DR. BOVE: We need data from the VA in order to confirm diagnoses that are reported to us in the health survey. That's for sure. We work with the VA, we've already talked to the VA's cancer registry about that. We're going to work with the VA on that, but this is something different.

Again, I think our study population is fixed. This is it. We've identified the main priority. I think that we have to stick with that in order for it to be a valid study. I mean, there are trade-offs here, and the more you try to bring in people that are brought in for all kinds of different reasons, the more questionable the study is. So I want to make sure, we want to make sure we have a clean study population. We have plenty of numbers here. Now --

MR. PARTAIN: Okay, you're talking about the veterans between '75 and '85 when you're saying your study population.

DR. BOVE: And the 1992-2002 (sic) group.

MR. PARTAIN: Well then use the VA as a fail-safe on that study group. I mean, theoretically, if a veteran for some reason did register --

DR. BOVE: They don't have to register. These people are part of the study whether they registered or not. Now, you're bringing up another point so keep that in mind. These people are in the study. They don't have to register. A lot of them did register, but that doesn't, that makes no difference to us.

They're in the study because we identified them a priori, beforehand, using the DMDC and the 1999-2002 survey. They get into the study. We know nothing about their disease status. They're in this study because we've identified them before they had the disease basically. So that's why it's a clean group.

This other people, the registrars or anyone else coming in, we have no idea why they're coming in. We know why these are in. We chose them without knowing anything about their disease status.

MR. PARTAIN: You should be able to go back to the VA and check those people as a counterbalance or a check to your study. If you identified them, then go to the VA and say, hey, you have these social

security numbers of these people here treating on your system, and if so, what for? I mean, to me that's just, like I said, the point is the VA has a database for you guys to be able to --

DR. BOVE: We're going to get, they're going to report to us what their diseases are. You mean the people who don't participate?

MR. PARTAIN: Well, I'm saying the target group, the '75 and '85 Marines on the base. You're going to be going through and verifying conditions, health issues and what have you.

DR. BOVE: For those who participate.

MR. PARTAIN: For those who participate, right. But you're going to have their social security numbers there the target group that you know of.

DR. BOVE: Uh-huh.

MR. PARTAIN: You should be able to go to the VA and look for only those people that you targeted for study, and if they're in the VA system being treated for something, get that information for your study.

MS. RUCKART: And what we will be able to, if they sign the medical records release form giving us permission to access their records, and they list the VA as a treating center, a medical provider, a healthcare provider that treated them, then we'll go

to the VA and get the health records and be able to confirm what they reported. And also, if they didn't report something but the VA by researching their records shows they were treated for something else, we'll get that.

DR. BOVE: Well, you know, a lot of people did not get their care, most of the veterans did not get their care through the VA. So, I mean, we were talking about using the VA cancer registry, but that's why we're talking to 50 state cancer registries. Because that's not where we're going to get them, we're not going to get the information on cancers from the VA most likely for most of the people because they're not there. Just keep that in mind.

MR. FONTELLA: Jim Fontella. Are you saying, Frank, that because of the work situation, the Detroit VA is swamped because their people have no medical any more, and these military people are jamming into the VA getting treatment.

DR. BOVE: Okay, but that wasn't the case even a few years ago.

MR. FONTELLA: No, it just happened in the last couple years.

DR. BOVE: Yeah, 20-to-25 percent.

MR. FONTELLA: Yeah, there could be more.

DR. BOVE: That's fine. That's fine. I thought that the concern might have been for those people who don't participate. If they participate they will tell us what they have. We will go to wherever we need to go to confirm them, whether it's the VA or the state cancer registry or the doctor that treated them. So confirmation is a big job, but that's what we plan to do.

MR. STALLARD: Does that address your concern?

MR. FONTELLA: Okay.

MR. BYRON: I have one more. How about the cohort from Pendleton? Is everything going smooth there?

DR. BOVE: We're doing the same thing for the Pendleton group. In the mortality study we're using them all because you can do that in a mortality study. In the health survey we're taking a sample of 50,000 of the active duty and 10,000, of all the civilians there was only 10,000 roughly.

MS. RUCKART: And then all the females.

DR. BOVE: I was going to get to that. But Westat asked us how do you want to sample. Do you still want to do a random sample? I said no, get all the females included because there's small numbers on both sides, Pendleton and Lejeune, so we might as

well get them all and then take a random sample of the males so that's how it will be done from Pendleton. So it'll be 50,000, all the women and a random sample of the males to make that 50,000.

MR. STALLARD: All right. Morris is not standing at the microphone. He's sitting here waiting to give us an update.

MR. PARTAIN: Sorry, Morris.

WATER MODELING UPDATE (CONT'D)

MR. MASLIA: That's okay.

Just a couple of points, one, somewhere during my presentation this morning we discussed CLW document 1406 in reference to sampling that took place during January 1986. In re-reviewing that document again and getting clarification on some acronyms used in there, basically it's our determination that that sampling analysis was done by the Navy itself. N Read is the Natural Resource Environment ^ base maintenance office together the samples were taken.

So what I have done is officially sent an e-mail to Admiral Rodenbeck, who's ATSDR's point of contact for the Data Mining and Data Discovery Technical Workgroup, asking the Data Mining group to basically give us any and all sampling information

for January 1986. And I attached that CLW document as a reference.

MR. PARTAIN: If I'm not mistaken we've at that time -- and correct me if I'm wrong, Jerry -- I think the base had obtained equipment to do their own sampling through Betz.

MR. ENSMINGER: That was later on.

MR. PARTAIN: That was later on?

MR. ENSMINGER: That was addressed in that letter.

MR. MASLIA: May very well be. Anyway, we have requested that. If such samples exist that would be great for calibration purposes since we have none.

MR. BYRON: Also the USMC was doing samples for --

MR. MASLIA: Well again, we've looked at the external, I say external documents, you know, contractor and such. So anyway, just wanted to let you know that I have made that request for the, that's an activity definitely for the data mining group to undertake before they phase out or close out or whatever, and do that.

Secondly, on the issue of the FOIA review, UST file DVDs -- I know, Jerry, you asked me for a set -- we have now gone through four machines, and I have pulled one modeler off the job and we only have two of them done. We cannot duplicate them. We use

them live on the LAN and all I can tell you is you really need to, or the CAP needs to I guess go through the Department of Navy and, you know, I don't know what the legal issues or answers to that is.

But at this point, these DVDs will be in Chapter D and we will figure out a way, whether we have to bring on a contractor to compress them or whatever to do that, professionally stamp them out. But I've got two here, but as I said, we've gone through four machines and they keep corrupting.

So I've got two good ones here. A third one's burning, but it's just really a use of resources that we cannot continue to do. And it's not that we don't want to comply with your request or help you out with that.

MR. ENSMINGER: The problem I had with the first set was that the second ^.

MR. MASLIA: Okay, well, again, it could be any number of issues. A lot of the file names, and some of them appear I know on DVD number two, are not ISO 8.3 compatible. The names are 32-characters long, and that may be part of the issue. So here's two. I'll give you two. We're working on a third one. If you're still here, I don't know what time y'all

are finishing up, it's verifying it right now and we'll give you that set. But I really would ask you to understand the limited resources we have.

MR. BYRON: Also, we can get our own guys to copy these things.

MR. PARTAIN: I had the same problems. We've got a working thing on the computer. What we have to do is use zip drives to get back and forth. We're having the same problems with this. I've got an actual one-disk set that works, but trying to duplicate that set is almost next to impossible. You have to load it on a computer.

MR. BYRON: But is that you trying to duplicate it?

MR. PARTAIN: I've tried it. I've asked other people to try it.

MR. BYRON: ^ that does that for a living?

MR. PARTAIN: I mean, it's me trying it and people that are my friends. It comes down to money.

DR. BOVE: But correct me if I'm wrong, but Chapter D will have it, with these DVDs, they'll have a search, a proper search capability.

MR. MASLIA: What Chapter D will have, like Chapter C, we used proprietary software on the Chapter C DVD. That's out in Chapter A for Tarawa Terrace, to compress the files, to take all the white space out.

And that's why if you search the Chapter A DVDs, they search much faster than even doing a live search of just a plain Jane PDFs on your computer because you're searching white space, plain Adobe white space. So we will probably go to again some proprietary software which you pay by the page to compress these files, the FOIA review files that will be released.

But at this point in time we're not there and for us to spend any more effort and resources. I cannot tell you how precious the resources are. It takes away really from modeling and model input and things like that so that's where we stand with that. Again, if you have a question about a certain file or stuff and a reason why --

MR. PARTAIN: Well, another idea, why don't you just, ATSDR write Scott Williams to see if they can provide, the Navy provide a hundred disks to --

MR. MASLIA: We did and the answer was to file a FOIA request.

MR. PARTAIN: So much for the health-safety welfare concern for the Marines.

MR. MASLIA: That was the answer.

MR. ENSMINGER: Thank you, Morris.

MR. STALLARD: That was fast action from his

presentation this morning to clarifying that.

MR. PARTAIN: Thank you, Morris, for checking up on those samples.

DISCUSSION OF CAP MEMBERS' CONCERNS ABOUT ATSDR CAMP LEJEUNE WEBSITE

MR. STALLARD: What's the topic about the website?

MS. RUCKART: Well, you know, some of the CAP members expressed interest in wanting to discuss the website, and then I sent an e-mail asking for clarification about what specific issues you all wanted to discuss so we could have a focused discussion, and I didn't get a response. Do y'all still want to discuss our website?

Jerry?

MR. ENSMINGER: What?

MS. RUCKART: Did y'all still want to discuss the ATSDR website?

MR. ENSMINGER: No.

MR. STALLARD: Do you have anything about the, we moved on in the agenda to the website discussions. What are the issues? What are the issues?

MR. ENSMINGER: Well, I mean, you really have to search around on that website to find the stuff. You know, the water modeling's getting so big that it's difficult to track. And then a lot of stuff

that's been, it's basically hidden under some other link in there. I mean, it's really difficult to follow. I mean, I know how to get in there and ferret the stuff out. But people that are going to the ATSDR website for the first time...

MS. RUCKART: Christian is here.

Christian, do you want to...

MR. STALLARD: If you'd like to, you can say no.

MR. SCHEEL: Yeah, I'd rather get the feedback and then come back --

MR. BYRON: So we need to give you more feedback.

MR. SCHEEL: Yeah, I'd rather get the feedback and come back with a more considered answer than what I can do here.

MR. STALLARD: So it's a question of usability right now?

MR. PARTAIN: It's content and, if you type in Camp Lejeune ATSDR, then find it. But if you don't know ^ doing a Google search, give me something like that.

DR. BOVE: Give us your feedback and we'll get it down to Christian.

MS. RUCKART: Specific examples of things that you're having difficulties with because that's what Christian will need to be able to address your

issues.

MR. PARTAIN: I will do that. I mean, I wasn't paying attention to that prior to the beginning of this meeting this morning.

DR. BOVE: For example, trying to find, if you are interested in your levels of contamination you were exposed to at Tarawa Terrace, trying to get to that table is not easy, less easy before.

MR. PARTAIN: It's buried with time. It's not updated.

DR. BOVE: I'm not sure. There's some rules that we have to follow on the website. I'm not sure I know what those are, and so that's part of the problem. But anyway, that's just an example. If you have examples of difficulties where you think things need to be more easily accessible, just give them to us and we'll forward them.

MS. RUCKART: I would say this. I mean, typically when something is new we put that at the top. But if there are specific reports or subjects that you think should always be at the top because they're very key, then they can be still kept at the top.

And we just keep moving everything down like a chronological process. But if there's certain things that you always just want to be at the top

that you think are really important resources, we can consider that.

MR. SCHEEL: We would consider that.

MR. STALLARD: So let's get some, if there's anything else.

MR. BYRON: So maybe we put that on our website and ask if people are having problems and what problems they're having and get that back to you.

MR. PARTAIN: We can also link our website, too. Link the community websites up on the ATSDR page.

DR. BOVE: Do we have the link?

MR. PARTAIN: I've seen it there before. I don't know where they're at now. They're hard to find.

MS. RUCKART: It's on there, but it's under the community resources section.

MR. PARTAIN: Yeah, it's one of those hard-to-find things. It's there, but someone going through is not going to see it.

MR. STALLARD: So more to follow on that as we get your feedback then, right? This is updating what you said to have ATSDR officially request the --

MR. ENSMINGER: Distribution of Dr. Portier's letter to all their registrants.

MR. STALLARD: So I think we're closed out on the website discussion. So let's move now into the male

breast cancer discussion.

MALE BREAST CANCER OPTIONS

DR. BOVE: This has come up both internally and then, of course, because ^ what we should do about male breast cancer at this point. And I was asked by Dr. Falk several months ago to come up with some ideas, and I did. It wasn't really a formal presentation, but I had some ideas and I gave them to him.

Keep this, the same ideas are right here. I'm going to hand them out, but keep in mind at this point there have been a number of male breast cancers, quite a large number actually, identified. But we haven't done the other studies, the mortality study, the health survey.

There are other cancers that are probably likely to be in excess because they've been in excess in other studies, TCE or benzene or so on, such as non-Hodgkins lymphoma maybe or renal cancer. So the question is do we want to do anything about male breast cancer at this point or do we want to wait for some of the results of the other studies.

So that's why I put this together and so these are kinds of things that we could possibly do. We're not committed to anything at this point. And

this is basically just to start the discussion. So let me go through these possibilities.

And the first one is to treat it like we would treat, like a state agency actually treats a cluster investigation, or at least some state agencies. Some state agencies don't want to deal with clusters, but if they did want to deal with a cluster, how would they do it.

And the first thing they would try to do is get all the information they can from those cases, any information. First to confirm the case and then to get some information about socio-demographics of the case, the occupational history, any hobbies, anything that might be interesting about that case.

In this situation we want to know, of course, what their activities were at Camp Lejeune and any work activities as well, and any activities at Camp Lejeune. So that's the first thing is to get information from all the cases, confirm them, find out what might tie all those cases together besides the broad thing of Camp Lejeune. Is there some specific activities, specific areas of the base, specific times they were there where the contamination might have been higher or lower, anything. So that's one idea.

MR. PARTAIN: And by the way, Frank, when I talk to these guys as we find them, I find out, I ask what unit you were with, were you around the base, what type of job –- not everybody could remember everything -- so I did get a lot of that information in the spreadsheet that I have.

DR. BOVE: That's good. That's the kind of information that would be useful if we took this approach. I put a little, under A, sub-A, the difficulties of actually determining whether this is a, quote-unquote, real cluster or not. Because the problem is we only know what the denominator is. We don't know the population these cases came from, their age distribution and so on.

If it's just limited to those who were active duty, not dependents, just active duty people, we still don't have a good sense of the size of that population. Then if you throw in dependents on top of that we have no idea. So that's part of the problem. But it's not clear to me that that's necessary.

A lot of times cancer registries, state health agencies check to see if a cancer cluster's statistically significant. And even if it is, it doesn't necessarily mean that they can figure out

what caused it, and we've had several instances that we've found. Nevada's the classic example where the P-value, the statistical significance was off the charts. I mean, it was unbelievable. We still don't know why that cluster occurred.

So just knowing it's statistically significant or even a true cluster may not be as interesting or important as being able to tie the cases together or coming up with some kind of cause that might tie them all together. So I put that little sub-thing A there just to tell you that it's difficult to actually determine if it's a true cluster or not. That may not be necessary.

So the second possibility is to just look at the results of our two studies and that would be true of any cancer or any disease that came out of those two studies to explore further. We can explore that further depending on what the disease is. If it, for example, was lung cancer in the mortality study, then everyone would say, oh, it's due to smoking, we have smoking information. Of course, we can do some analysis to see how much smoking would have to occur to do ^ excess that will do that.

But if we wanted to get additional information

on those cases, we could do what they call a nested case control study. Take a case of lung cancer, take a random sample of other people and get more information on their smoking habits to rule that out. So there are options once we get the results of the two studies. So that's the second approach.

MR. PARTAIN: But, Frank, what about, I mean, like we've talked from the very beginning, male breast cancer is a rare disease, and if we look at the studies and what have you, there's going to be, I mean, there should be a low number. So at what point does a number mean, like you mentioned earlier, become statistically significant? I mean, are we at that point now with 66?

DR. BOVE: Well, that's the problem. I don't know what the denominator is.

MR. PARTAIN: Because doing the health survey we may identify a few more, but we're still in that same boat. It's a rare disease. It doesn't show up very often, but yet we've got a group here, but we can't determine what it means.

DR. BOVE: I've done an off-the-cuff, back-of-the-envelope evaluation based on very rough notions of how big the population was, and not really knowing about dependents at all. And you can come up with a

figure anywhere between 60 and 70. But you haven't ascertained them all anyway.

MR. PARTAIN: Yeah, that's just us poking around.

DR. BOVE: Again, I don't know. But the difficulty is we'll never be sure what the denominator is, and I'm saying that that may not be a useful exercise anyway. If we can relate the drinking water to the cases, that's what's important, not determining whether it's a true cluster. Because as I said, at Fallon it was definitely a cluster, but we have absolutely no idea what caused it so you're at a dead end. So proving that it's a cluster may not be the most important thing to do here. What is more important is being able to make a case that those cancers are related to the drinking water exposure.

MR. PARTAIN: I mean, because we've got constituents of the population as far as breast cancer that range from exposure zero to mid-30s, what have you, with the majority of them being over the age of 18 because it was by far the most population of Marines. But we've got children. We've got infant. We've got in utero. We've got children and the adults so we're all over the place.

DR. BOVE: You're all over the place, right. And that's why I'm saying I don't think we can ever

determine what, how many you have to have to be a true cluster. But again, I'm not so sure that the answer to that question is something we really are interested in. We're interested in can we link the drinking water to it.

That I think is the, a couple things, one, I think the mortality study we expect something like, we may expect about three cases. The mortality study's not a good way to look at male breast cancer. The survey will, I think, expect to see, and this could change, but something on the order of 11 cases. So you have a little bit more power. You don't have a lot of statistical power because, you're right, it's a rare cancer.

MR. PARTAIN: So in the survey you're expecting 11 cases?

DR. BOVE: Yeah, I think when I did this, yeah. Again, I had to make some assumptions so give or take, but that's how many I'd expect.

MR. PARTAIN: And you're talking about the survey, the veterans between '75 and '85. That's what you're referring to, right?

DR. BOVE: Let's see. Yeah. No, no, I tried to include everybody in this.

MR. BYRON: That's out of the 163,000 that

registered? You're saying no, and he's shaking yes for a second. Which is it?

DR. BOVE: I'm looking at my notes and what I did was I included, I assumed that the participation rate was 50 percent -- maybe high, maybe not –- and I included the survey people, too.

MS. RUCKART: The registrants you mean?

DR. BOVE: No, it's just the active duty, yeah. It's just the active duty. It's not the civilians, so out of the active duty portion, 11 cases. I'm sorry because I did this awhile ago and I'm trying to look at my notes.

MS. RUCKART: We sent out approximately 220,000 to active duty people and 50 percent of them --

DR. BOVE: It includes the 4,000 in the survey that aren't, you know.

MS. RUCKART: So about 220,000 active duty give or take that 50 percent of those participate in the survey, so like 110,000 active duty Marines participating.

DR. BOVE: I did that to get a sense of what the statistical power is for male breast cancer. It's not high, but it's much better than the mortality and the morbidity studies.

MR. PARTAIN: And when you mentioned the scratch pad

on the back of the envelope, you said 60 or so. What number are we using for that?

DR. BOVE: Let's do that calculation.

MR. PARTAIN: Sorry, I'm just throwing it out there. I just want to understand it.

MR. STALLARD: And Jim had a question.

MR. FONTELLA: See if I can find that.

DR. BOVE: Yeah, my best guess of how many males were potentially exposed in Lejeune between '55 and '85, I made a couple of assumptions. If there were 222,000 Marines at the base at any one time, bottom line, I assumed something like 600,000 males were potentially exposed. Males period, 600,000. Now it goes back to remember when I was saying to the media somewhere between 750,000 might have been at the base, and then I was criticized for making that statement. And then the Marine Corps actually tried to do a somewhat similar exercise and came up with roughly the same answer. But the problem with all these things is there's not data. What I simply did was there's --

MR. PARTAIN: You made a scientific guess, extrapolated.

DR. BOVE: This is how simple, I knew how many people were there from '75 to '85, right, and

multiplied by three. And to tell you the truth you could do that or you can do a little bit more elaborate exercise and come up with roughly the same answer. In other words --

MR. PARTAIN: So basically --

DR. BOVE: -- what that tells you is that we don't have information.

MR. PARTAIN: But when you mention a guess of 60 or so cases, you're basing that on 600,000 males exposed between '55 and '85.

DR. BOVE: Right.

MR. PARTAIN: Are you assuming males --

DR. BOVE: And their age distribution because I had to guess that again, and then the U.S. rates for male breast cancer, age-specific rates. So doing that, because that's how you have to do it, determining how much time a person has as they go on in life they accumulate person time that goes into each different age box, 35 to 44, 45, 50, so it's hard to explain.

MR. PARTAIN: Yeah, because they've got latencies of ten to 20, 30 years later.

DR. BOVE: Right. And then doing that and that's how I came up with the figure somewhere. I think it was --

MR. PARTAIN: So that figure would be just Marines, not dependents of Marines, right?

DR. BOVE: I don't want to put too much weight on this because there's so many --

MS. RUCKART: But includes dependents, right? Because we would consider anyone who was on the base.

DR. BOVE: Yes. I guess there are about 55 cases on the base. An additional 15 cases in situ of male breast cancer. So it comes out to 70.

MR. PARTAIN: What was the other? Fifteen? That 55?

DR. BOVE: Fifty-five on base and 15 in situ. So but don't put these numbers down. It's simply, I was trying to get a handle because there are all kinds of numbers were thrown out there. The Marine Corps or Navy had a number out there which didn't make any sense to me.

MR. PARTAIN: They said 400 cases for 400,000 exposed.

DR. BOVE: Right. You have to do something like I did, but of course, you'd like to have actual data to base it on than a lot of assumptions. But this is how you have to do it. So these numbers are more in the ballpark than any of the other numbers out

there. But take it with a grain of salt because I'm working from, I'm guessing as to age distribution. I'm guessing as to how many people were there. There are all these guesses going on because I don't have the data to work from.

MR. FONTELLA: Frank, the last CAP meeting you mentioned the Brinton report where there was 4,500,000 male veterans that were surveyed through the Veterans' system between 1969 and 1996 where 642 of them had male breast cancer. Now that number, when you look at that number, that is when you look and you breakdown of one male per 100,000 men, and that's a huge, huge number also. And they didn't take environmental factors or family risk factors into account. So, I mean, can you draw from that as well?

DR. BOVE: That's number four on my list here. I'll jump right down to number four and skip over three. No, that's fine. Just what you said. There was a previous VA study of 600-and-some, 42 cases. We don't know much about those cases of the study. Yeah, that's a request to go to the VA to revisit that.

MR. FONTELLA: Well, if you look at the time period and from the '60s through the '70s with Agent

Orange, I just found the two studies, two dockets, that were in the VA appeals claim process where they won, it was not male breast cancer, but it was on blood diseases, AML and there's another blood disease, from benzene exposure. They proved that benzene was in Agent Orange. They had to prove it.

The VA had to hire an independent metal expert to investigate the fact, find out for sure whether benzene was in the manufacturing process or the distribution process of Agent Orange. And they proved their case, and they were awarded their claims. So when you look at all these men that had breast cancer in that Brinton report, they didn't do any environmental exposures or talk to these men. None of them were interviewed. Could it possibly be that possibly Agent Orange might be...

DR. BOVE: Well, again, well, some of that information they probably could get from the data linkage effort. Maybe they'd have to interview them for Agent Orange. There's some data from the DMDC that could be used, but I would bet if they really wanted to do it right, they'd have to interview these people. They would even interview them anyway out of respect.

MR. FONTELLA: These are all military men as well.

All the military was in Viet Nam, obviously, not just Marine Corps.

DR. BOVE: But this included all the services, these 642 cases. So anyway that's the fourth possibility to revisit these cases and to do a study. And that would be a VA study.

The third approach had to do with in case our health survey didn't work out well that we've always talked about a data linkage study with the cancer registry similar to what we do in the mortality study. It's never been done nationwide because the 50 state cancer registries, many of them have rules that they cannot give out this information without a consent form.

However, the VA cancer study, the Gulf War cancer study used, I think it was like 20 cancer registries, somewhere around that number. What they did was pretty ingenious I thought, and we're thinking about it in case our health study is not as helpful as we hope it is and that is to get information from the cancer registries that want to participate without getting personal identifier information but still getting enough information so you can do an analysis.

And that would be -- you give them peoples'

names, social security numbers, whatever information you have. They would give you back the number of cancers in particular age groups, types of cancers, and if you have an exposure category, the cancers in each one. They could give you that information so that all the information you would need to do it for an analysis you'd have, but you would have no idea who these people are. You'd know nothing about the cases, who they were.

And so it would have to take some doing because that was simple yes, no in the Gulf War. We just want to have exposure levels. We want to say, you know, certain different levels of contamination. So it will be a little more difficult, but it's something to think about.

Again, we probably want to wait and see what happens with the health survey before we embark on it. And this is something we can always put in the background until then. And we can look at any cancer, male breast cancer, leukemia, whatever.

MR. STALLARD: When is the health survey expected to be completed?

MS. RUCKART: Well, you know, we have the two phases so the first phase we're going to begin with the mailings in March, and we're going to mail those out

through July. But we're going to continue to receive surveys through September to allow for the full wave to be completed. And then there's processing that needs to go on to input the results. And during that time we'll be having our expert panel meetings and then the contractor will continue to process and deliver a final dataset to us based on the results of the health survey, self-reported diseases.

In March of 2012 at some point close to that time frame we would begin the second phase of confirmation if the Agency decides to move forward with that. And then I don't have the timeline for that phase since that's unclear if we'll be conducting that or not.

DR. BOVE: I think we can safely say that it would be probably by the time the data are in and the analysis, report writing, all the clearances, we'd be talking sometime in 2013, probably.

MS. SIMMONS: That's phase one?

MS. RUCKART: No, phase one would be completed in March of '12, but that would include the processing of all the results received by the contractor and then delivering to us a final dataset. Then before they actually deliver the final dataset, we'll know

if we're moving forward with the confirmation.

And as Frank said, if we did move forward, the time we conduct that effort and get the data and analyze that and write all the reports for that that would be some time in 2013 but it's less clear for exact dates.

DR. BOVE: Yeah, I would bet it would take at least a year of hard work to confirm all the self-reported. That may be optimistic. Getting medical records, getting the information from the cancer registries and the VA and so on is going to take time. That's a big job. That's why ATSDR decided to wait on that going forward until we see if the health survey has enough participation. That was pretty much the reason because it's expensive, time consuming, a huge effort. But if you want a valid study, you have to do that. So that's what the Agency has to weigh.

MR. STALLARD: Are there any other questions about all that?

MR. FONTELLA: Jim Fontella. You say on here about previous VA cancer study on male and female breast cancer. That study, that Brinton report, was just on males.

DR. BOVE: We had a study in 2007.

MR. FONTELLA: A different one.

DR. BOVE: I'm not sure if it's different or not. I have to double check to make sure. They had a large number of people that looked at it with male and female breast cancer. It may be the same study.

MR. FONTELLA: The copy that I have says all males.

DR. BOVE: No, no, no, but they also did a, they did females, too, and they compared the two in terms of various parameters like survival rate, I think it was. I have to go back and look at it but nothing again about what service they were in or anything of the sort for males or females. And that's more of trying to get a handle where the differences are in breast cancer. Are there similar things going on? In fact, they did find some similarities.

MR. BYRON: I was looking at the registration, registrants by state and looking at registrants overseas, and I was just curious how we had 562. We have that many fellow soldiers from Africa come to the U.S. for training or --

MR. ENSMINGER: Could be former Marines that live there.

MR. BYRON: That's what I wondered, you know. That's more likely that they're moved over there. I was just curious.

MR. STALLARD: So I suspect that as we move forward the male breast cancer study issue will remain an agenda item as will the studies that Frank and company are doing.

DR. BOVE: I'm sorry?

MR. STALLARD: I said that will be a recurring agenda item and update and all that.

DR. BOVE: So what I handed to you is definitely a draft. Again, if you have any ideas along this score, you know, discuss it at the future CAP meetings.

MR. ENSMINGER: It would be interesting to see what the, if it did in fact create this large number of males that have breast cancer, good god, can you imagine what it did to women? The end result was most of the women that were affected at Lejeune were all dependents. You had some government service employees that worked at the base, and you had some women Marines and women Navy personnel, but for the most part they were dependents.

MR. BYRON: You know the sad thing is is that it's so much more common in the population that will they ever link it to Camp Lejeune?

MR. ENSMINGER: Yeah, well, I mean, how are you ever going to find them all either?

DR. BOVE: But, you know, the mortality study is problematic in this regard, too, but there is some power. There is some power in there. So if they died of breast cancer... You know, we may be able to see something. It's not going to be great but there are other cancers, too, that are also going to have a little power. Going back to our feasibility assessment, I think you can see it up there where we had the power calculations. We've done more recent ones. Actually, I don't know if I've presented --

MR. ENSMINGER: How many females are in this cohort?

DR. BOVE: I think it's four or five percent of the active duty. I have to go back and look. But I did do power calculations. I actually did a whole set of power calculations last year when we were negotiating with the Navy around funding both for the mortality study and the morbidity study. I don't remember if I've ever presented that here, but if I haven't, maybe I'll put that on the agenda and I'll go over that next time.

MR. PARTAIN: Frank, I was going to ask you. Since we had this group 20, 75 and 85 that we studied, we have the number. Can we give the calculations for major cancers? I mean, we've got tons of kidney cancers on our website, bladder cancers, non-

Hodgkins lymphoma. Can we get the, out of that group that we know we've been studying, we know we have the number, can we get the calculations for that to see what is expected out there?

It'd be nice to have, at the next CAP meeting if we could have that because we do our own work and we try to talk with people on the site. And I think Jim took on himself and collated a bunch of our kidney cancers.

And what, we had a hundred and something?

MR. FONTELLA: Well, it was I think 175 or something like that out of less than 2,000. It was almost ten percent. It was like eight or nine percent.

DR. BOVE: What I did was, think about what I was trying to do here. I was trying to convince. First of all, the mortality study is pretty straightforward. But the morbidity study, health survey morbidity study, I had to come up with some different participation rates.

So what I think I used was 50, 40, 30, something like that. And I don't know if I did like down to 20 percent participation. I wanted to show that even in a very low participation, this is such a huge survey that you've got pretty good statistical power.

So that was one of my agendas was to show that, but I didn't do it for a hundred percent participation because that's not real, but that's sort of what you're asking me to do. That can be done.

Again, I'm not so sure what the utility of that is because, I mean, that's the point of the health survey is to use that information, the information from the water modeling, to look at those who respond, exposure-response relationships. But I could do, it's possible to do what you suggest.

I haven't thought about doing that before. But I could look at the age distribution of the DMDC cohort. I can look at the national age-specific cancer rates. And with a few assumptions I could do that, yeah.

(group discussion ensued)

MR. PARTAIN: I mean, if that was the perfect world, perfect survey, a hundred percent participation and with perfect participation, anyway and there's 100 kidney cancers expected, and we've already identified 150, well, there's, you know, for our purposes that's something we can work on and help collate and get ideas and stuff like that.

DR. BOVE: I can certainly do that exercise.

WRAP-UP

MR. STALLARD: We need to talk briefly about our next meeting, and I believe that's going to be in April, is it? March?

MS. RUCKART: Yes, well, Christopher Stallard is not available the entire month of March, so --

MR. STALLARD: So it can be March. I mean, Lander did a great job.

MS. RUCKART: Well, that's true, but I just looked at options for April because I just went under the assumption that everybody would want you here.

MR. STALLARD: The work has to go on. So you all decide it, and we'll make it work whatever.

MS. RUCKART: Well, as you know, I sent that e-mail letting you know that the conference room scheduler wasn't available until today, so I couldn't even look at the rooms and consider everybody's availability, well, Christopher's availability and internal ATSDR staff. So anyway I've reserved the room several days in April and wanted to put those out there now for discussion. April 4th is a Monday; April 5th, Tuesday; Monday, the 11th; Thursday, the 14th; also Tuesday, the 12th; and Wednesday, the 27th.

MR. FONTELLA: When is Easter?

MS. RUCKART: Easter is like the 22nd, 24th,

something like that, but there's the dates that Morris is unavailable, and then Easter Monday is like I think the 24th. So like that week of Easter I didn't look at because I kind of thought it's hard for people to be traveling. So that's why I was looking at the first and second week, and then I selected one day the last week but figuring y'all probably want to meet in the earlier part. I focused on the first two weeks. So we have Monday, Tuesday, the 4th and 5th, and then the second week: Monday, the 11th; Tuesday, the 12th and Thursday, the 14th.

MR. ENSMINGER: Fourth and 5th.

MR. STALLARD: I'm actually in town for some of that time in March, but they're going to schedule me for something so early April would be --

MR. ENSMINGER: The 4th and 5th.

MR. BYRON: Is this before the study goes out, the survey?

DR. BOVE: Yeah, I think now.

MR. ENSMINGER: What was the 4th?

MS. RUCKART: The 4th is a Monday. So that's the date everyone wants?

MR. FONTELLA: And that gives us enough time like if there's anything that we need before the survey goes

out, enough time to react to it?

MS. RUCKART: The survey will start by then, but the first wave will not even be completed so we'd have time for --

(group discussion ensued)

MR. STALLARD: Well, I'm humbled that you want me to be here. Thank you, so it's the 5th.

MR. PARTAIN: If you do, then move the CAP to Africa.

MR. STALLARD: Hey, wait. Thank you for bringing that up. We still need to come up --

MR. ENSMINGER: Well, I thought Dr. Portier when he was talking about some other venues, I thought he was talking about going back to the community where this thing happened.

MR. STALLARD: That's been presented before.

MR. PARTAIN: And we've asked for that.

MR. ENSMINGER: Well, I mean, let's face it. The only reason we're meeting here is because Camp Lejeune, I mean, it was a transient population of people that are spread out now all over the world.

If you were running a regular CAP in a community, it would be at the community. So this thing about, what Dr. Portier said about, well, that brings up the issue of transportation for his staff

and all that, well hell, you've got to do that anyhow in a regular community.

MS. RUCKART: Right, then we wouldn't be traveling all of you in. I think maybe he's talking about it from that perspective. We wouldn't be traveling the community members in for that meeting.

MR. ENSMINGER: Oh, yeah. Well, you've got to travel here.

DR. BOVE: The reason to have it here is because a lot of the staff are here. You can get here, as they said, we can stream it live. Now you could have it in Washington. You could have it at Camp Lejeune. You could have it anywhere in the country for that matter.

CAPs that are, in other situations the CAP is in the community because you want the community to be involved. You want to actually, you have CAP members but you leave it open for community members to come, and some CAP meetings are almost like public meetings where a lot of people are in attendance. And the ones at Otis Air Force Base were not like that, but that was the CAP I participated in before this.

But, I mean, if it's here I don't know if you'd get more participation if you had it at Camp Lejeune

or not. Mike, there certainly was a lot of people at the Wilmington.

MR. PARTAIN: How about the Bahamas?

DR. BOVE: Well, we couldn't stream it live so you'd lose out on that. Now how many people are listening in live? At one point staffers were doing that and certain media people were and that's important. So there are trade-offs.

MR. FONTELLA: I think bringing it to the community and at least giving the community an opportunity to be there is important. Like Jerry said, we're spread all over, but Camp Lejeune is North Carolina being the highest state with registrants and everything.

But there's a lot of people in Jacksonville, in and around the area, and I think it's important that we do get out there and do a meeting there. Give these people the opportunity to come in and say something or ask questions and participate whereas, they can't.

DR. BOVE: That makes sense. I'm almost wondering if there's yet another mechanism. I'm thinking back to the Wilmington meeting where the audience really participated quite a bit. And I think that besides having a CAP meeting in the area maybe some kind of

open session where CAP members are there as well, and we actually get a lot of questions. That that's the point of the meeting is to get a lot of questions and information out to the people who haven't had a chance to do that.

That's not to replace a CAP meeting. That's in addition, to think about that as well. Because I thought the Wilmington meeting was useful. There were a lot of, as I said, we had tons of questions all over the map, and I think that was good. And whereas, we have more restricted focus in a CAP meeting, we do want to get some things done, so we may want to think of other possibilities.

MR. STALLARD: That would be a media opportunity because the community is so widespread.

DR. BOVE: Yeah, we wouldn't have to worry about cameras and studio crews.

MR. BYRON: This is Jeff. I can almost say for sure that nobody's interested in one in Atlanta outside of the facility. I don't think we ever had that intention at all. I think we were thinking closer to the affected community. I have no interest in one.

MS. RUCKART: Well, what Mary Ann just said is that would be like a public availability session. So

like Frank's saying, in addition to CAP meetings. CAP meetings would be held here. We have a specific purpose. There's an agenda. It may not really be of interest to the community at large, but this other type of format they might be interested in.

DR. BOVE: It's not quite a public availability session because I would want actually the CAP members to control it or at least lead it or whatever instead of ATSDR. We would be there. It would be a forum.

I don't like, public availability session I have some problems with. What I'm trying to express here is sort of a more open thing where CAP members are very much involved in the, if not running the thing.

MR. STALLARD: Think about the retired community that might likely come out.

MR. BYRON: And on two you can probably just put slash Wilmington, North Carolina. I think you guys are over there, right? You're up in Wilmington, too, as well as Jacksonville, aren't you?

MR. STALLARD: So then what we need to do is sort of figure out what venue would be appropriate and whether we're going to do a CAP meeting in conjunction with that or some other public

opportunity for meeting and sharing information.

MR. PARTAIN: And I would make the suggestion, I mean, that would be good to do that, like you said, do a CAP-sponsored thing where we can get out to the public. It's important we hear from everyone else. And to get this to kick off we would need to have help from the Marine Corps in the form of a letter from ATSDR announcing the meeting going to registrants informing that this is going to take place in the community and have the Marine Corps disseminate that to the 162,000 registrants or the 167,000 registrants.

MR. STALLARD: So are we talking about like a civic center full of people? A major, large scale, I mean, we'd have to plan that in how much of a response, you know, from 1,000 people or 100 people. Well, it's an idea.

DR. BOVE: I'm trying to remember. There was a pretty good crowd in Wilmington. Tom Sinks was there.

MR. ENSMINGER: I was there.

DR. BOVE: How did they do the outreach for that? I mean, was it just a newspaper doing that? But that's an important avenue.

MR. PARTAIN: Well, Jerry and I have been going out

and doing little informational meetings.

(group discussion ensued)

MR. PARTAIN: Frank, Jerry and I have been going out doing informational meetings, Pittsburgh and what have you and stuff, and we're going to do one in January in Florida again. But we did the same things in the community.

I mean, they're frustrated. They don't know what's going on. They don't have information. When they call the Marine Corps, they get nothing from them or go call a lawyer or what have you. And they want to know what's going on, and they need information. And when we do the meetings they're like, oh, my god.

And if we can do this with the CAP and do it on a large scale where we get a bunch of people, I think it would be very beneficial to the community. And the community deserves this. I mean, they need to know what's going on.

DR. BOVE: That's why I suggested it. Now, we need to talk more maybe about logistics. I think it would be good to have it soon because, again, the survey's going out. I think it's --

MR. PARTAIN: Maybe that's the way to kick off the survey. It would be an excellent way to garner

participation rates in the survey because you're going to explain and understand and people will have an opportunity to find out why it's important that they participate.

DR. BOVE: I mean, we need to do this at the end of the day when we have the water modeling done. When we have the studies we'd have to do something like this anyway. But it may be worthwhile to do it before then.

MR. PARTAIN: Well, that's something we need to put on the table and talk about. Because I think the community, that's something the community really needs to have.

MR. STALLARD: And so an idea is born. And that means that this has to be discussed before April 5th.

MR. BYRON: This needs to be discussed before March if you want to get them to be there.

MR. STALLARD: Yeah, just getting the venue alone takes time.

Was there anything else? Any of the CAP members? Any last closing comments?

(no response)

MR. STALLARD: Thank you all for your participation. Thank you. Have a safe journey home, and thank you to the audience for being here and discussing our

process.

(Whereupon, the meeting was adjourned at 2:50 p.m.)

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I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of Dec. 9, 2010; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither kin 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 19th day of January, 2011.

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