

**THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**

convenes the

**NINETEENTH MEETING**

**CAMP LEJEUNE COMMUNITY ASSISTANCE**

**PANEL (CAP) MEETING**

APRIL 5, 2011

The verbatim transcript of the  
Meeting of the Camp Lejeune Community Assistance  
Panel held at the ATSDR, Chamblee Building 106,  
Conference Room A, Atlanta, Georgia, on April 5,  
2011.

**STEVEN RAY GREEN AND ASSOCIATES**  
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**P A R T I C I P A N T S**

(alphabetically)

BLAKELY, MARY, CAP MEMBER  
BOVE, FRANK, ATSDR  
BRIDGES, SANDRA, CAP, CLNC (via telephone)  
BYRON, JEFF, COMMUNITY MEMBER  
CLAPP, RICHARD, SCD, MPH, PROFESSOR (via telephone)  
DAVIS, DEVRA, PROFESSOR, CAP MEMBER  
ENSMINGER, JERRY, COMMUNITY MEMBER  
FLOHR, BRADLEY, VA  
FONTELLA, JIM, COMMUNITY MEMBER  
MASLIA, MORRIS, ATSDR  
PARTAIN, MIKE, COMMUNITY MEMBER  
PORTIER, DR. CHRISTOPHER, DIRECTOR NCEH/ATSDR  
RODENBECK, SVEN, REAR ADMIRAL (via telephone)  
RUCKART, PERRI, ATSDR  
SIMMONS, MARY ANN, NAVY AND MARINE CORPS PUBLIC HEALTH  
CENTER  
STALLARD, CHRISTOPHER, MODERATOR  
TOWNSEND, TOM (via telephone)

**P R O C E E D I N G S**

(9:00 a.m.)

**WELCOME, INTRODUCTIONS AND ANNOUNCEMENTS**

1  
2       **MR. STALLARD:** Good morning, everyone. Welcome to  
3 our CAP meeting this morning. There are some new  
4 faces we see at the table so what we're going to do  
5 is just go around and I'd like you briefly to  
6 introduce who you are, what your affiliation is and  
7 then we'll go over the operating guidelines that  
8 keeps us all focused and on track. And then we'll  
9 go into updates from CAP members. But I think, Dr.  
10 Portier, before we start, do you have anything right  
11 now or do you want to wait till we go around?

12       **DR. PORTIER:** I just wanted to welcome everybody to  
13 Atlanta. I'm happy to be here. Today you'll see  
14 more of me than you saw last time. Last time you  
15 recall I was Vik Kapil, and this time I'm myself.  
16 Vik is manning the Emergency Operation Center on our  
17 main campus because of the Japan crisis. And so I  
18 will be here.

19       **MR. STALLARD:** Welcome, thank you.

20               And so when we go around, please be reminded  
21 that push your button, so to speak, when the red  
22 light comes on, and when you're finished turn it

1 off.

2 So let's start with introductions. We'll start  
3 over here with Jim and go around.

4 **MR. FONTELLA:** Jim Fontella, CAP member.

5 **MR. BYRON:** Jeff Byron, CAP member.

6 **DR. DAVIS:** Devra Davis, CAP member.

7 **MS. SIMMONS:** Mary Ann Simmons, Navy-Marine Corps  
8 Public Health Center.

9 **DR. PORTIER:** Chris Portier, Director of National  
10 Center for Environmental Health and Agency for Toxic  
11 Substances and Disease Registry.

12 **DR. BOVE:** Frank Bove, Division of Health Studies.

13 **MS. RUCKART:** Perri Ruckart, Division of Health  
14 Studies.

15 **MR. FLOHR:** Brad Flohr, Department of Veterans  
16 Affairs.

17 **MS. BLAKELY:** Mary Blakely, CAP member.

18 **MR. PARTAIN:** Mike Partain, CAP member.

19 **MR. ENSMINGER:** Jerry Ensminger, CAP member.

20 **MR. STALLARD:** Welcome everyone. And on the phone  
21 we have?

22 (no response)

23 **MR. STALLARD:** Anyone on the phone?

24 (no response)

25 **MS. RUCKART:** Sandy, are you on the phone? Tom?

1 Dick?

2 **MR. STALLARD:** I guess not so we'll move on. So  
3 what I'd like to do is acknowledge and welcome Mary  
4 as our newest addition to the CAP as a member.

5 As is our custom we generally talk about  
6 guiding principles that keep us focused and working  
7 together toward a common goal and in harmony. So we  
8 start with zero personal attacks, focus on the issue  
9 at hand, remember that this is a public meeting,  
10 live streaming.

11 Members of the audience are here, and we're  
12 glad that you're here listening. You may be invited  
13 to speak at some point, but if not invited we ask  
14 you to refrain from your contributions.

15 Please turn your cell phones off or on silent,  
16 say your name before speaking and push the red  
17 button so that our reporter can capture. This is  
18 taken down. Respect for the speaker meaning, of  
19 course, that we can only hear one voice at a time,  
20 and again, our principle of openness and  
21 transparency in these proceedings as we continue to  
22 work toward resolution.

23 And with that I'm sure that, Jerry, this would  
24 be an appropriate time to start the CAP updates.

25 **CAP UPDATES/COMMUNITY CONCERNS**

1           **MR. ENSMINGER:** Yeah. We discovered a report. It's  
2 CERCLA Document Number 428, which is dated May of  
3 1988, and it was a remedial investigation that was  
4 done by Environmental Science and Engineering. In  
5 that report the contractor warned the Department of  
6 the Navy and United States Marine Corps about  
7 interim measures that needed to be taken during the  
8 remediation process of all the contamination plumes  
9 that were at base.

10           One of those interim protective measures that  
11 they were warned about was ambient air quality  
12 sampling within the buildings that were located  
13 above the contamination plumes, especially in the  
14 Hadnot Point industrial area. If you will look at  
15 CERCLA 260, it was an internal evaluation of how  
16 they were going to execute these interim protective  
17 measures, primarily the vapor intrusion, and also  
18 the ambient air quality sampling.

19           The Assistant Chief of Staff of Facilities,  
20 Colonel Dalzell, wrote a letter to the Commanding  
21 Officer of the Preventive Medicine Unit at the Naval  
22 Hospital asking them to do a work-up and point paper  
23 about how they would execute this ambient air  
24 quality sampling in these buildings. They therefore  
25 went and did this entire point paper on how they

1           were going to execute this if they could.

2           And the Commanding Officer of the Preventive  
3           Medicine Unit came back to the Assistant Chief of  
4           Staff of Facilities in writing and told them that  
5           with the current personnel that they had on staff  
6           and not having the special equipment required to do  
7           the sampling, their recommendation was that they  
8           contract it out.

9           Then we find CERCLA 47, Document Number 47  
10          which is the meeting minutes of the TRC Committee,  
11          which is the precursor of a RAB that later became  
12          Restoration Advisory Board. These are required by  
13          law. The TRC meeting, the Assistant Chief of Staff  
14          of Facilities, Colonel Dalzell, and the base  
15          environmental engineer, Bob Alexander, announced to  
16          the public that these interim protective standards  
17          and measures were going to be taken.

18          And then on 5 October in CERCLA 260 again  
19          there's a letter from the Colonel Dalzell, Assistant  
20          Chief of Staff of Facilities, to LantDiv telling  
21          them, providing them with the PMUs, Preventive  
22          Medicine Units, evaluation and their recommendation  
23          that this stuff be contracted out, and he requested  
24          guidance from LantDiv on how they were going to  
25          execute this. They needed money, and they needed to

1 contract. After that, it's crickets until 1999 at  
2 which time Building 1101 had to be evacuated.

3 **DR. DAVIS:** What's crickets mean?

4 **MR. ENSMINGER:** Crickets means nothing. We can't  
5 find any document that says that any air quality  
6 samples were taken, and I find no documents where  
7 there's any analytical results for any air quality  
8 samples.

9 **DR. DAVIS:** During that time period I was Executive  
10 Director of the National Academy of Sciences Board  
11 on Environmental Studies and Toxicology. We had a  
12 Committee on Toxicology that was completely funded  
13 by the Department of Defense. And that Committee  
14 would routinely recommend standards and levels for  
15 actions to be taken with respect to military housing  
16 with the number of contaminants.

17 Now it's been, as you know, many years, but my  
18 recollection is that the Committee on Toxicology of  
19 the National Academy of Sciences National Research  
20 Council actually did issue recommendations on some  
21 of the same pollutants that you're talking about  
22 here. Now whether they talked to one another, of  
23 course we don't know, but the fact is there was  
24 guidance.

25 And I think it's just relevant to establishing

1 the fact information here to know that there was  
2 such guidance. Whether it was used or not is  
3 another question, but it did exist. It is perhaps  
4 relevant and it would be worthwhile for this group  
5 to obtain that information because the Committee on  
6 Toxicology existed for at least 30 years to provide  
7 that kind of guidance and advice.

8 **MR. STALLARD:** Thank you, Devra.

9 **MR. ENSMINGER:** Now Jim Fontella has done an amazing  
10 job on researching this stuff and all the  
11 requirements and regulations required by the State  
12 of North Carolina, EPA. You name it; he's got it.

13 But my question to ATSDR is this. This report  
14 was written in May of '88. This was a identified  
15 exposure pathway, and this was written three years  
16 before ATSDR showed up at the front gate at Camp  
17 Lejeune. Why wasn't this addressed in that '97  
18 Public Health Study? Here we go. This is another,  
19 this is another shortfall, and this should have been  
20 identified and addressed in that '97 Public Health  
21 Assessment.

22 And we're back to the benzene issue. They  
23 wrote that off. They knew about it. It was in the  
24 indexes. But if the Public Health Assessment is  
25 going to be reissued, which I'm aware that it's

1 going to be after the water model's completed, this  
2 pathway's going to have to be addressed because we  
3 have an individual who worked in Building 1101 that  
4 we ran into at a meeting in Roanoke, Virginia.

5 She worked in that building from 1987 through  
6 1990. She's got multiple myeloma and another  
7 ailment that is directly linked to benzene exposure.  
8 And she was at Camp Lejeune. She came from Camp  
9 Pendleton to Lejeune in 1987 and went to work at the  
10 FLSC, which is the Fleet Logistic Support Center.

11 **MR. FONTELLA:** Jim Fontella. Let me just add  
12 something to that, Jerry.

13 I've got toxicology reports from the ATSDR's  
14 own site that says breathing certain -- I don't have  
15 it right in front of me. I've got it in my book  
16 here. Breathing certain levels per million of  
17 benzene causes multiple myeloma. It's in your tox  
18 reports.

19 **MR. STALLARD:** Can I have your attention, please?  
20 The purpose of this session is to update on what  
21 you've been doing or new discoveries since our last  
22 meeting.

23 Now clearly there's an issue about this  
24 discovery of the 1988 report for which Dr. Davis has  
25 some feedback on and others would like to comment on

1           this vapor intrusion. So what I'd like to suggest  
2           is that we go around the table and finish what have  
3           I been doing, what's new, that you'd like to share  
4           with the group. And it looks like we're going to  
5           have a more concentrated discussion on this topic.

6           Would you agree?

7           (affirmative responses)

8           **MR. STALLARD:** Okay, great.

9           Do we have anyone on the phone at this point in  
10          time?

11          (no response)

12          **MR. STALLARD:** Welcome, Mike.

13          **MR. PARTAIN:** This is Mike Partain. Along with Jim  
14          and Jerry we're working on the vapor intrusion  
15          issue, we created a timeline for that which has  
16          since 1948. And also we're up to 79 with breast  
17          cancer from Camp Lejeune at this point in time. Had  
18          a couple more individuals contact me since the last  
19          CAP meeting.

20          **MR. STALLARD:** Thank you, Mike.

21          Mary.

22          **MS. BLAKELY:** I don't have anything to say.

23          **MS. RUCKART:** Mary, since not everyone is familiar  
24          with you, would you want to just say a few words  
25          about how you're connected to Camp Lejeune and just

1           introduce yourself, please?

2           **MS. BLAKELY:** Yes. I was a child on the base. My  
3           father was in the Marine Corps. He retired after, I  
4           believe, 24 years. He went to Viet Nam twice. He  
5           was a crypto-analyst at the end of his career, and  
6           we were stationed on the base. And we lived at  
7           Berkley Manor from 1968 to 1970, and then we were  
8           stationed back again in 1976.

9                     And I finished growing up in Jacksonville, and  
10           my father currently lives in Jacksonville still. My  
11           mother, she was diagnosed with brain cancer in  
12           September of 1995, and she was dead by August of  
13           '96. The cancer spread throughout her body, and she  
14           had no chance to fight it, it was so aggressive.

15                    And currently, I don't know for sure, but we  
16           believe my father might have lung cancer. They  
17           found a mass on one of his lungs, and he has a  
18           problem with his kidney.

19                    The way that I found out about this was  
20           watching a report on CNN where Mike and some of the  
21           other male breast cancer victims were talking about  
22           Camp Lejeune, and it perked my interest because they  
23           mentioned Holcomb Boulevard which is near Berkley  
24           Manor. And so that's when I found out about  
25           everything, and I've spent the last -- I don't know

1           -- almost two years reading and trying to keep up  
2           and understand and learn all I can. I don't know  
3           what else to say.

4           **MR. STALLARD:** That's great. Thank you, Mary.  
5           Welcome.

6                     Good morning. Anything to talk about?

7           **MR. FLOHR:** Not at this time.

8           **MR. STALLARD:** Welcome again, Jeff.

9           **MR. BYRON:** This is Jeff Byron. I don't have  
10           anything to report presently. I just want to let  
11           you know that I'm here to get the update from ATSDR.

12           **MR. STALLARD:** Jim.

13           **MR. FONTELLA:** Jim Fontella, and I've been working  
14           about a month and a half now on looking through the  
15           disks all over again, looking for more information  
16           on the timeline of the vapor intrusion from 1987  
17           feasibility study all through up to 2010 which is  
18           still a problem.

19           **MR. STALLARD:** Is it? And for clarification, Jim,  
20           where is this information coming from? Where is --

21           **MR. FONTELLA:** Well, most of it's coming from the  
22           Navy Portal and the UST, North Carolina UST,  
23           Underground Storage Tank Program. And there's not -  
24           - I have some CERCLA documents in here, several in  
25           my portfolio I brought today, but most of it has

1           come from the documents from the Navy.

2           And there's a lot of documentation referred to  
3 here but no sampling. So there's more documents out  
4 there that we don't have, want to bring that up  
5 right now so we can try to get to we need to -- I  
6 did have documentation on levels that we don't have,  
7 and we know they're there.

8           **MR. STALLARD:** Thank you.

9           **MR. ENSMINGER:** My question is was any air quality  
10 sampling done between '88 and '99? This is  
11 something that ATSDR needs to go after.

12          **DR. PORTIER:** Chris. Jim, Mike, Jerry, thank you  
13 guys for spending so much time and effort to go and  
14 look up this information and look for it. I can't  
15 give you an answer as to why it wasn't in the '97  
16 document. I can speculate as to why it was not in  
17 the '97 document.

18          It's typical when ATSDR goes into a community -  
19 - and whether I agree with this or not, I haven't  
20 quite decided because I'm not sure of the magnitude  
21 of the issue. But it's typical when ATSDR goes into  
22 a community that if they see post on an occupational  
23 exposure, that occupational exposure's turned over  
24 to NIOSH to look at because it's really, NIOSH  
25 handles occupational exposures.

1           From my perspective if you're looking at a  
2           community, and the community has the same exposures  
3           in an occupational setting in the community, we  
4           probably should be looking at both. So we're  
5           looking into when we're going to do this and when  
6           we're not. But I speculate that back in '97 they  
7           saw this, and they said that's NIOSH's problem.

8           As to us doing vapor modeling for the  
9           assessments we're doing right now, it's problematic,  
10          and it's problematic for a number of reasons. But  
11          the biggest one Morris put on me yesterday which was  
12          quite clear, and that is because there's no samples,  
13          because there's very, very few samples available to  
14          us, anything we do with vapor modeling, with vapor  
15          estimation and vapor intrusion is going to require  
16          the completed water modeling.

17          And so whether we jump aggressively and go  
18          looking for samples with our data mining group,  
19          that's going to depend upon when they finish all the  
20          data mining they're already doing for us for the  
21          water modeling because we've got to get that  
22          finished first. That's got to be our priority. And  
23          then if we have time before we start doing analyses  
24          in mortality data, before we start doing analyses of  
25          the health study, then we can spend time looking at

1 the vapor intrusion issue and seeing how big a  
2 problem it is or not.

3 The one thing you point out is very important  
4 in these studies. If we have highly exposed  
5 individuals who, for example, the worst case would  
6 be they're highly exposed in the occupational  
7 setting but they're in the low exposure group for  
8 water. That could bias the analysis in the wrong  
9 direction. It could make an effect look a little  
10 less of an effect. And so it is a concern of ours.

11 There's no doubt we're going to be looking at  
12 this very carefully and seeing what we can do. But  
13 it requires us to be able to reconstruct  
14 occupations. It requires us to be able to  
15 reconstruct vapor intrusion, which is -- you think  
16 the water modeling's hard? I think vapor intrusion  
17 modeling is going to be almost as hard, and so it's  
18 going to take time and effort before we can give you  
19 a solid answer as to whether we think this is a  
20 problem and whether we can do it.

21 **MR. STALLARD:** Dr. Davis.

22 **DR. DAVIS:** EPA at that same time, 1988 to '93, had  
23 a program called the Leaking Underground Storage  
24 Tank Program, LUST for short. And it might be some  
25 data from the LUST Program could be relevant. I

1 know of one published study that found a significant  
2 increase in leukemia associated with fairly short-  
3 term and high-level exposures. The study was  
4 published by Edwin Talbot (ph), my colleague at the  
5 time at the University of Pittsburgh.

6 Took, of course, ten years to get it all  
7 together, but they were able to show with this  
8 modeling that vapor intrusion from leaking  
9 underground storage tanks into basements, into homes  
10 was significantly associated with an increased risk  
11 of leukemia. And I don't think it was just  
12 childhood. I don't remember now whether it was  
13 childhood or adult, but as you may be aware,  
14 leukemia, multiple myeloma, blood dyscrasias,  
15 hematological abnormalities, anemias, hemolytic  
16 anemia, as a sort of general category of diseases  
17 associated with volatile organic compounds, in  
18 particular benzene, but others as well.

19 So it may be that rather than having to go to  
20 the incredible expense it would take to reconstruct  
21 all this, you might be able to draw upon the data  
22 that's been developed in the LUST system just as an  
23 example rather than sort of keep going on this sort  
24 of data excavation exercise.

25 **MR. ENSMINGER:** Well, the only problem is that there

1           were actually four different areas in the Hadnot  
2           Point industrial area where you had different  
3           contamination plumes. It just wasn't fuel. You had  
4           several plumes of TCE and PCE and vinyl chloride and  
5           then you had the big fuel plume, and then we find  
6           out there's two of those that merged together, the  
7           1100 and the Hadnot Point fuel farm.

8                         However, this vapor intrusion issue didn't  
9           raise its ugly head until after, supposedly, the  
10          water contamination ceased. They're not going to  
11          cross each other until you take a look back with a  
12          model and say, hey, this was a really, very real  
13          problem, and it goes back even further.

14          **MR. BYRON:** This is Jeff Byron. Would you have even  
15          been looking for vapor intrusion in '88? I mean,  
16          this studies that we're looking at have been touted  
17          from '57 to '87 is when the exposure occurred. Now  
18          we're up to '88 to '97.

19          **MR. ENSMINGER:** Yeah, well --

20          **MR. BYRON:** I don't want to ignore it, but you know,  
21          this could stretch out forever, okay? And I want to  
22          get back to my life as the rest of the individuals  
23          in here, and I have a family to raise, grandchildren  
24          I want to take care of. I'm getting a little tired  
25          of all the delay, okay? I want to see some real

1 reports come out of this thing that mean something.  
2 Some summaries that are accurate and that Congress  
3 can determine what they need to do to help these  
4 individuals.

5 And to be honest with you it just looks like  
6 you're opening up another time frame here. I don't  
7 see where -- it is relevant, no doubt. All those  
8 individuals who were exposed and it should be done.  
9 But I don't want to see it hold up the in utero  
10 studies, mortality study any longer than it is.  
11 It's already projected 2013.

12 I've been at this for eleven years now. To be  
13 honest with you it's starting to wear on my  
14 business, my brother's business. They don't  
15 appreciate me taking off all this time, and I'm sure  
16 there are a few others that have responsibilities  
17 here from their boss, too. I know Mike does because  
18 I've heard it.

19 So let's get on with this thing. I'm not  
20 saying don't close the door, but those need to be  
21 looked at after the other studies are done. Thank  
22 you.

23 **MR. FONTELLA:** This is Jim Fontella.

24 **MR. STALLARD:** Wait, wait, wait. We have Mary Ann  
25 waiting to speak.

1           **MS. SIMMONS:** I just wanted to add on actually a  
2 couple of points. Jeff, you're right. Probably  
3 vapor intrusion hasn't been a well-studied or well-  
4 thought-out pathway by EPA until like in the last  
5 five or six years, so it's a fairly new thing that  
6 people are looking at the environmental world.

7           Second, when ATSDR used to do their public  
8 health assessments, 'cause I've been on several of  
9 the trips, they do not look at occupational issues.  
10 That was, I never heard the NIOSH connection. It's  
11 always said that there's programs in place to do  
12 this which was OSHA, so NIOSH...

13           And third, years ago -- and I'm not saying this  
14 is right either -- but occupational exposure limits  
15 are magnitudes higher than what's acceptable for the  
16 environmental world. And so even if you do indoor  
17 air quality studies for an occupation, it's likely  
18 not going to set off any alarms because the OSHA  
19 limits are so much higher than what the  
20 environmental limits are.

21           And so even if there was air samples done --  
22 and I have no idea. We talked about that earlier.  
23 But it's likely that there would have been either no  
24 exposures or something so low in comparison to  
25 occupational regulations that it wouldn't have

1 tripped off alarms. Again, I'm not saying right or  
2 wrong. I'm just saying that's how it was.

3 **MR. FONTELLA:** Jim Fontella. We have the limits in  
4 these buildings, and it specifically the limit on  
5 one were 50,000 parts per million.

6 **MR. ENSMINGER:** Million.

7 **MS. SIMMONS:** Yeah, that was just one.

8 **MR. FONTELLA:** Well, no, no, no. It was between  
9 January and March of 2000 there were like 169 hits  
10 at 50,000 parts per million in that building and the  
11 LEL level was one hundred percent. Now it was 1999,  
12 January of 2000 and March of 2000. And then after  
13 that we don't have any readings in that building at  
14 all until 2000 and I think '08.

15 But I have documents here that state on a  
16 continuing basis that that building was being  
17 monitored and had hits. You know, they blamed it on  
18 the air sparging, and then they cut the air sparging  
19 off, and they were still getting hits on the  
20 building. In 2007, they were getting hits on the  
21 building at 5,000 parts per million.

22 Now this is after 1987, and these people were  
23 exposed, and what about these people's health? I  
24 mean, breathing this. I mean, this is a big deal.  
25 I mean, if you don't put it in your public health

1           assessment this time, these people need to be  
2           studied and warned of what's going on because these  
3           levels are high. And 50,000 parts per million  
4           according to the ATSDR tox report if you breathe  
5           20,000 parts per million, you die.

6           **MS. SIMMONS:** This is Mary Ann. No doubt that  
7           situation -- I don't remember all the details, but  
8           the building I think was vacated during that time  
9           period.

10          **MR. FONTELLA:** Yeah, it was vacated, but they were  
11          still taking samples in there --

12          **MR. STALLARD:** Yeah, they were.

13          **MR. FONTELLA:** -- as a warehouse so people were  
14          still in and out breathing, even if it's for a short  
15          period of time. But while the building was occupied  
16          they were complaining about vapors for several years  
17          before they did any tests in the building. And even  
18          when they cordoned off -- I've got FOIA documents  
19          here -- even when they cordoned off part of the  
20          building with the highest FID levels in the country,  
21          they showed high levels, they didn't do anything.  
22          There was no action at all.

23          **DR. DAVIS:** And this is 50,000 ppm of what?

24          **MR. ENSMINGER:** Of benzene.

25          **MR. FONTELLA:** And there's another question about,

1           you know, we talked about benzene --

2           **MR. STALLARD:** Question, clarification.

3           **DR. DAVIS:** No, no, let's be really sure. You say  
4           50,000 ppm of benzene?

5           **MR. ENSMINGER:** Yep.

6           **MR. FONTELLA:** Yes, per million in the building.

7           **DR. DAVIS:** Wait, wait, but that seal up has been  
8           shaken here, and I have to say to you that would be  
9           a level that would cause --

10          **MR. FONTELLA:** Explosion.

11          **DR. DAVIS:** Well, no, it would cause a lot of  
12          problems, including you would expect symptoms in  
13          people for any length of time, so I see the people  
14          around the room shaking their heads no, and Mary Ann  
15          is saying no, so this is a fact. We need to --

16          **MR. FONTELLA:** I've got the levels here. I've got  
17          all the facts.

18          **DR. BOVE:** Three people were evacuated because of  
19          illnesses actually. So they had acute illnesses.

20          **DR. DAVIS:** So, for example, you would expect nose  
21          bleeds. You could see --

22          **DR. BOVE:** But they had enough symptoms that they  
23          had to be evacuated.

24          **MR. FONTELLA:** Yeah, they had to evacuate the  
25          building. But here's what I've got here, 639

1 readings between January and March of 2000, between  
2 1,000 parts per million and 50,000 parts per  
3 million. Now noted that that's all the machine goes  
4 up to is 50,000 parts per million. So it could be  
5 75,000 parts for all we know.

6 Now, there were also 355 readings of 50,000  
7 parts per million and a hundred percent LEL in that  
8 building. And that's not including all of the  
9 levels between ten parts per million up to a  
10 thousand parts per million which were thousands.

11 **MR. ENSMINGER:** Yeah, and, Jim, don't forget the  
12 PowerPoint we found from the industrial hygiene  
13 people at Camp Lejeune where they stated in there  
14 that people had been complaining about fuel vapors  
15 for years, fumes in those buildings for years before  
16 it was evacuated.

17 **MR. FONTELLA:** In November of '99 they checked that  
18 building, they were getting complaints of benzene in  
19 it, in that building, and they had three meetings  
20 with base officials and did nothing. They didn't  
21 test any samples. They didn't do nothing. This was  
22 ignored for the whole month of November of 1999.  
23 And I have the documents right here. They're OHM  
24 documents.

25 I mean, these are things that we're coming

1 across. We focus on certain issues, and this is why  
2 it was passed over in the past, because we had other  
3 things that we're focusing on. But when you look at  
4 the documents, the documents speak facts.

5 I mean, this is from their contractors, and  
6 these are levels. And here's all the levels I was  
7 talking about right here, and I'll be happy to give  
8 them to anybody because I've got them on my  
9 computer.

10 I sent --

11 **MS. BLAKELY:** Mary Blakely here. I'd like to add to  
12 what Jeff said and to Jim. I think that the human  
13 factor is being forgotten here regarding the time  
14 that this is taking. People are getting sick still.  
15 My father is sick. There's a human face to this.

16 **MR. BYRON:** This is Jeff Byron again, too. I see  
17 you repeating what's been going on for 30 years,  
18 okay? He says to me that the levels on cape  
19 couldn't even be taken because it was beyond the  
20 meter limit. I think this has come up before.

21 I've even stated this many years ago about  
22 being beyond the meter limit. People told me, oh,  
23 it's because they were below the instruments read.  
24 I never believed that not one lick. Those quality  
25 managers at aerospace, something that's beyond the

1 meter limit that means it's above it, not below it.  
2 And I'll get arguments about that.

3 **MR. ENSMINGER:** Let me read everybody an excerpt out  
4 of the announcement that they made at the TRC  
5 Committee meeting where they announced this to the  
6 public that they were going to initiate these  
7 things.

8 **MR. STALLARD:** And when was that?

9 **MR. ENSMINGER:** This was August of 1988.

10 **MR. PARTAIN:** Eleven years before.

11 **MR. ENSMINGER:** And this is the base environmental  
12 engineer, Bob Alexander. I'll read verbatim. The  
13 reason for the ambient air monitoring as was  
14 described in the feasibility study is in these soil  
15 and gas hot spots we want to be sure that there are  
16 no compounds present inside the work spaces in these  
17 buildings that may be near these things which could  
18 have a long-term chronic adverse health effect on  
19 the occupants of that building, the Marines and the  
20 civilian employees that work there.

21 So we're going to work with our Naval Hospital  
22 Command to complete ambient air monitoring inside  
23 those areas. These folks are the industrial  
24 hygienists and the preventive medicine people who  
25 have the technology and the expertise to use these

1 types of sampling devices that are familiar with the  
2 threshold limit values of that and are established  
3 for safe exposure over a long term to certain  
4 compounds.

5 Damn it, somebody knew back in '88. I don't  
6 want to hear this crap that well nobody was  
7 sampling. It's right here. They announced this to  
8 the public they were going to do it. I want to see  
9 the samples. Where are they?

10 **MR. STALLARD:** Okay.

11 **MR. PARTAIN:** I would strongly recommend that ATSDR  
12 put that request in writing. Make them say there  
13 are no samples or they did not do the sampling one  
14 way or the other. Mary said a few minutes ago, oh,  
15 that was one time. Well, if you only sample one  
16 time, you're going to have one value. That's it.

17 But there is a problem here, and that document  
18 was produced in 1988. Building 1101 was evacuated  
19 in 1999. So you have eleven years where nothing is  
20 done. It's the water contamination all over again.

21 **MR. STALLARD:** Can I say something here, folks,  
22 because we have to be sensitive that we have a  
23 process that's going on to address the needs that  
24 we've identified up to the last one. This new  
25 information and lack of information and data,

1           although important, it will be addressed, we don't  
2           want to derail the process that we're making --

3           **MR. ENSMINGER:** No, I'm not asking that.

4           **MR. STALLARD:** I know. I'm just saying so what I  
5           suggest is we need to have a strategy for how this  
6           group address that issue and make it an agenda item  
7           and work with ATSDR.

8           **MR. ENSMINGER:** Well, it's my understanding that  
9           DHAC already has a vapor intrusion specialty group.  
10          Is that right?

11          **DR. CIBULAS:** We have one individual who has some  
12          good expertise in vapor intrusion. That's correct.

13          **MR. ENSMINGER:** And I'm not asking this to overlap  
14          Morris's work. I don't want Morris to even be  
15          involved in this because he's got his mountain of  
16          work cut out for him with the water modeling. But I  
17          mean, there's no need to allow this to lapse and  
18          wait when you start gathering all this information  
19          or sending these letters out saying, hey guys, the  
20          amount of this stuff in '88, you're going to  
21          initiate it. If the sampling does exist, where are  
22          the results?

23          **MR. STALLARD:** Yes, Dr. Davis.

24          **DR. DAVIS:** Just a point of clarification. Can  
25          someone here technical tell me what F-I-D stands

1 for?

2 **MR. FONTELLA:** Flame ionizing detective.

3 **DR. DAVIS:** Okay, but it's those are the levels that  
4 are 50,000 ppm, but what do we know that is? It's  
5 not necessarily just benzene.

6 **MR. FONTELLA:** That's another point. That's another  
7 point I was trying to make. When they test for the  
8 chemicals in the buildings, do they just test for  
9 benzene or are they going to test for all VOCs in  
10 the building? They've got plumes of TCE in the  
11 ground and PCE in the ground. I'm sure there's  
12 vapor intrusion somewhere in there.

13 There's buildings, what, 1100, 1101, 1102,  
14 1103, 1104, 1105, 1108; building 1200, 1201, 1202,  
15 1220; 1301; 1068; 505 were all being monitored  
16 between the years of 2000 and 2008, and there's no  
17 sampling in any of these buildings, but I've got  
18 five or six documents in here that says these  
19 buildings are being sampled on a regular basis,  
20 weekly and monthly. Where are they at?

21 **MR. STALLARD:** Where's the data?

22 **MR. FONTELLA:** Where's the data? It's out there.  
23 They've got it. Fifty years they're supposed to  
24 keep that information. We need that information.  
25 We want to know why and what. And if somebody's

1 going to do a study on vapor intrusion like this  
2 gentleman says he has somebody, he needs that  
3 information, and we need it.

4 **MR. ENSMINGER:** Well, this kind of cuts against the  
5 grain of what the United States Marine Corps likes  
6 to put in their public affairs statements about the  
7 health, safety and welfare of our people are one of  
8 our top priorities that we see the recommendations,  
9 and they even announce that to the public that  
10 they're going to execute this stuff and initiated  
11 it.

12 Now which one is it? Did they do the sampling  
13 or didn't they? And if they didn't, why not? I  
14 mean, it was identified as an exposure pathway by  
15 your own people.

16 **MR. PARTAIN:** Now a month after the TRC meeting  
17 where Bob Alexander made that announcement that  
18 they're going to, he also said that they were  
19 waiting on the purchase of, approval for purchase  
20 one key piece of equipment to do the testing. We  
21 know after the meeting, a commander at the Naval  
22 Hospital wrote back to Dalzell and says we can't  
23 help you. You need to get an independent  
24 contractor.

25 A month after the TRC meeting a letter went out

1 from Colonel Dalzell to all the TRC members, you  
2 know from the Board, and let me read a paragraph  
3 from that.

4 (Reading) Interim measures to deal with any  
5 immediate health risks to the Hadnot Point  
6 Industrial area have been or are being implemented -  
7 - and the vapor intrusion is one of the five that  
8 was recommended by the contractor. These measures  
9 include continual assessment of active water supply  
10 wells, continued groundwater monitoring, cessation  
11 of continuing sources of contamination, ambient air  
12 monitoring, and underground space monitoring.  
13 Specific tasking has been made to the appropriate  
14 Marine Corps base agencies, and they are  
15 implementing the measures. A full report of the  
16 interim measures will be made at our next TRC  
17 meeting.

18 There's no record of any, the next TRC meeting  
19 was scheduled for '89, and I believe it was  
20 canceled, and I've yet to find any records of any  
21 follow-up on this at any of the TRC meetings.

22 **MR. STALLARD:** Okay, well, you have brought up this  
23 issue. It's clearly evident that there's things to  
24 be done in terms of data mining. What I'd like to  
25 suggest, do you have -- I'm going to allow one more

1 before we move on with the people who have allocated  
2 time to be here at a certain time.

3 But, ma'am, you stepped up, and do you have  
4 something to contribute? Please say your name.

5 **MS. WILDER:** Sure. My name is Lynn Wilder. I'm the  
6 Associate Director for Science for DHAC, and I do  
7 have industrial hygiene experience. And just to  
8 clarify the values that were, that you were speaking  
9 about. It's a real-time monitor, flame ionization  
10 detector, so the flame burns anything that's organic  
11 in the air. So it can also be methane. I'm not  
12 familiar with what's in the groundwater, but there  
13 are a lot of different things that make up that  
14 50,000 parts per million so it's not specific to any  
15 one compound.

16 **MR. FONTELLA:** Are you including separating --

17 **MS. WILDER:** You have to sample for it, and that  
18 means taking a time-weighted sample and sending it  
19 to a lab.

20 **MR. FONTELLA:** Okay, the question is if you were  
21 doing the sampling, would you go in there, wouldn't  
22 you go take that information to the lab and say I  
23 want it tested for benzene, TCE and PCE and PCE or  
24 VC because we know that that's in the media as well,  
25 that that's in the groundwater? We know that.

1           **MS. WILDER:** I would as an industrial hygienist,  
2           yes. What they use is a screening method so when  
3           you get a reading that high, yeah, you want to  
4           follow up and do some air sampling and send it to a  
5           lab.

6           **MR. FONTELLA:** Well, that's the point because  
7           they're only concentrating on benzene, but  
8           personally -- and I'm not a scientist or a chemist,  
9           but I believe with the amount of TCE at some of  
10          those buildings, 703,000 parts per billion that were  
11          in the soil right next to the building, right next  
12          to the, I mean, it makes sense to me that there were  
13          other things inside that building besides benzene.

14                 And the plumes on the south side of 78, and  
15          they co-mingled with the plumes later on on the  
16          north side. I mean, the plumes on the south side of  
17          TCE were a lot bigger, and why would they test on  
18          the north side and not do any testing on the south  
19          side? I believe there was testing on the south  
20          side. But we don't know that either because where  
21          are the figures? Where are the documents?

22                 If you, the people in here, the scientists, I  
23          know and I believe, and I've got a strong respect  
24          for everybody I've met in this organization. I  
25          believe if you were to go to do a test, you would do



1           **MR. MASLIA:** Good morning. Good to be here and be  
2           able to report on the status and update of the water  
3           modeling. What I'm going to present this morning is  
4           just where we are in the terms of completing water  
5           modeling, what tasks we have completed, and where we  
6           are. I'd also like to update you on some of the  
7           reports, chapter reports, that we're in the process  
8           of working as well.

9           The report chapters, you notice a list of all  
10          the proposed chapters is in the forward section of  
11          the Chapter C report that has been published, and we  
12          are not necessarily releasing them in alphabetical  
13          order, mainly to maintain concordance with the  
14          Tarawa Terrace report numbering system. So Chapter  
15          A is always the summary of findings and will be the  
16          last one out.

17          But Chapter C, of course, was released in  
18          October and provides the installation restoration or  
19          CERCLA sites that we worked on. And in Chapter B is  
20          the geohydrologic framework. That is the  
21          information that is basically needed to form the  
22          conceptual model groundwater flow for the various  
23          models that we are doing. It has been drafted.  
24          It's been sent out for external peer review. The  
25          peer reviews have come in. We are addressing them,

1 nothing extraordinary, more just technical fine  
2 turning.

3 And we should have that submitted through for  
4 the ATSDR-NCEH E clearance as an electronic  
5 clearance system that tracks the report as everyone  
6 reviews it in the chain that needs to review it. So  
7 we're looking at mid-April to submitting that for  
8 electronic clearance by ATSDR.

9 **MR. ENSMINGER:** How long have you been working on  
10 that, Morris?

11 **MR. MASLIA:** Well, Chapter B really, the data has  
12 been worked since like 2007 gathering the data.  
13 That is basic data. Chapter B will be just like  
14 Chapter C. It's basic data. The Chapter B, the  
15 difference is Chapter C and D -- if I might jump  
16 ahead -- have no interpretation. It just presents  
17 the data and not in order, whereas Chapter B already  
18 starts getting into interpretation of different  
19 water levels, different geologic pics and stuff like  
20 that. And that's why that one will take longer to  
21 review because there's interpretation in it.

22 Chapter D will be the equivalent of Chapter C,  
23 and that is a data report that lists above ground  
24 and underground storage tanks that have pertinent  
25 information for the water modeling, and that is

1           being currently written. Of course, there's a lot  
2 more designated underground than above ground  
3 storage tanks that were CERCLA sites, the fuel  
4 farming example. That's being drafted, and we  
5 intend to submit that for peer review by the end of  
6 May.

7           And then Chapter G is the water level report,  
8 and that again will present the measured water  
9 levels and the groundwater flow. The groundwater  
10 flow is the water level match. You may have  
11 remembered that from Tarawa Terrace, it shows that  
12 the different aquifers, what an aerial view of the  
13 water level looks like or what we think based on the  
14 data that has no modeling in that it's based on  
15 hydrogeologic. But you'll be able to determine  
16 directions of groundwater flow, gradients and stuff  
17 like that. But it's again from the data, from the  
18 data.

19           Now, with those, although those are still being  
20 drafted in writing, because we have the data we can  
21 progress along with the modeling, but those are  
22 needed when we put out modeling results. These  
23 reports have to be out there for the public to  
24 justify the conclusions with the modeling.

25           So in terms of modeling, the results of the

1 modeling, that is all the modeling, the three  
2 dimensional groundwater flow -- and I'll get to the  
3 titles of the models in a minute -- the fate and  
4 transport of single species PCE as a source, TCE as  
5 a source and benzene will be in that as well as  
6 degradation products for TCE and PCE. Those will  
7 all be summarized just like in the Tarawa Terrace  
8 reports in Chapter A. So you'll have some  
9 simulations, example simulations. And then the  
10 executive summary again will be a less technical  
11 version of Chapter A just again like we did with  
12 Tarawa Terrace, you know, 20, 30 pages of that.

13 Then the other chapters are actually the  
14 details that make up Chapter A. And the way we  
15 wrote for Tarawa Terrace, the way we're doing here,  
16 Chapter A will stand on its own. In other words  
17 someone who's doing a peer review will have  
18 sufficient information from Chapter A to peer review  
19 it and say where did you get this information, where  
20 did you get the assumption. But if they're  
21 wondering how we assigned each parameter value in  
22 the model, they would go to the different other  
23 chapter reports.

24 **MR. ENSMINGER:** Before I forget this, Morris, can we  
25 get a copy of your slide show here?

1           **MR. MASLIA:** It's been -- let me check. It's been  
2           cleared through my division. I'll have to send it  
3           up another chain of clearance to release it publicly  
4           because I got it --

5           **MR. ENSMINGER:** What, this?

6           **MR. MASLIA:** -- I got it cleared for a presentation  
7           only. I'm just following the rules.

8           **MR. ENSMINGER:** I figured if you're presenting it  
9           publicly that --

10          **MR. MASLIA:** Well, you check off on the clearance  
11          thing that it's for a presentation only so I will  
12          put it, resubmit it back in and get it --

13          **DR. PORTIER:** Morris, let's just say it's cleared.

14          **MR. MASLIA:** Okay.

15          **DR. PORTIER:** Give them a copy and then put it into  
16          the system and we'll make it official.

17          **MR. MASLIA:** Thank you. I can provide you, Jerry,  
18          with hard copies.

19          **MS. RUCKART:** No, ^ already has electronically, but  
20          I didn't distribute for the reason he just gave.

21          **MR. MASLIA:** Yeah, I'll make you copies.

22                        So basically our goal is that we're still on  
23          track as of right now is to have public -- when I  
24          say public -- a clear and published Chapter A and  
25          Executive Summary by sometime at the end of December

1 of 2011.

2 With that let me just quickly again go over,  
3 and I just compared for the Tarawa Terrace area,  
4 these are approximate values but generally the area  
5 that we're working in now at Hadnot Point, Holcomb  
6 Boulevard is an order of magnitude more in data,  
7 more in complexity. And as an example there's a  
8 hundred water supply wells, only actually 96 of them  
9 supplied water for drinking purposes. There were  
10 two irrigation wells for the golf course, one  
11 emergency standby for the Naval Hospital that was  
12 not used except in emergency, and one well that they  
13 drilled that was never hooked up to the system.

14 **MR. ENSMINGER:** And the golf course irrigation wells  
15 weren't drilled 'til '87.

16 **MR. MASLIA:** Right, but I'm saying in accounting for  
17 everything so that's what you have. But again on  
18 the contaminant sources these right now are just  
19 identified potentially for the modeling. We have to  
20 actually go through and see if it's an actual source  
21 or it is a hotspot from, it's been carried from the  
22 source to by groundwater. What may appear as a  
23 source may not be a source and may just be a  
24 degradation pathway in the groundwater that's been  
25 carrying the source from the original source.

1           **MR. ENSMINGER:** Meaning the pool?

2           **MR. MASLIA:** Well, yeah, yeah, by pumping by natural  
3 groundwater flow.

4                       So let's go into our modeling analyses, and  
5 here I've got a map on the next slide so I will show  
6 you. So the steady state pumping, that is, we  
7 needed that to establish certain parameters which  
8 are not necessarily time bearing for things like  
9 conductivity of the aquifer, the average long-term  
10 infiltration so we developed that, and we did that.  
11 We call it a regional for people working in larger  
12 areas.

13                      It's not, but it's going to the natural  
14 hydrologic boundaries. So that's the big outer  
15 boundary. And that represents about 50 times larger  
16 than the Tarawa Terrace model. But it includes all  
17 the streams, all the paleo channels and, of course,  
18 Northeast Creek there. Those are hydrologic  
19 boundaries and that's what you need to successfully  
20 calibrate the model. It is calibrated to long-term  
21 water without pumping, as well as to defend it under  
22 peer review.

23                      The transient, because wells were there  
24 pumping, it obviously changed the groundwater levels  
25 so we need to do a transient model because that's

1           what drives the flow velocities for the transport of  
2           contaminants.

3           And we will use the big regional model just as  
4           a transition model to check the smaller areas.  
5           Those are the two areas, the smaller ovals so to  
6           speak, the lower one being the industrial area, and  
7           the upper one going north-south being the landfill  
8           area. And that is because those are in the middle  
9           of the hydrologic boundary, and there are no good  
10          boundaries.

11          There's no stream or creek or river that  
12          influences that so we have to use a bigger model to  
13          tell us what is happening from month to month to  
14          month to make sure that we can defend those smaller  
15          areas. And outside the smaller areas there are no  
16          sources that impacted the drinking water supply  
17          wells.

18          So those are the two areas. The industrial  
19          area obviously will have PCE, TCE and a benzene  
20          model. And the landfill area will be PCE, TCE fate  
21          and transport on that.

22          And just to show you what happens from the  
23          regional standpoint here I've got a little animation  
24          here. You can see the water levels moving, and  
25          that's basically an animation of 40 or 45 years.

1           And you can see the holes going in there. That's  
2           the wells pumping.

3                   But what you don't see, this is good, is the  
4           boundary down here are barely, barely moving.  
5           You're not getting this one going all the way up  
6           here or this one comes all the way out here. It's  
7           moving slightly, and that's what we want to see  
8           because that means we've got boundaries where we can  
9           expect there will be very little contaminant  
10          concentration at those boundaries. You have to make  
11          an assumption that at those boundaries we either  
12          have zero concentration coming out or zero flux, and  
13          that's how this bigger model is --

14          **MR. ENSMINGER:** Run that again.

15          **MR. MASLIA:** Okay. Again, these are wells right  
16          here. That's Well 602 right there.

17          **MR. ENSMINGER:** I was watching that the first time  
18          you run it. I wanted to look at 651 out there on  
19          Piney Green Road.

20          **MR. MASLIA:** Six fifty-one is right up there. Now  
21          some of them depending on how much they pump and  
22          when they pump and all that sort of stuff you may  
23          not see nice round circles because of the aqua  
24          properties around it. If the aqua properties can  
25          supply a lot of water, they're highly transmissive,

1           you don't get a deep draw down.

2           **MR. BYRON:** Run it again, Morris.

3           **MR. MASLIA:** So again, the larger model has  
4           basically allowed us to establish what the water  
5           levels should be over time in the smaller areas, and  
6           that's what we use to justify. But what you see out  
7           here there's nothing going on out here. And the  
8           reason that's critical if we're ever going to finish  
9           modeling in a realistic time.

10           If we tried to do fate and transport over this  
11           whole area but there's only sources here, fate and  
12           transport takes forever to run. I don't care how  
13           big of a PC or how many you have so we're trying to  
14           narrow the modeling area to really load it and  
15           justify and where the impact is.

16           Unlike Tarawa Terrace, Tarawa Terrace was  
17           basically about the size of, the whole model area  
18           was about the size of these areas like that. So  
19           that's why in Tarawa Terrace we didn't have the  
20           narrow the fate and transport. We just used the  
21           entire grid. That's basically where we are with  
22           respect to that.

23           So the contaminant fate and transport, as I  
24           said, the way we're working that is ATSDR staff are  
25           working on the single species models, the TCE and

1 the PCE as well as preparing the data and background  
2 for Georgia Tech where we're doing the multi-  
3 species, multi-phase just like we did with Tarawa  
4 Terrace and then also the benzene in the HB 204  
5 area.

6 And that's just a map showing where the IR and  
7 UST sites of the data that we've obtained for these  
8 local area models.

9 **MR. FONTELLA:** What are those square symbols?

10 **MR. MASLIA:** That's the underground, above ground  
11 storage tank locations, and the whitish in-descript  
12 areas are the IR sites that were in Chapter C. If  
13 you see a perfect circle, it looks like a perfect  
14 circle, that just means that's the extent of the  
15 sample. That doesn't mean that ^ necessarily went  
16 out to that, but that's just the extent and they  
17 really did not define an actual boundary for the IR  
18 site, and that's in Chapter C.

19 So the last thing is the intermittent water  
20 supplies between Hadnot Point and Holcomb Boulevard  
21 treatment plants. And, of course, we talked about  
22 that. While we do have a calibrated water  
23 distribution system model, we are simulating, after  
24 much discussion, what we call an event-based  
25 scenario.

1           That is, when we have documentation in the  
2 logs, and we have the log that they said they turned  
3 on the booster pump or turned on the valve, we will  
4 then run that distribution model and look at minimum  
5 scenarios, average scenarios and maximum scenarios  
6 for that time.

7           And then we will also do some uncertainty Monte  
8 Carlo, uncertainty looking at model parameters. And  
9 we'll provide a range of concentrations and be able  
10 to tell you with some degree of probability what  
11 areas of Holcomb Boulevard contaminated water went  
12 to when it was transferred from Hadnot Point. And  
13 this is the piping, the water pipelines. This down  
14 here is Hadnot Point. And, of course, that's the  
15 booster pump right there so we're treating it as  
16 just a reservoir for modeling terms.

17           And when we know the booster pump was turned  
18 on, then we run the distribution model and we'll be  
19 able to look at different areas and see what  
20 percentage or what volume of the water went to what  
21 areas and from that extract data concentration or  
22 range of concentrations for that particular event  
23 for that particular time that the transfer took  
24 place.

25       **MR. ENSMINGER:** Is that the Naval Hospital between

1 Brewster and Midway Park?

2 **MR. MASLIA:** Up on top, center top, that's the new  
3 Naval Hospital as opposed to Hospital Point.

4 **MR. ENSMINGER:** Now I'm correct in saying that there  
5 were only eight wells on the Holcomb Boulevard  
6 system up until 1987.

7 **MR. MASLIA:** That sounds right.

8 **MR. ENSMINGER:** Now have you guys taken into  
9 consideration that the new Naval Hospital opened up  
10 in the beginning of 1983?

11 **MR. MASLIA:** And with respect to?

12 **MR. ENSMINGER:** That would have put one hell of a  
13 load on the unexpanded Holcomb Boulevard system  
14 beginning in 1983.

15 **MR. MASLIA:** Now this distribution system modeling,  
16 water distribution system modeling is a little bit  
17 different than groundwater modeling. And the reason  
18 is, is this type of modeling, particularly the model  
19 we use which is EPA-Net II, is a public domain model  
20 held by EPA. And it's what's referred to as a node  
21 link command model and at each location we happened  
22 to use hydrant locations just because there as you  
23 say how much water is being drawn out of the system  
24 in this case or how much is being delivered to a  
25 certain area.

1           So in fact there are demand nodes up at the  
2 Naval Hospital. There's water going from the  
3 distribution system to the Naval Hospital. And the  
4 reason we know that is, is we calibrated the model  
5 based on field data that we collected in 2004. In  
6 2004, the hospital was working, I mean, was  
7 operating. So that's one of the things we can do.

8           Because with the Toms River, New Jersey, is  
9 with the distribution model approach to this, is we  
10 can take present-day information, which is very  
11 good, and, in fact, have how they operated  
12 historically, whether they operated the same, at a  
13 lower level or what.

14       **MR. ENSMINGER:** But what I'm saying is when they  
15 opened that new hospital, that was a new demand on  
16 an already small system. It was only a two million  
17 gallon a day system, which wasn't on that system  
18 previously. It was, the old hospital was on Hadnot  
19 Point.

20       **MR. MASLIA:** Right, but that's why we're assuming,  
21 what our assumption is when they turned on the  
22 booster pump, the booster pump was going to supply  
23 any water that the system needed no matter who's  
24 pulling the water out. And that is because the pump  
25 will cavitate or you have negative pressures if you

1           have more demand than the pump could supply. This  
2           was a huge pump. This was 700 gallons per minute.  
3           When that pump goes on, it supplies whatever water  
4           they needed. So, if in fact --

5           **MR. ENSMINGER:** At Hadnot Point?

6           **MR. MASLIA:** Yeah. No, the hospital. The hospital  
7           was demanding water, and they could not supply it  
8           with the -- well, that's when they would indicate,  
9           for example, you'd see a note that they turned on  
10          this booster pump. This booster pump then would  
11          supply, the way it worked, that booster pump will  
12          supply whatever water the system is demanding.

13                 That's the way the model is worked. It is  
14                 defined as a demand-based model. So if there's a  
15                 demand, if there was a demand over here, a high  
16                 demand here, you turn this booster pump on. It's  
17                 going to satisfy that demand or it's going to tell  
18                 you there's negative pressure in the pump, and it  
19                 cannot operate. And typically, they don't operate  
20                 pumps under negative pressure because it cavitates  
21                 the ^.

22                 And so that's why I'm saying it's different  
23                 than a groundwater model because a groundwater model  
24                 the groundwater's flowing, and you just pull water  
25                 out of the system. And if you don't have the right

1 number of wells, you're not going to pull the right  
2 amount of water. A distribution model does not work  
3 that way. You've told it what the demands are and  
4 where the demands are located and water to supply  
5 that will turn that pump on. It's going to supply  
6 all that water.

7 **MR. ENSMINGER:** Well, I took notice in their log  
8 books where there were multiple, a lot of entries  
9 after '85 after they said they took all the wells,  
10 the contaminated wells, offline. There's a lot of  
11 entries in those logbooks without turned on booster  
12 pump. What the hell was going on prior to '85? We  
13 know that the new hospital opened in early '83. I  
14 mean, they just didn't get that big water demand.

15 **MR. MASLIA:** Well, typically in this area, when they  
16 turned on, from the logbook that they had, it was  
17 typically in late spring and early summer. Anyway,  
18 that's again -

19 Was there a question?

20 **MR. BYRON:** Yes, I have a question for you. There's  
21 two irrigation wells for the base golf courses.  
22 Were they capable of providing enough water in the  
23 system? Because in the past we said the valves were  
24 open to --

25 **MR. MASLIA:** Well, the golf course wells are

1 another, for example --

2 **MR. ENSMINGER:** Well, I know what he's saying.

3 Morris, let me answer that.

4 **MR. MASLIA:** Okay.

5 **MR. ENSMINGER:** What they did was they used water  
6 hazard ponds to draw all the irrigation water out  
7 of, and then after they irrigated the golf course,  
8 they replenished those ponds with those wells. So,  
9 yes, to answer your question they had enough water  
10 to water the golf courses.

11 **MR. MASLIA:** But one of the things we found during I  
12 think last year when we were at Lejeune is, of  
13 course, we found the maps for the sprinkler systems  
14 on the golf courses. And that was important because  
15 if not, we would not know what the demand for this  
16 model would be. We would have to just assume  
17 something like how much the wells pulled which is  
18 not exactly a direct. But now we do, and we've  
19 coded that into the model. We took the sprinkler  
20 system map, backed out -- we had Chris Fletcher as a  
21 matter of fact, who used to work in the sprinkler-  
22 irrigation business, and so he helped us back out  
23 what the capacity of each of the individual  
24 sprinklers were. And then we added that into the  
25 models. The model does include the golf course

1           sprinkling using, of course, obviously treated water  
2           at that time.

3           **MR. PARTAIN:** So, Morris, so in theory once you got  
4           all the different points to demand loads that was  
5           being placed upon the Holcomb Boulevard system,  
6           you'll be able to go back and extrapolate that back  
7           to 1972 to determine what kind of demand was being  
8           placed on that system. And then in theory, we know  
9           how much water was being produced by the eight  
10          wells. If that demand exceeds the capability of the  
11          production wells, then in theory they're opening-  
12          closing valves, the booster pump in the valves.

13          **MR. MASLIA:** I'll say --

14          **MR. PARTAIN:** Is that correct? Is my reasoning  
15          correct?

16          **MR. MASLIA:** Let me just... Unlike the groundwater  
17          model where we are continuously operating it from  
18          1941 through 1990, through 2005, 2008, this water  
19          distribution model, the time scale on it runs 24  
20          hours, usually run a distribution model has a  
21          typical 24-hour pattern. So it is calibrated to  
22          when we saw an entry in the logbook routinely turned  
23          on the booster pump.

24                        We will then run the model for that time  
25          period. We may run it for a week, but that's

1 typically all you run a water distribution system  
2 model and see under those conditions what the  
3 distribution of contaminants would be. We have a  
4 certain amount, we know the volume. The model will  
5 tell you how much water was being demanded, how much  
6 water was being moved. You can look at the demand  
7 and then look at what the wells could supply and  
8 also water in the elevated storage tanks and see if  
9 it exceeded or not the capacity.

10 **MR. PARTAIN:** Well, what about prior to '85 because  
11 --

12 **MR. MASLIA:** Yeah, we've got it prior to '85. In  
13 other words we've got readings in there. I think  
14 we've got some readings in the '70s. Again, we  
15 don't have continuous readings.

16 **MR. PARTAIN:** Well, you mention that you're going  
17 back to the logbooks and looking for when they've  
18 activated the booster pumps and turned the valves.

19 **MR. MASLIA:** That's correct.

20 **MR. PARTAIN:** We've got a set of logbooks that are  
21 missing for how long a period?

22 **MR. MASLIA:** It's from '72 to about '78, yes.

23 **MR. PARTAIN:** And there's a period in the '80s that  
24 are missing, too, '82-'83 or '83-'84. My question,  
25 I noted when I was, in my recollection of the

1 logbooks though the notations on activating the  
2 booster pump between Holcomb Boulevard and Hadnot  
3 Point, they weren't really notating that in that, in  
4 the check-in log, until after the contamination  
5 started to, the contaminated wells started to shut  
6 down in '84. And then these people were noting, you  
7 know, when people farted and stuff like that. They  
8 were notating everything in there. So what about  
9 prior to '85?

10 **MR. MASLIA:** We've got entries. In fact, I've shown  
11 a graph before. I didn't bring it with me, but we  
12 have entries before that. We have found entries in  
13 that and also just some separate documents that  
14 would say that. So we do have, but a point I guess  
15 I want to make is we're doing event phases. So  
16 we're doing it when we see an entry or we have  
17 information that they turned on the booster pump,  
18 and we're looking at a period of time around that  
19 event.

20 And then we will look at all these separate  
21 events and see is the contamination spreading  
22 differently or is there a bigger or smaller  
23 percentage in a certain housing area or not. But  
24 you just, typically you do not run a water  
25 distribution system model continuously like you do

1 in time like a groundwater model. Because it's a  
2 24-hour based event you may run it for a few days or  
3 a week, maybe a month at the most, but that's it.  
4 And because we do have very limited and sporadic  
5 information, and we're going to an event base with  
6 all these separate events.

7 **MR. STALLARD:** Let me check in. We're ten minutes  
8 into what was going to be our break at 10:15 through  
9 no fault of Morris. We started late. So what I ask  
10 is, A, we can break now and come back in ten minutes  
11 and then have Morris finish up with --

12 **MR. MASLIA:** I'm done unless you have questions.

13 **MR. ENSMINGER:** I have one question.

14 **MR. MASLIA:** Yes.

15 **MR. ENSMINGER:** Your documentation of the missing  
16 JTC lab reports and this thing with Elizabeth Betz.

17 **MR. MASLIA:** Elizabeth Betz I'd like to defer to  
18 Sven because that is really being done under the  
19 data mining and technical work group between him and  
20 Scott Williams. I think they're trying to get all  
21 the (inaudible).

22 With respect to the JTC reports, those are the  
23 JTC Environmental Labs, we have, of course, a letter  
24 from the Navy to get the exact date on it, showing  
25 that they have submitted these numbered reports to

1 EPA. We have asked both the Navy for everything  
2 that they have. We've asked EPA Region IV. EPA  
3 Region IV claims total amnesia on the whole thing.

4 We had a person go down, not that was working  
5 for us but that was a colleague that was down at  
6 EPA, and he said there's nothing there. There's  
7 nothing there even in terms of Camp Lejeune. Where  
8 they sent it we don't know. We've asked and we  
9 spent weeks and months on that.

10 I did have, just this past week, one of our  
11 temporary contractors go through the Navy letter and  
12 listed all the JTC report numbers going through what  
13 we published on the, in the Tarawa Terrace reports,  
14 and then also going through what the Navy now refers  
15 to as the Consolidated Index File, the BAH files  
16 that they collected back in 2005 or '07, something  
17 like that to see if any of those missing reports  
18 showed up there, but they did not.

19 So at this point I think our approach is this  
20 should be really an issue to be handled between EPA  
21 and the Navy. I mean, in other words the Navy said  
22 they sent them with the letter. They obviously were  
23 not attached to the actual cover letter. EPA, as I  
24 said, claims amnesia on the whole situation.

25 Why, I don't know, but I wouldn't know where to

1 start other than if this agency or somebody needs to  
2 get on top of EPA and ask, one, why they have  
3 nothing for Camp Lejeune if it's an active NPL and  
4 remediation other than their annual reports  
5 (indiscernible). Why we have a letter -- and y'all  
6 have it, too -- from the Navy listing all these  
7 reports that they sent, and they cannot produce a  
8 single one of them.

9 **MR. ENSMINGER:** Go figure, the ones that showed  
10 contamination --

11 **MR. MASLIA:** Well, and anyway all I'm saying is, I  
12 mean, we have put as much effort and staff on this  
13 even with these documents that are Consolidated  
14 Index to make sure that we did not miss any reports.  
15 One thing we did, our contractor told us, is that on  
16 a lot of these reports you'll have a cover page and  
17 then have several JTC. Ignore the cover page  
18 because many times the cover page misnumbered or  
19 misidentified the reports that are --

20 **DR. DAVIS:** What's a JTC?

21 **MR. MASLIA:** It stands for JTC Environmental  
22 Laboratories. I don't know what JTC stands for.

23 **MR. PARTAIN:** It's analytical sampling for tap  
24 water.

25 **DR. DAVIS:** Is it GOCO? Was it a part of the

1 government?

2 **MR. MASLIA:** No, no, no, no, no, no. It's a private  
3 contractor, and they did some sampling between '84  
4 and about '86, '87.

5 **DR. DAVIS:** So they're legally required to have  
6 records?

7 **MR. PARTAIN:** They don't exist anymore.

8 **DR. DAVIS:** So they've committed, they've violated  
9 the law?

10 **MR. ENSMINGER:** The EPA's violating their own law.

11 **MR. STALLARD:** So have you got the answers that you  
12 asked for?

13 **MS. RUCKART:** I just want to check in because we've  
14 been told there are some technical difficulties and  
15 people can't call in, but it sounds like somebody's  
16 on the phone.

17 So if someone's on the phone, can you please  
18 just identify yourself and help us verify that the  
19 systems are working even if it's the Closed  
20 Captioner? Is anyone on?

21 (no response)

22 **MS. RUCKART:** Because we heard some feedback where  
23 it sounds like somebody is dialing in and also  
24 viewing it over the internet so I just want to  
25 check. Please just identify yourself if you're on

1 the phone so we can help identify our IT problem.

2 (no response)

3 **MR. STALLARD:** Okay. So is this the appropriate  
4 time?

5 **MR. MASLIA:** Yeah, and one thing, Jerry. I know  
6 Sven and Scott are working on their list of things.

7 **MR. ENSMINGER:** Well, you guys had a phone call --

8 **MR. MASLIA:** Well, I've got that, and we wrote down  
9 those notes. And Sven, Bob Faye and I are all in  
10 agreement with them. The Navy is not.

11 **MR. ENSMINGER:** Why? Do they deny that she spoke?

12 **MR. MASLIA:** No, no, no, no, they're in denial in  
13 reference to one sampling done.

14 **MR. PARTAIN:** Are you talking about CLW and 1406 and  
15 the 2,500 parts per million?

16 **MR. MASLIA:** Yeah.

17 **MR. PARTAIN:** So the Navy is in denial that that is  
18 an actual valid --

19 **MR. MASLIA:** No, no, well, they're in denial that  
20 she said what she said, but four out of five people  
21 heard her say it.

22 **MR. STALLARD:** She knows what she said.

23 **MR. ENSMINGER:** And now she's lawyered up, and you  
24 can't get her to cooperate with us in writing?

25 **MR. MASLIA:** All I know is Sven and Scott are

1 working --

2 **MR. ENSMINGER:** The one thing, the one thing I  
3 wanted to bring out right now here publicly during  
4 this meeting --

5 **MR. STALLARD:** Listen up, folks.

6 Go ahead.

7 **MR. ENSMINGER:** This is important. Why is this  
8 falling on Sven and Scott Williams' shoulders? Your  
9 damn Office of Legal Counsel should be involved in  
10 this thing. If she's lawyered up, then your Office  
11 of Legal Counsel needs to get involved in this and  
12 get up with her attorney. That's what you guys have  
13 an Office of Legal Counsel for here.

14 **MR. MASLIA:** My understanding is -- and it was from  
15 the Navy that is requesting the official, legal.  
16 We're satisfied with what we wrote down at the  
17 meeting and the notes that we took. We have no  
18 issues with the notes that we took.

19 **MR. ENSMINGER:** So what they're trying to do is make  
20 her change her story?

21 **MR. MASLIA:** Well, I don't know, but I'm saying I  
22 wrote, you know, we were all on the phone. Three of  
23 us were in the same room, that we took hand notes.  
24 We went over one question, one issue in particular  
25 three times to make sure. I wrote that. All the

1 people at ATSDR saw my notes and were in agreement  
2 with that. We have no issues with our notes.

3 **DR. DAVIS:** A question of clarification.

4 **MR. MASLIA:** Yes.

5 **DR. DAVIS:** As you all have been working on this and  
6 know much more of the details than I think most,  
7 certainly more than I. The issue we're focusing on  
8 right now is documenting past exposure and the  
9 glaring gaps in information that suggests a cover  
10 up. That's what this is, right? That's what we're  
11 concerned about, okay? And we have people who have  
12 disclosed information, then we have missing  
13 information, et cetera. That's a separate set of  
14 issues from the thing that brought you all together.

15 The thing that makes you unique is that in this  
16 room there is an extraordinary number of people who  
17 have had male breast cancer and whose family members  
18 have suffered other diseases. That's what's brought  
19 you together. The tasks of epidemiologists of ATSDR  
20 is can you show whether or not there's significant  
21 damage to people because of these exposures.

22 But these are two totally separate issues. One  
23 is what happened in the paths of exposure, and  
24 that's what we're all focusing on in this  
25 discussion. But the larger issue is what has this

1           meant for your health and what will it mean for the  
2           future of people who were exposed to those  
3           conditions which we can't thoroughly document  
4           because of these missing pieces of information.

5           So my question to you is what is the goal of  
6           this meeting? What do you hope to achieve by the  
7           end of today? We're here for one day, and what do  
8           we want to go forward with? Because we're focusing  
9           on this debate about the past, and I think it's  
10          important that people ought to be held accountable.  
11          And if there is evidence, which it sounds like there  
12          may be, of withholding information, you can show  
13          that. We live in what is a democracy. We're  
14          supposed to have access to information. The right  
15          to know is fundamental. So what is the goal here?

16          It sounds like we could have the entire meeting  
17          and talk about who did what and why we don't have  
18          information. But what is the ^ here? What are we  
19          trying to do today?

20          **DR. BOVE:** We need to take a break. Actually, our  
21          facilitator had to take a break, but Sven is  
22          supposed to call in at 10:30. Now the problem might  
23          be we've been having technical difficulties all day,  
24          so he may not be able to call in because he won't be  
25          able to get in.

1           I understand that, and he hasn't called in so  
2 that tells me that Dick Clapp can't get in, neither  
3 can Tom Townsend. We've brought it to the attention  
4 of the people who deal with that. We've been told  
5 they don't understand why, our IT problems here.

6           But let me back up and say the purpose of these  
7 meetings is the epidemiology. But in order to  
8 determine exposure we need to get certain pieces of  
9 information and nail down certain contamination  
10 levels. So that's why this discussion is useful.  
11 You guys want to take it further and that's fine,  
12 but for the science purposes we still need the  
13 documentation as to what...

14           But let's take a break and come back as quickly  
15 as possible, five or ten minutes. We have proof  
16 that there is documentation is what I'm saying  
17 though.

18           (A break was taken at 10:35 a.m. Meeting reconvened  
19 at 10:50 a.m.)

20           **MR. STALLARD:** Do we have anyone on the phone with  
21 us at this point?

22           (no response)

23           **MR. STALLARD:** We're waiting for Rear Admiral Sven  
24 Rodenbeck to call in.

25           **DR. DAVIS:** While we're waiting could I have some

1 discussion which -- I want to reflect on a  
2 conversation I had with Mary Blakely and some others  
3 during break. We were talking about -- and Frank,  
4 you and I discussed this before -- I can tell you we  
5 can get him on his cell phone and put him on a  
6 speaker here.

7 **MR. STALLARD:** Who's just joined us, please?

8 Welcome. Sorry that we had difficulties with  
9 the number.

10 Who's on the phone? Anyone? Dr. Clapp, you on  
11 the phone?

12 **DR. CLAPP (by Telephone):** Yes.

13 **MR. STALLARD:** May I have your attention, please?  
14 Rear Admiral Rodenbeck?

15 **REAR ADMIRAL RODENBECK:** Yeah, I'm on.

16 **MR. STALLARD:** Well, we apologize for the technical  
17 glitch here, not to mention we got a little  
18 sidetracked in terms of the agenda, but we're on it  
19 now, and we're looking forward to your presentation  
20 on the Data Mining Workgroup Update.

21 **DATA MINING WORKGROUP UPDATE**

22 So if I could please have everyone's attention  
23 in the room, we'd like to welcome Rear Admiral Sven  
24 Rodenbeck for his portion of the agenda.

25 So go ahead, sir. Please take it away.

1           **REAR ADMIRAL RODENBECK (by Telephone):** All right,  
2           thank you. And as far as the data mining, we've had  
3           a conference call back in February 15<sup>th</sup>. Of course,  
4           the summary of that meeting has been posted on the  
5           website. We're making slow but steady progress.

6           You may have noticed that we have added some  
7           new sub parts to some of the action items that we  
8           originally closed out. We did that instead of just  
9           adding new action items. It was a matter of, you  
10          know, which way do you want to list this thing.  
11          Since it was related to some particular items, we  
12          just reactivated them, and what we're doing is just  
13          trying to make sure we're hitting everything.

14          Most of the activity of the data mining is  
15          actually trying to find information that's beyond  
16          the control of the federal government or not in  
17          possession of the federal government whether that be  
18          Navy or ATSDR. Therefore, we're getting ready to  
19          send letters to former lab contractors and some  
20          small consultants to see if they have anything that  
21          is not in the Navy repositories and stuff. And  
22          that's basically it.

23          We really are going to try to close out this  
24          activity as far as related to the groundwater  
25          modeling, water distribution modeling and the health

1 studies here in the next month or so. And, of  
2 course, we have the activity related to vapor  
3 intrusion to take up after that, and that's it  
4 really.

5 **MR. STALLARD:** Let's see if we have any questions  
6 here from the CAP members in the room.

7 **MR. FONTELLA:** Jim Fontella. Sven, the last time  
8 you spoke when you were at the meeting, you said  
9 that there was some other documents that you had  
10 like maybe a hundred memos and telephone logs and  
11 stuff or e-mails. And you asked if we wanted those  
12 and nobody answered yes so you would decide. Well,  
13 we'd like those documents, please.

14 And also the testing results, I have  
15 documentation that said that buildings, all the  
16 1100-series buildings, 1200-series buildings, one  
17 1300-series building, a couple 1000-series buildings  
18 were tested for vapor intrusion between 2000 and  
19 2008, I believe. And we have no records of any of  
20 the sampling results although the documents  
21 themselves say these buildings were sampled, some of  
22 them on a weekly basis, that had a lot of vapor  
23 problems, and some of them on a monthly basis who  
24 were like once in awhile. We would like you to seek  
25 those documents for us as well.

1           **REAR ADMIRAL RODENBECK (by Telephone):** April and  
2 June we'll be doing the water modeling and health  
3 studies and stuff and take that forward. As far as  
4 the e-mails and everything your first comment, I'm  
5 sorry. I'm not following what that was related to.

6           **MR. FONTELLA:** You spoke last time at the last  
7 meeting that there were some other documents, and  
8 you asked us if we needed those documents. You  
9 apparently said they really weren't much. They were  
10 just like memos and interoffice things like that,  
11 but from what I've looked at in my last  
12 investigation in the last month and a half or so, a  
13 lot of these documents that are handwritten or  
14 interoffice memos speak volumes for some of the  
15 things that were going on, and I would like that.  
16 If you look at the transcript at the last meeting, I  
17 think you'll be able to see what we, what I'm  
18 talking about.

19           **REAR ADMIRAL RODENBECK (by Telephone):** Okay, I'll  
20 look at that again.

21           **MR. FONTELLA:** Thank you very much.

22           **MR. STALLARD:** And now, Jerry.

23           **MR. ENSMINGER:** Sven, this is Jerry Ensminger.

24           **REAR ADMIRAL RODENBECK (by Telephone):** Hi, Jerry.

25           **MR. ENSMINGER:** What's going on with this thing with

1 Elizabeth Betz that Morris was telling us about?  
2 Somebody wants a written, signed, sworn statement  
3 from her now or what?

4 **REAR ADMIRAL RODENBECK (by Telephone):** A sworn, we  
5 asked her to provide responses in writing to some  
6 questions. And for whatever reason she has not  
7 responded to frequent e-mail requests over a month's  
8 period. I know beginning of the year she had some  
9 health issues, and she responded back -- I think it  
10 was late January, early February -- that she would  
11 get back to us. And then we haven't heard anything.  
12 I'm just hoping she hasn't had a relapse.

13 **MR. STALLARD:** Thank you.

14 Any other questions for Rear Admiral Rodenbeck?  
15 (no response)

16 **MR. STALLARD:** All right sir, well, thank you for --  
17 wait, I guess we do have one more.

18 **MR. PARTAIN:** Hey, Sven, I'm sorry. This is Mike  
19 Partain. I just remembered something. When you  
20 mentioned going back towards --

21 **MR. ENSMINGER:** Time out. I was taking care of  
22 something else. I got distracted.

23 It's my understanding Elizabeth Betz is  
24 lawyered up. And if that's the situation, she's not  
25 going to respond to anybody. That's what you have

1 an Office of Legal Counsel for here, and I recommend  
2 that you go to your Office of Legal Counsel and get  
3 them involved and send her a legal letter telling  
4 her that you need this stuff and use your lawyers.  
5 That's what they're here for.

6 **REAR ADMIRAL RODENBECK (by Telephone):** We don't  
7 have that type of legal authority, I don't believe,  
8 Jerry.

9 **MR. STALLARD:** To depose someone?

10 **MR. BYRON:** He just said write a letter.

11 **MS. BRIDGES (by Telephone):** ^

12 **MR. STALLARD:** Hello, Sandra.

13 **MS. BRIDGES (by Telephone):** Yes.

14 **MR. STALLARD:** Welcome.

15 **MS. BRIDGES (by Telephone):** Yes, sir, thank you.

16 **MR. STALLARD:** Okay, now, Mike, you have something  
17 to say?

18 **MR. PARTAIN:** Sven, this is Mike again. When you  
19 mentioned about going towards the independent  
20 contractors that were doing the testing, are you, is  
21 MACTEC of Gainesville, Florida, on your list?

22 **REAR ADMIRAL RODENBECK (by Telephone):** I don't  
23 recall.

24 Morris, do you recall?

25 **MR. MASLIA:** Say this again.

1           **MR. PARTAIN:** MACTEC out of Gainesville, Florida,  
2           they're the ones that EOC eventually morphed into  
3           MACTEC.

4           **MR. MASLIA:** The name sounds familiar, but I --

5           **MR. PARTAIN:** Because they were the ones doing the  
6           connecting studies, say four and five.

7           **MR. ENSMINGER:** And their warehouse --

8           **MR. PARTAIN:** And they're the ones the warehouse  
9           burned.

10          **REAR ADMIRAL RODENBECK (by Telephone):** Now, M-A-C -  
11          -

12          **MR. MASLIA:** M-A-C-T-E-C?

13          **MR. PARTAIN:** Yeah, M-A-C-T-E-C. There are several  
14          employees that are still working there that have  
15          been there since the '80s. And also the W-A-R that  
16          did the initial assessment study is based out of  
17          Gainesville, Florida, too. And they're actually  
18          still in business and have a website. Some of the  
19          employees that were actually involved in the report  
20          I think are retired but were high up in the company.

21          **REAR ADMIRAL RODENBECK (by Telephone):** Okay, we'll  
22          cross-reference.

23          **MR. STALLARD:** And Morris is writing down notes  
24          here.

25          **MR. BYRON:** Isn't that what the Mafia would say when

1           the Department of Justice would say we want to see  
2           your records for the union? The warehouse burned  
3           down.

4           **MR. STALLARD:** Okay, Sven, I think that concludes  
5           the time we have allotted to you and the questions  
6           that were for you.

7           **REAR ADMIRAL RODENBECK (by Telephone):** Okay.

8           **MR. STALLARD:** So thank you again for calling in and  
9           sorry for the delay.

10          **MR. ENSMINGER:** Hey, Chris. Hey, Sven, this is  
11          Jerry Ensminger again. Now, the thing about the  
12          vapor intrusion, the point we're trying to make with  
13          that is we don't want this stuff overlapping each  
14          other and delaying Morris' work on water modeling.  
15          But there's no sense in any delay on this stuff and  
16          they can run parallel to each other, and these  
17          requests can go to the Department of the Navy. Why  
18          wait?

19          **REAR ADMIRAL RODENBECK (by Telephone):** We're trying  
20          to close things up so we're not delaying Morris and  
21          Frank.

22          **MR. ENSMINGER:** Well, I don't want anybody delay --  
23          I mean, but they've got plenty of people over there.  
24          They've got more than one person working on this  
25          issue. I mean, Scott Williams, he's got all kinds

1 of little helpers, you know? I don't want to  
2 overload his brain, you know, but...

3 **MR. PARTAIN:** Well, the other thing, too, Sven, is  
4 someone needs to make the request of the original  
5 committee; there are records that they were told to  
6 test in 1988. They said they were going to do it.  
7 There are no analytical results. We need to have in  
8 writing from the Navy that they either did or did  
9 not do the results. I mean, did or did not do the  
10 tests.

11 **REAR ADMIRAL RODENBECK (by Telephone):** I  
12 understand.

13 **MR. STALLARD:** Before I sign off, let me just look  
14 around the room one more time.

15 Are we done with Sven for today?

16 (no response)

17 **MR. STALLARD:** For those of you who are on the phone  
18 and not speaking, would you please mute your phone?  
19 I think we're hearing Jeopardy or something in the  
20 background or some feedback.

21 **MS. BRIDGES (by Telephone):** Mine's muted.

22 **MR. STALLARD:** Okay, great.

23 All right, Sven. Thank you very much.

24 **REAR ADMIRAL RODENBECK (by Telephone):** All right.

25 **MR. STALLARD:** Bye.

1           **REAR ADMIRAL RODENBECK (by Telephone):** Bye.

2           **Q&A SESSION WITH THE VA**

3           **MR. STALLARD:** So now we're more back on schedule  
4           with the agenda, and this is the time that we have  
5           allotted for question and answer with Mr. Bradley  
6           Flohr and Dr. Terry Walters, but she's not here,  
7           right? And so, please...

8           **MR. FLOHR:** Thank you. I'm pleased as usual to be  
9           here and to let you know that the subject of Camp  
10          Lejeune and the water contamination is still a very  
11          big issue in Washington. And that following our  
12          last CAP meeting with about seven or eight staff  
13          members from Senator Burr and Senator Hagan and  
14          Congressman Miller, and I believe another  
15          congressman and their staffs, talked with them about  
16          what the VA is doing.

17                 Also after our last CAP meeting I believe I  
18                 gave you the latest updates, and I think I told you  
19                 we had reviewed about 195 claims that had previously  
20                 been denied before we got to where we are now, and  
21                 reviewed those in our offices in Nashville. And  
22                 after going back and thinking about what we had  
23                 done, we decided we needed to take a look at those  
24                 195 not just in terms to see who was granted and who  
25                 was denied but look at the evidence that was used

1 and see if there was anything that was, could be  
2 done better.

3 So our staff in Nashville did that, and we  
4 found about 30 claims that we thought could benefit  
5 from additional review, perhaps new medical  
6 opinions. We sent those claims to Louisville also.  
7 And then we looked at perhaps getting new medical  
8 opinions, things like that.

9 We also determined after meeting with the  
10 Senate and House staffs that we should write a  
11 separate training letter on Camp Lejeune. As you  
12 know in April of 2010 we issued a training letter on  
13 environmental exposures. Those were mostly  
14 deployment related exposures from the current  
15 deployments. We did have a separate item about Camp  
16 Lejeune and also Camp Atsugi in Japan, which is  
17 another environmental exposure, but we decided we  
18 needed to do a complete training letter just for  
19 Camp Lejeune. We drafted one.

20 We have shared it with ATSDR. We shared it  
21 with our DOD/VA Deployment Health working group  
22 members, which includes, of course, Navy, Marines  
23 and other services that are part of the Deployment  
24 Health work group that we have. We got meaningful  
25 comments back from both DOD and ATSDR. We've

1 incorporated those into and accepted pretty much all  
2 of the comments we received in this training letter.

3 It's currently in our Undersecretary's office  
4 for final concurrence. I hope to get that done  
5 within the next week or so and provide that  
6 nationwide, but to Louisville, of course, but to all  
7 our offices so they're more aware of the situation.

8 Louisville is processing claims and they have  
9 contacted me frequently with questions. They sent  
10 about six cases to my staff for us to look at and  
11 provide them with our opinion as to what the proper  
12 action is in that particular case, and also that  
13 they will have a means then to look at similar cases  
14 and take similar actions.

15 They are granting and denying claims. They've  
16 done so far about 42 and have granted about 28  
17 percent of those which is significantly higher than  
18 the 195 that had previously been done. But the  
19 state of knowledge is much higher now than it was  
20 back then as well.

21 So we continue the work list. We've received  
22 letters from Senator Hagan that we have responded  
23 to. As I said, we're in frequent contact with her  
24 staff and Senator Burr's staff. And so that's about  
25 all I have for now. Well, Perri and Frank came up

1 in February, I believe, met with our Deployment  
2 Health work group, which again is a joint VA/DOD  
3 initiative, to look at the current deployments, but  
4 Camp Lejeune has been dominating the working group  
5 for the last four months. I think that's been the  
6 number one issue.

7 We have met with the Navy, with the  
8 Undersecretary of the Navy on a couple of occasions,  
9 with Deputy Secretary Gould of the VA, and to see  
10 what they could do to help the VA. Actually, our  
11 main charge to them was keep supporting ATSDR, keep  
12 funding them because that's really what the VA  
13 needs, is the best scientific information that we  
14 can get to make the decisions.

15 So Terry Walters was not able to be here today.  
16 She was going to dial in, but with some of the  
17 problems we've had perhaps she couldn't do that.  
18 That's about all I have, but I'll certainly  
19 entertain any questions.

20 **MR. FONTELLA:** Brad, on the training letter, like a  
21 couple weeks if I was to e-mail you, would there be  
22 a chance to get that training letter, a copy of that  
23 training letter?

24 **MR. FLOHR:** As soon as it's signed off on I will  
25 send it down to Perri, and she can send it to you.

1           **MR. PARTAIN:** And, Brad, out of curiosity is there  
2 any way that we could find out how many male breast  
3 cancer cases are in the VA system that are Marines,  
4 and of those how many had any connection to Camp  
5 Lejeune?

6           **MR. FLOHR:** I'll see what we can find out.

7           **MR. PARTAIN:** I'd like that.

8           **MR. FLOHR:** We have about, right now we have about  
9 600 claims in Louisville, so we did have to like go  
10 in and -- I think our systems captures that. I'll  
11 see what I can find.

12          **MR. PARTAIN:** Because I'm curious to see how many --

13          **MR. ENSMINGER:** No, they've already done the study.

14          **MR. PARTAIN:** But they didn't do it by service.

15          **MR. ENSMINGER:** I know.

16          **MR. PARTAIN:** If you had the study that was done a  
17 couple years ago, we identified over 600 cases of  
18 male breast cancer in the VA system. I'd be curious  
19 to know of those how many were Marines, and of those  
20 how many had any connection to Camp Lejeune if you  
21 could try to find out.

22          **MR. FLOHR:** I'll see what I can do.

23          **DR. DAVIS:** A clarification of that question.

24          **MR. STALLARD:** Brad, did you have a response to  
25 that?

1           **MR. FLOHR:** No, just that I will see what I can do.

2           **DR. DAVIS:** I just want a clarification to that  
3 question. Do you have a case definition that you're  
4 working with now for Camp Lejeune-related claims?  
5 In other words categories of different diseases that  
6 you're expecting. Is that something that you're  
7 expecting the ATSDR to give you or you have a  
8 working definition now?

9                         For example, some of the VOCs that have been  
10 reported and confirmed to have been in the water are  
11 associated with kidney cancer, non-Hodgkin's  
12 lymphoma as well as testicular cancer as well as the  
13 concerns about male breast cancer. So do you have a  
14 case definition there?

15           **MR. FLOHR:** No, we're not waiting for anything from  
16 ATSDR, not if it's already common knowledge of what  
17 the chemicals in the water can cause. We provide  
18 that information as part of our training letter.

19           **DR. DAVIS:** So my question is so these -- to follow  
20 up on Mike's question, you could break this down by  
21 service, Marine and others? And when you say you  
22 have 600 claims in Louisville, are those all claims  
23 from Camp Lejeune?

24           **MR. FLOHR:** Yes.

25           **DR. DAVIS:** They are. Do you have any idea what

1 number of them may or may not involve children?

2 **MR. FLOHR:** No. VA doesn't compensate children.

3 **DR. DAVIS:** So is there ever an example in the VA,  
4 for example, the dioxin issue, the Agent Orange  
5 issue which with I have some familiarity, where  
6 children of military dependents have been  
7 compensated through the VA?

8 **MR. FLOHR:** Not that I'm aware of. Spina bifida for  
9 Agent Orange is something that Congress enacted in  
10 law. There's been no such mandate for Camp Lejeune.  
11 The only way that we would compensate a dependent,  
12 and actually could be a dependent, but if someone  
13 under the age of 18 became permanently and totally  
14 disabled prior to age 18, the veteran parent can  
15 receive additional benefits if they're in receipt of  
16 compensation for that child. Where there is no  
17 parent living, the child can --

18 **DR. DAVIS:** But it's a total disability?

19 **MR. FLOHR:** Absolutely, by age 18.

20 **MR. BYRON:** My question for you there. You said if  
21 the parent was currently getting disability? So the  
22 child's disability would be predicated based on  
23 whether the parent, a veteran, had filed with the  
24 VA?

25 **MR. FLOHR:** Only veterans that were receiving

1 compensation at the rate of 30 percent or more are  
2 eligible for additional compensation for a child.  
3 Whether it's an under age 18 child --

4 **MR. BYRON:** So if your child was harmed by this, but  
5 you haven't come down with any symptoms, then you  
6 have no avenue for help?

7 **MR. ENSMINGER:** These congressional bills that are  
8 moving forward, Senator Burr's bill and Congressman  
9 Miller's bill, will, if they get passed, will  
10 address these, both of those things.

11 **MR. FLOHR:** It'll provide healthcare for dependents.  
12 I don't know about monetary compensation.

13 **MR. BYRON:** The healthcare is extremely important,  
14 right now that's what it's really about for my  
15 family; it's not money.

16 **MR. ENSMINGER:** Right.

17 **MR. FLOHR:** I also had an opportunity recently to  
18 review the Science Review Board, EPA Science Review  
19 Board, report on TCE. It's a 300-and-some page  
20 report ^ TCE at the level of a known human  
21 carcinogen. The Science Review Board was completely  
22 in tune with that, and they had a lot of comments  
23 that you'd be interested in I think down the road on  
24 TCE, potential exposures there and then what they  
25 might cause.

1           **DR. BOVE:** The last we heard was sometime maybe in  
2 August, but it's unofficial.

3           **MR. FLOHR:** Any other questions?

4           **MR. ENSMINGER:** Yeah, the last we heard Halogenated  
5 Solvents Industry Alliance was asking for a meeting  
6 with the Director of Research and Development Branch  
7 at EPA Headquarters up in Washington. I thought all  
8 that behind the closed doors crap was cut out by  
9 President Obama's, what was that thing he put out?

10          **MR. PARTAIN:** Integrity of science.

11          **MR. ENSMINGER:** Integrity of science, but that  
12 evidently is still going on. So I called my buddies  
13 over there at Halogenated Solvents Industry  
14 Alliance. The tentacles still reach in.

15          **DR. DAVIS:** I'd like to volunteer when we know that  
16 a meeting is planned. I could offer to attend it as  
17 a representative of the CAP. That way we could try  
18 to promote more a concept of open and free.

19          **MR. ENSMINGER:** Well, they requested a meeting and  
20 they got -- with the head of the R and D, and they  
21 got referred down to the lowest level. And they  
22 have to work their way up to get this meeting  
23 approved now. So that's a good thing.

24          **MR. STALLARD:** But thank you for your willingness to  
25 serve.

1           Are there any more questions for our, for Brad?

2       **MR. ENSMINGER:** No, but I do have one comment, and  
3       it's a good one. And there's some of the things  
4       that I'm seeing coming out of -- and I told Brad  
5       this, Mr. Flohr this, down at the cafeteria during  
6       the break that a lot of the things that I'm seeing  
7       coming out of the Louisville move are good and  
8       positive. And, you know, I know that the VA is a  
9       lot of people's whipping boys. I mean, everybody's  
10      got something bad to say to them, but very rarely do  
11      they ever hear anything good, so there's your  
12      goodie.

13      **MR. STALLARD:** Hold on just a minute, Tom. I'll get  
14      to you.

15      **MR. PARTAIN:** Credit where credit's due here. This  
16      is Mike, and I don't know. This is more of a  
17      curiosity question. Jim and I were talking this  
18      morning about occupational health exposures and  
19      stuff and that he would show me some documents from  
20      the DOD where someone is exposed to benzene  
21      occupationally that while in service they monitor  
22      these people for yearly checkups and stuff like  
23      that. If someone separates from service, say you've  
24      got a bulk fuel handler who's been pumping gas in  
25      and out of fuel tankers and everything. He's

1 monitored. He's fine. And then he separates, goes  
2 on with his life. Does the VA continue monitoring  
3 him once he's done occupationally or is that  
4 something that ceases once --

5 **MR. FONTELLA:** Actually, I can understand that. I  
6 can answer that question because it's until  
7 termination, whether they're fired, they quit or  
8 retire, they examine them on a yearly basis, all  
9 this medical exam, and after that it's over with.  
10 That's what it says in the documents that I read.  
11 It's a DOD document as well.

12 **MR. FLOHR:** The VA wouldn't be aware of those  
13 individuals unless they came to the VA on a claim,  
14 sought medical treatment at which time they're  
15 eligible.

16 **MR. FONTELLA:** I believe that is also for civilian  
17 workers. I think it's for civilian workers. I  
18 don't think it's for military. That's what I  
19 believe. I have some documents with me that will  
20 tell you exactly how often they're treated, but I  
21 don't have the PDF that'll come into the subject  
22 matter that tells you if they're civilian or  
23 military. I don't remember that, but I believe that  
24 they're civilian personnel.

25 It's like a workmen's comp thing that they

1           examine them every so often to see if anything has  
2           come up for as long as they work there. Some  
3           chemicals are on a yearly basis, some are on two.  
4           There's different for whatever chemical it is to see  
5           if there's any reaction or illness involved.

6           **MR. STALLARD:** Tom, sorry we missed you this  
7           morning, but welcome. Do you have a question?

8           **MR. TOWNSEND (by Telephone):** Yeah, I've been on  
9           since six o'clock this morning. The wrong number  
10          was given. Has Mr. Flohr spoken already?

11          **MR. STALLARD:** No, in fact, this is his time  
12          allocated, and we're glad you could join us.

13          **MR. TOWNSEND (by Telephone):** My claim with the  
14          Veterans Administration from about three years ago  
15          has gone to the Board of Veterans' Appeals and is  
16          back on the State. The VA examiners are not getting  
17          out because I went for a compensation exam at the  
18          Spokane Veterans Center. The examiner didn't even  
19          know about the letter from the VA about Camp  
20          Lejeune.

21          **MR. STALLARD:** Tom, you might not have heard but  
22          there's a training letter that's in the final  
23          clearance at the Undersecretary's level that Mr.  
24          Flohr was talking about. So hopefully that  
25          awareness issue will be clarified.

1           Tom, when you speak, can you make sure you're  
2 really close to the telephone so that we get the  
3 clarity of your voice, please.

4           **MR. TOWNSEND (by Telephone):** Is it better now?

5           **MR. STALLARD:** Yes, that's better, thank you.

6           **MR. TOWNSEND (by Telephone):** Okay. Well I had the  
7 notice in my hand and I asked the examiner, I said  
8 have you read this about the Camp Lejeune exposed  
9 people, that the Board has accepted the fact that  
10 we've been exposed. And she just carried on like  
11 she didn't even care or know about it.

12           **MR. FLOHR:** That shouldn't be the case because even  
13 in our April 2010 training letter, we prepared an  
14 addendum for examiners on Camp Lejeune that's going  
15 to be sent or is to be sent with a request for an  
16 examination to whoever's doing it to make them aware  
17 of the issue.

18           **MR. TOWNSEND (by Telephone):** I had a copy of that,  
19 Mr. Flohr, in my hand, and she had not read it. So  
20 my exam, I don't know what the hell is going on with  
21 my exam. Fortunately, I was given a consult with a  
22 civilian neurologist that confirmed that my  
23 neuropathy does exist. So it just goes on for years  
24 at a time trying to get the VA to get the damned  
25 things squared away.

1           **MR. FLOHR:** I'll take that back and discuss it with  
2           Dr. Walters in VHA and make sure that they're aware  
3           of it. They take whatever action they need to take  
4           to ensure that all the examiners are aware.

5           **MR. TOWNSEND (by Telephone):** Well, the document  
6           that I have still has the National Academy of  
7           Sciences on it.

8           **MR. FLOHR:** Probably that would be true, I think. I  
9           think our current training letter will have  
10          different language. And as I said I think the last  
11          time I was at a CAP meeting, the fact that ATSDR and  
12          the NRC are at loggerheads on this subject doesn't  
13          mean that the NRC report did identify 14 diseases  
14          with limited suggested evidence in association.

15                 And that's a good thing for veterans that  
16          points out to any examiners there is some  
17          association between TCE and PCE particularly and  
18          those 14 conditions. That's not a bad thing.

19          **MR. TOWNSEND (by Telephone):** Well, it's just  
20          dragging on in my case, a resolution for my  
21          situation. I'm waiting for the remand to go to the  
22          Board of Veterans Appeals.

23          **MR. FLOHR:** Well, I wish you good luck with that,  
24          sir.

25          **MR. STALLARD:** Will his case come back through

1           Louisville?

2           **MR. ENSMINGER:** Yeah, his stuff is being  
3 transferred.

4           **MR. FLOHR:** There's a claims remand by the Board.  
5 It should go back to Louisville.

6           **MR. STALLARD:** Okay.

7           **MR. TOWNSEND (by Telephone):** I don't want to go to  
8 Louisville unless I have to.

9           **MR. FLOHR:** You don't have to.

10          **MR. TOWNSEND (by Telephone):** I don't have to?

11          **MR. FLOHR:** No.

12          **MR. TOWNSEND (by Telephone):** I've been in the  
13 system for three years.

14          **MR. FLOHR:** Only the claim would go back to  
15 Louisville. You wouldn't have to go along with the  
16 claim.

17          **MR. FONTELLA:** Yeah, Brad, Jim Fontella. With the  
18 DRO hearing and stuff like that, that would be a  
19 video situation in your area to Louisville? Would  
20 that be the situation for a face-to-face hearing or  
21 a traveling judge?

22          **MR. FLOHR:** It could be, yeah, one of those. The  
23 VA, DVA, if someone requests a tele-Board hearing  
24 they're really getting more into doing video  
25 hearings now. So that's certainly a possibility.

1           **MR. STALLARD:** Well, yes?

2           **DR. DAVIS:** Mr. Flohr, I'm very impressed with what  
3 you had to say, and I wonder if under the  
4 circumstances here that our caller on the phone that  
5 the examiner was not well informed. Now is there  
6 something that you can do, that ATSDR can do at this  
7 point so that people don't feel like ping-pong balls  
8 in a system that's not responsive rather than simply  
9 putting them back out there again?

10                   I know because others have contacted me who  
11 I've given advice to about filing an IC that there's  
12 a cultural shift, which I think is a good thing, but  
13 is there something that could be done officially so  
14 that people don't feel like they're just back in the  
15 system. It's going to take eight-ten years? He's  
16 been floating around for three years also?

17           **MR. FONTELLA:** Two-and-a-half years.

18           **DR. DAVIS:** Right. And is there something that  
19 could be done here that would just facilitate the  
20 system being more responsive since there is a  
21 general willingness to see that done?

22           **MR. FLOHR:** I don't know. All I can do is take it  
23 back to our Veterans' Health Administration. There  
24 are people there who are responsible for doing  
25 examinations and bring the issue to their attention

1 so they can make sure all the people that do  
2 examinations are aware.

3 **DR. DAVIS:** Is there something the CAP could do to  
4 help you? In other words say a sense of the CAP  
5 that we would hope that the VA would continue on its  
6 positive direction here and make additional efforts  
7 so that -- in this case it sounds like you had an  
8 examiner who was not well informed -- that the  
9 burden does not lie on the person making the claim,  
10 but in fact, the presumption, rebuttable presumption  
11 if you will, is in favor of the claimant?

12 **MR. FLOHR:** If we had such a recommendation --

13 **DR. DAVIS:** Well, I don't want to -- could we as a  
14 CAP make that recommendation? Is that agreeable?  
15 That we would like to facilitate the processing of  
16 claims recognizing the awareness on the part of  
17 ATSDR that there is a legitimate case for these  
18 claims, for this 14 different disorders that have  
19 been identified?

20 **MR. FLOHR:** That was just the NRC report --

21 **DR. DAVIS:** I understand. Sir, I don't want to get  
22 into the numbers. Just simply a sense of the CAP so  
23 that the presumption would shift here.

24 **MR. FLOHR:** There are no presumptions.

25 **DR. DAVIS:** Well in this case the presumption was

1           since the examiner didn't know, there was no claim  
2           processed, and so that's what I'm referring to.

3           **MR. FLOHR:** No, but the claim was processed.

4           **DR. DAVIS:** Well, yes, continuing rather than being  
5           awarded, however. So I'm just, I'd like to do it in  
6           a constructive manner so that just if the CAP --

7           **MR. FLOHR:** We may have to speak about that offline.

8           **DR. DAVIS:** Yes, I understand. Having been in the  
9           government I know. That's why I'm asking what we  
10          could do that would be constructive and not just  
11          finger pointing.

12          **MR. FONTELLA:** Jim Fontella. My claim was denied  
13          last September I believe it was, and bringing  
14          something up to my service officer I brought the  
15          first initial training letter to him because they  
16          said that benzene was presumptive in the water. And  
17          obviously, the training letter said that benzene,  
18          TCE, PCE, all of the above was in there.

19                 And I asked him, and what he told me was that,  
20          you know, some of these ROs don't even look at the  
21          training letters. Could there be something that  
22          issued from your office or the Headquarters Veterans  
23          Administration to have a little meeting between them  
24          and have everybody discuss that this is a training  
25          letter.

1           This is viable information that needs to be  
2 discussed in your own regional office so they know  
3 it's there. So if some of that paperwork, I mean, I  
4 see people. They pick up papers, and they put it  
5 off to the side and never do look at it or read it.  
6 So I mean, they would have it. There'd be no excuse  
7 then.

8       **MR. FLOHR:** To try and overcome problems like that,  
9 that's why we consolidated the health claims  
10 process.

11       **MR. FONTELLA:** Into the one, right. You're right.

12       **MR. FLOHR:** It shouldn't be a problem.

13       **MR. FONTELLA:** No, you're right. I didn't think  
14 about that. But that's what happened. I'm just  
15 saying on a personal basis that's what happened with  
16 mine, and I know that's happened to a lot of others  
17 as well. And I feel good about the process in  
18 Louisville as well so I'm just...

19       **MR. FLOHR:** And I'm not making any excuses but like  
20 I said, we have about 600 claims pending in  
21 Louisville, and we're going to get, the VA's going  
22 to get like four-and-a-half million claims this  
23 year. So it's a very small number, and it's easy  
24 for people not to know sometimes everything that's  
25 going on. And that's why bringing it all to

1           Louisville should alleviate that problem.

2           **MR. BYRON:** May I make a suggestion?

3           **MR. FLOHR:** Sure.

4           **MR. BYRON:** This is Jeff. I know there's a VA  
5           facility in my area. Now that we're here, you know,  
6           we've had a lot of problems in the past, I'm going  
7           to go down there and find out what they know about  
8           Camp Lejeune. And if they don't know anything, then  
9           I suggest that we direct them to Louisville so that  
10          they find out. Tell them there is a training letter  
11          in the works. Once it's okey-dokey it'll get out  
12          there.

13          **MR. FLOHR:** We expect that all of our training  
14          letters get read, distributed and shared by our  
15          regional offices. I can't put every regional office  
16          in the nation ^. And we review, do a quality review  
17          and make sure that they ^.

18          **MR. BYRON:** Because I know that there are  
19          individuals in my area that went to the VA, and I  
20          think it's in Virginia, and they saw notices about  
21          Camp Lejeune there. So that is happening, maybe not  
22          widespread enough.

23          **MR. STALLARD:** Okay, so there's concern. There's  
24          definitely positive effort moving forward to get the  
25          word out in the training letters. The question for

1 the CAP is to what extent can you be sure that  
2 they're read and used and applied.

3 Yes, Tom.

4 **MR. TOWNSEND (by Telephone):** The training letters  
5 going to the Veterans Administration, I don't know  
6 if they go to the medical centers.

7 **MR. BYRON:** This is Jeff. And right now I suggest  
8 that you get one to them if it's concerning your  
9 claim because if they don't know about it, they  
10 can't help you. And if they haven't gotten the  
11 avenue to get that, take the initiative. You're a  
12 Marine.

13 **MR. TOWNSEND (by Telephone):** Well the medical  
14 center --

15 **MR. STALLARD:** Brad.

16 **MR. FLOHR:** Not necessarily for the medical center  
17 although a lot of the information in it is for doing  
18 examinations providing ^. We'll be sure and share  
19 that with Veterans' Health Administration when it's  
20 been signed off on.

21 **MR. STALLARD:** Great, well thank you. We have a few  
22 minutes now. We're a little bit ahead of schedule.

23 **DR. DAVIS:** Just to clarify that. There are  
24 training materials that have been developed for the  
25 examiners. And the issue here is that they haven't

1           been widely disseminated yet or there've been some  
2           glitches in the system.

3           Given that we are all in the internet age  
4           wouldn't it be easy to just simply post these on an  
5           accessible website so that all claimants would have  
6           access to it? And then rather than having the  
7           burden of taking it along, they could simply link  
8           and refer it to the examiner on the spot. That  
9           might be a simple thing the VA could do.

10          **MR. FLOHR:** It's possible.

11          **DR. DAVIS:** Yeah, since it's already established,  
12          proved, et cetera, simply upload, put a link on both  
13          the websites as an example of something that would  
14          then reduce the burden here. Because it is, I don't  
15          think it's even though, yeah, the Marines, they can  
16          do everything.

17          But, frankly, I don't think the burden should  
18          be on the claimants at this stage given what they're  
19          dealing with so why not at least make them available  
20          just as, for example, for social security and  
21          disability. It's all out there now. You ought to  
22          just post it out on the website. It's already been  
23          approved, and then perhaps many of these problems  
24          would be obviated.

25          **MR. BYRON:** And I wanted to thank the VA for

1 reviewing the other 195 cases because last time we  
2 spoke I wasn't sure that was going to happen. I  
3 don't know that you were sure that it would.

4 **MR. FLOHR:** I wasn't sure, but it --

5 **MR. BYRON:** All I can say is that you had to come to  
6 these meetings in the past year and see that the  
7 VA's in the room, makes a...

8 **MR. STALLARD:** That's a positive turn of events.

9 Mike, did you have something?

10 **MR. PARTAIN:** Yeah, I wanted to change gears, just  
11 kind of step back to the last CAP meeting, and you  
12 know, Dr. Portier concerning the Marine Corps  
13 Handbook and the response back, a couple questions.  
14 Number one, in the letter you recommended or talked  
15 about having the Marine Corps revise their book. To  
16 date I haven't seen any action taken on that on  
17 their part.

18 Granted I know you don't have the authority to  
19 tell them what to do, but the question I'm having --  
20 I'm sorry. The feedback's distracting me here. In  
21 your letter, in the response back you indicated that  
22 ATSDR was going to rely on what's being planned and  
23 done, and there was no indication that there was  
24 going to be, that y'all were going to send a letter  
25 out to the community.

1           And I go back to my original point at the  
2           January CAP meeting where, not January but the  
3           generalized CAP meeting, the damage has already been  
4           done by the Marine Corps in the form of their  
5           communications, you know, minimizing, the book very  
6           clearly states that any future studies are  
7           pointless. To me that is an incredible de-motivator  
8           for anyone who participated in any study.

9           I still stand on the position we have got to  
10          communicate what you guys are saying to the  
11          community. Because right now all the communication  
12          that is being done in the community is one-sided,  
13          and it is in the form of the Marine Corps.  
14          Nothing's changed. They still control the  
15          information. They still control what's being said.

16          And I fear that when it comes time for studies  
17          that people are not going to be participating as  
18          much as they should be because they've already been  
19          told, you know, so what, it didn't hurt you,  
20          nothing's going to happen, we're not going to ^.  
21          Further studies are pointless because it's not going  
22          to be able to answer your questions.

23          What are your thoughts on it, Dr. Portier?

24          **DR. PORTIER:** Well, I have the same concerns.

25          There's no doubt that our hands are somewhat tied in

1 terms of the communication strategy. When you do a  
2 study like this, there are certain requirements that  
3 the Institutional Review Board has in terms of how  
4 you communicate with the subjects so that you don't  
5 bias the stuff you're studying. You don't cause  
6 tremendous response problems with the study.

7 That said, after I got your letter and after we  
8 were unsuccessful in getting a firm response from  
9 the Marine Corps about the correction or change to  
10 be used in that booklet, we changed the cover letter  
11 for the study. The cover letter that is going out  
12 has much stronger language than it had before about  
13 why we're doing this study, and why we think it's  
14 very important.

15 In addition, we're looking into -- we haven't  
16 decided on anything yet -- communication strategies  
17 that the study is going on. We want people to look  
18 at our website. If you were at Camp Lejeune or Camp  
19 Pendleton, could you take a look and see what we're  
20 doing and why it's important. So we're looking into  
21 doing those things.

22 We will not do direct mailing to everybody  
23 involved saying that we disagree with the National,  
24 with what the Marine Corps is saying, saying that we  
25 disagree with what the National Academy says. That

1 we will not be doing because that would bias clearly  
2 the type of study we're trying to do.

3 **MR. PARTAIN:** Dr. Portier, wouldn't conversely the  
4 same argument be made by the actions that have been  
5 done by the Marine Corps harm the Navy? Their  
6 conduct and their direct communication to the  
7 population study has significantly biased,  
8 negatively biased, the study. And they're still  
9 free to do this again.

10 **DR. PORTIER:** If they sign the communication  
11 agreement that we just sent back to them, they are  
12 not free to do that again. We would be aware of it  
13 beforehand, and we've got a commitment from them  
14 that they would not do this because we made it very  
15 clear that such a communication would be violating  
16 the IRB rules, and it would undoubtedly upset the  
17 quality of the overall study that they are paying  
18 for. And hopefully, that will not happen.

19 You can be assured if it does happen once we  
20 start this study, I am going to be livid and the  
21 Marine Corps will definitely be hearing from me in  
22 no uncertain terms that this type of behavior was  
23 unacceptable. And they can be assured that your  
24 close watchers in Congress would also get this  
25 message from me that we were livid.

1           **MR. ENSMINGER:** They sent a letter, a dear  
2 registrant letter, to every person that was either  
3 already registered with them and every new  
4 registrant that has signed up with them since. This  
5 letter states that the NRC assessed PCE, TCE,  
6 benzene and vinyl chloride. That is a damn lie.  
7 They said they assessed the exposure to all four of  
8 those chemicals and the health outcomes for them.

9           They did not assess benzene and vinyl chloride.  
10 It wasn't even in the damn law when this study came  
11 up. The law stated that they would assess the  
12 exposure and health outcomes to TCE and PCE. That  
13 was all that was in the law. You look at the NRC's  
14 health outcome charts. It says right there in small  
15 lettering, for TCE and PCE only unless otherwise  
16 indicated.

17           **DR. DAVIS:** Let me respond to that. As I said  
18 before the break there are two separate issues this  
19 group is looking at. One is exposure, and that's  
20 what your comments are on right here. And the other  
21 is the health consequences that may or may not be  
22 related to that exposure.

23           In fact, I'm going to take another tack now. I  
24 think we could beat this horse to death about  
25 exposure, the limitations, the cover up, the missing

1 data. That is all record. Nobody's debating that  
2 at this point. I'd like to suggest rethinking what  
3 the health issues should be here.

4 **MR. ENSMINGER:** You're missing the point here. The  
5 point is they sent a letter to everybody who is  
6 going to be part of this study telling them that  
7 they, that these exposures and the health outcomes  
8 to those exposures were assessed in this study.

9 **DR. DAVIS:** Yes.

10 **MR. ENSMINGER:** That's bullshit. They weren't.  
11 Excuse my mouth, but I'm pissed.

12 **DR. DAVIS:** I understand, and I understand why, but  
13 let me --

14 **MR. ENSMINGER:** But you're going off track here. I  
15 want them to correct that letter. I want everybody  
16 that received that letter to get another letter from  
17 them saying those two chemicals were not assessed.  
18 I mean, it's right in the damn report.

19 **MR. BYRON:** That's only fair. We're doing what the  
20 Marine Corps's done so far.

21 **MR. PARTAIN:** I mean, what we're doing with this --  
22 and I'm going back to my point -- is blaming the  
23 manipulation because what the end result is, the  
24 studies and everything, the studies are ongoing and  
25 will go on.

1           **DR. PORTIER:** Back in the Communication Room, could  
2 you cut the speakers in here, please?

3           **MR. PARTAIN:** And here's a quote right out of the  
4 Marine Corps Handbook on Camp Lejeune. A central  
5 issue in toxicology at Camp Lejeune is whether doses  
6 were sufficient to produce specific adverse effects.  
7 The lowest dose -- I'm sorry. Lowest dose at which  
8 adverse health effects have been seen in animal or  
9 clinical studies are many times higher than the  
10 worst case highest assumed exposures -- keyword  
11 assumed -- assumed exposures at Camp Lejeune.

12           I mean, that's the argument they're making.  
13 They're basically saying in layman's terms so what  
14 you were exposed. It didn't hurt you. And that was  
15 coming out of the NRC report. And we're battling  
16 this.

17           I mean, if we just sit there and say, well, we  
18 did look at the studies. We've looked at the  
19 epidemiology, but when you have a scientific bias  
20 skewed, and then they're going around telling  
21 people, well, you were assessed for chemicals that  
22 weren't looked at. I see a disaster coming with the  
23 studies.

24           **MR. ENSMINGER:** When my senators went and approached  
25 the Marine Corps representative about this letter

1 and whether it addressed or assessed benzene and  
2 vinyl chloride in the NRC report, do you know what  
3 Scott Williams told them? Oh, benzene's mentioned  
4 in the report 87 times. Who gives a damn how many  
5 times it was mentioned?

6 It wasn't assessed. And now that damn letter  
7 that's signed by General Ruark and formally by  
8 General Payne says that those two chemicals were  
9 assessed and health effects for those exposures were  
10 included in that chart in the NRC report. And if  
11 these people, I'm telling you, if integrity and  
12 credibility were money, these damn people would be  
13 bankrupt, and they're general officers in the Marine  
14 Corps. That is a damn lie. It's right there in  
15 black and white.

16 **MR. BYRON:** And this is Jeff Byron. As I remember  
17 the CAP was asking for follow-up letters to  
18 encourage participation, not an initial letter to  
19 destroy that participation. And that's what we've  
20 got, and I'd like to know if we're going to get more  
21 of it. Is that how they're going to encourage it?  
22 Is this the Commandant's signature on the letter  
23 that asked people to participate in the health  
24 survey?

25 **DR. PORTIER:** When was this letter going out?

1           **MR. BYRON:** Well, it has been mailed out.

2           **MR. PARTAIN:** Are you talking about the registrants'  
3 letter? It was originally mailed out in June of  
4 2009, and it's sent out to anyone who, that letter  
5 is sent out along with -- they may have changed it  
6 since then, but my understanding is that letter,  
7 along with an executive copy of the NRC report, is  
8 sent out to everybody that calls in or e-mails or  
9 what have you to the Camp Lejeune registry.

10          **MR. FONTELLA:** Yeah, even today.

11          **MS. RUCKART:** It is recently because I forward names  
12 that we get where people try to register. I forward  
13 them along to the Marine Corps, and I get an  
14 automatic reply, and it's what they're saying.

15          **MR. PARTAIN:** And that's what they send. So they  
16 continue to send --

17          **MR. ENSMINGER:** When General Payne just left and  
18 General Ruark took over his duties, General Ruark,  
19 they re-did that letter for General Ruark's  
20 signature. It's got the same damn lies in it.

21          **MS. BLAKELY:** And this is Mary Blakely with the CAP.  
22 Unfortunately, the people that you're sending these  
23 studies to will trust the Marine Corps over anybody  
24 else.

25          **MR. ENSMINGER:** Not all, but a lot of them.

1           **DR. PORTIER:** So thank you for telling me this.  
2           This violates our communication agreement with the  
3           Marine Corps even though they have not signed it  
4           because we have not approved that letter for going  
5           out. We haven't even reviewed it. We have no idea.  
6           I will check on this, and we will stop this if we  
7           can possibly stop it.

8           **MR. BYRON:** It's violating humanity.

9           **MR. PARTAIN:** If we have computer access before -- I  
10          can't bring it up right now -- I'll show you exactly  
11          where it's at on the internet. It's sitting there.  
12          And one thing before we break. When we're talking  
13          to ATSDR, I'd like to see the possibility of getting  
14          a webpage set up for ATSDR that contain the letters  
15          you have, the information you have. Because people  
16          are still looking for information. They're  
17          confused, what have you. But we need to have the  
18          letters, like the January letter that you sent to  
19          the Marine Corps, have these people set up on  
20          y'all's site, too, so people can see it. It may be  
21          now, but I haven't seen it.

22          **DR. DAVIS:** I'm working with the Israeli government  
23          on a related project that might be relevant here  
24          which is to provide information on known and  
25          suspected carcinogens for people. ATSDR has done an

1           excellent job with that with your tox profiles. And  
2           you simply could link your existing -- because  
3           you've got some really good information there, your  
4           tox profiles -- and link it to Camp Lejeune.

5           **MS. RUCKART:** We have.

6           **DR. DAVIS:** You have that --

7           **MS. RUCKART:** It's on our website.

8           **DR. DAVIS:** I didn't see that because that actually  
9           refutes what the letter from the Commandant said.

10          And we need to get this auto-reply and simply say  
11          for information look here, and try to drive it. You  
12          know how search engine optimization works. Try to  
13          drive information to there, and, frankly, make sure  
14          that the Marine Corps's well aware of this.

15          **DR. BOVE:** We actually have a lot of information on  
16          the website. A literature search that we did for a  
17          feasibility assessment, but we also have listed  
18          diseases people we think are associated.

19          **DR. DAVIS:** Which is what Mr. Flohr was talking  
20          about, right?

21          **DR. BOVE:** Well, actually we have quite a lot more  
22          because we do have our disagreements with the NRC  
23          report and it's including (inaudible). First of  
24          all, the limited suggested category they have we  
25          think needs to be bumped up with those diseases.

1 But there are diseases that were in a lower  
2 category, some of those also need to be bumped up at  
3 least one or two. So we didn't put together a chart  
4 like the NRC did. Instead we have a list of the  
5 diseases with references on our website as well as  
6 ^.

7 **MS. RUCKART:** Plus links to the tox profiles.

8 **MR. STALLARD:** We're going to use this opportunity  
9 to break right now because we've run over all  
10 morning.

11 **MS. BLAKELY:** Just may I say one --

12 **MR. STALLARD:** No, you may not. You can come back  
13 right after lunch and bring it up.

14 But listen, what I wanted to say, this is  
15 important because what you have brought up into  
16 awareness is the degree to which we have, are trying  
17 to work with our colleagues and the information that  
18 they're putting out that could bias the efforts of  
19 the research. And this is important for you to  
20 know, and so thank you for bringing that up.

21 And then you have more time with Dr. Portier  
22 because he has agreed and extended an invitation to  
23 spend time at lunch. So be back at 1:30, and we  
24 will resume. For those on the phone we will resume  
25 at 1:30.

1 (Whereupon, a lunch break was taken from 11:55 a.m.  
2 to 1:30 p.m.)

3 **MR. STALLARD:** Frank and Perri you're here. So the  
4 question is knowing that you're in control of your  
5 time, Perri, do you want to do the update that we  
6 didn't get to this morning, do a brief update.

7 Who do we have on the line?

8 **DR. CLAPP (by Telephone):** Dick Clapp is here.

9 **MR. STALLARD:** Welcome back, Dick.

10 **MS. BRIDGES (by Telephone):** Sandy Bridges.

11 **MR. STALLARD:** All right, Sandy.

12 And that's it. Okay, thank you.

13 **RECAP OF PREVIOUS CAP MEETING**

14 **MS. RUCKART:** First I'll briefly remind us about  
15 summary and action of our last meeting, then we'll  
16 get into talking about some updates on our health  
17 studies. So we kind of touched on some of these  
18 anyway so -- plus I handed it all out to you to read  
19 it.

20 Last time you all were interested in seeing a  
21 copy of Dr. Portier's letter to the DOD/USMC  
22 discussing the NRC report, and we provided that to  
23 you and also ^ VA that letter.

24 We already talked about the letter concerning  
25 the NRC report to everyone on the USMC registry. I

1 think we're pretty well covered on that. You can  
2 read more details here about ^ history.

3 Again, last time the issue of media requests  
4 for CAP meetings was brought up, and we discussed  
5 that we handled it on a case-by-case basis. We did  
6 not get any media requests for this meeting.

7 Brad also touched on the fact that we met in  
8 February, a couple months ago, to discuss ways to  
9 continue to facilitate dialogue between our two  
10 agencies and answer any questions the VA had. I  
11 think we all felt it was a very productive meeting.  
12 We had ^ discussion, a lot of time for Q and A on  
13 our work, and we discussed that we would have some  
14 regular meetings, face-to-face meetings that Brad  
15 and I just talked about today. We possibly could  
16 couple that with the VA's coming here the day before  
17 and stay for our CAP meeting so we'd have a lot more  
18 ^.

19 And we also said we would supply the VA with  
20 the IRB-approved materials both for our current  
21 studies and the analysis plans for those studies.

22 And the CAP asked Mary Ann to follow up on what  
23 groups received information and notification from  
24 the USMC. I saw that Mary Ann sent everybody an e-  
25 mail.

1           **MR. ENSMINGER:** Hey, Perri, can you hold on a  
2 second?

3                     Sandra? Sandy?

4           **MS. BRIDGES (by Telephone):** Yes, yes.

5           **MR. ENSMINGER:** You need to mute your phone. I hear  
6 you carrying on a conversation back there somewhere.

7           **MS. BRIDGES (by Telephone):** No, I'm not. Nobody's  
8 here but me.

9           **MR. ENSMINGER:** Well, somebody doesn't have their  
10 phone muted.

11           **MS. BRIDGES (by Telephone):** It's not me.

12           **MR. STALLARD:** Okay, you're forgiven.

13           **MS. RUCKART:** So Mary Ann is distributing the  
14 document. She also emailed it out in response to  
15 the question at the last CAP meeting about updates  
16 on the USMC notification efforts.

17                     We already heard from Morris again today, but  
18 just to briefly discuss what he said before. At the  
19 last meeting he provided copies of the Chapter C  
20 report. He discussed Chapter D last time. He  
21 provided more updates on that today.

22                     He discussed his conversation with Elizabeth  
23 Betz, and you know what's going on with that. He,  
24 again, brought that up today. And last time Sven  
25 provided an update on what had happened between the

1 CAP meetings. He again did that. I believe he said  
2 today he was going to follow up on some item that he  
3 mentioned last time that you all wanted  
4 clarification on, like, I think you asked about  
5 that.

6 **MR. ENSMINGER:** I'm sorry?

7 **MS. RUCKART:** You asked Sven to go back and review  
8 the transcript, Jerry, from the last meeting because  
9 there's something he mentioned last time that you're  
10 now interested in --

11 **MR. ENSMINGER:** That was Jim.

12 **MS. RUCKART:** Jim, okay.

13 And Brad as usual gave updates from the VBA.  
14 As you know all the claims are consolidated in  
15 Louisville. He went there in December to meet with  
16 them and I think everyone feels pretty good about  
17 how that's progressing.

18 And, again, we're still committed to completing  
19 the birth defects and childhood cancer study.  
20 Again, we're waiting on the water modeling to  
21 complete that.

22 We provided an update on the mortality study,  
23 which I can get into here in a minute. We have some  
24 good news to report. We were able to whittle down  
25 the number of unknown vital status. That's, I

1 think, very helpful. And we provided an update on  
2 the health survey. Again, I'll discuss that in a  
3 minute. We don't have to talk about where we were  
4 the last time. We'll get into where we are now.  
5 That's the most important.

6 We also mentioned that we're going to have the  
7 expert panel meeting for the health survey in  
8 January. There were some bad weather issues for  
9 Atlanta, so we actually held that meeting in March.

10 At the last meeting we had a brief discussion  
11 about the ATSDR Camp Lejeune website. Since that  
12 point the water modeling pages have been revised a  
13 little bit with the hopes of making that information  
14 more prominent so you don't have to go all the way  
15 down. They put a little side box where you can  
16 click on to get what is perceived to be the most  
17 valuable information to people. So let us know your  
18 feedback on that.

19 We presented some possible options for  
20 evaluating male breast cancer. We're going to again  
21 talk about that here in a little bit.

22 And there was a request from the CAP that we  
23 calculate how many cancers and other diseases will  
24 be expected in the survey if there's a hundred  
25 percent participation so you can compare that with

1           what you're seeing reported on your website. I  
2           think Frank will have something to recap here later.

3           And we're going to be talking about this at the  
4           end. There was a request to have a CAP meeting and  
5           public forum in North Carolina, and we've been  
6           working on that, and we'll talk about that at the  
7           end, our planning the next steps for that.

8           So just to jump right in to updates on the  
9           study -- Well, first of all, any questions about  
10          that?

11         **MR. PARTAIN:** Yeah, real quick, on the notification  
12          summary for the activities of the Marine Corps and  
13          everything, thanks for sharing that with us. You  
14          also may want to add to your distribution list --  
15          On your notification and advertising, I'm not sure  
16          if you're aware of this, but feel free to advertise  
17          in Leatherneck and everything. April 21<sup>st</sup>, the  
18          premiere of the Camp Lejeune documentary, "Semper  
19          Fi, Always Faithful," will be held at the Tribeca  
20          Film Festival.

21         **MS. SIMMONS:** What? I'm sorry.

22         **MR. PARTAIN:** The premiere of "Semper Fi, Always  
23          Faithful" will be held at the Tribeca Film Festival  
24          on April 21st. It would be nice to see y'all  
25          advertise that in the Leatherneck magazine and the

1 different outlets that you do. Feel free to post it  
2 on the Marine Corps's website, too. Also, ^, the ^  
3 Headquarters, but it'd be nice. We're going to have  
4 a question and answer session after the first  
5 showing of the film on April 21<sup>st</sup>. Jerry and I will  
6 be there, and it'd be nice to have General Ruark or  
7 somebody from Headquarters Marine Corps come down  
8 and participate.

9 **MR. STALLARD:** Where will that be again?

10 **MR. PARTAIN:** This will be at the Tribeca Film  
11 Festival, April 21<sup>st</sup>, this year, roughly two-and-a-  
12 half weeks from now.

13 **MS. SIMMONS:** I'll pass it along.

14 **MR. PARTAIN:** I'll expect to see y'all there.

15 **MORTALITY STUDY**

16 **MS. RUCKART:** So on the mortality study, things are  
17 progressing on schedule so this is very good news.  
18 So far we've identified 43,000 deaths for the period  
19 1979 to 2008. Two thousand nine deaths are not yet  
20 available but should they become available for the  
21 study we'll include them.

22 **DR. DAVIS:** I'm sorry, what's the total number of  
23 deaths?

24 **MS. RUCKART:** About 43,000 and that's in the Camp  
25 Lejeune and Camp Pendleton cohort of deaths

1           occurring from 1979 to 2008. Death among the  
2           Marines --

3           **MR. PARTAIN:** Forty thousand out of how many?

4           **MS. RUCKART:** Forty-three thousand.

5           **MR. PARTAIN:** Forty-three thousand out of what's  
6           your baseline?

7           **DR. BOVE:** Close to 500,000, about ten percent.

8           **MS. RUCKART:** Of the Marines who were stationed at  
9           Camp Lejeune --

10          **DR. DAVIS:** Is it Marines only or is it their  
11          families?

12          **MS. RUCKART:** It's just the Marine Corps and the  
13          civilian workers.

14          **DR. DAVIS:** So it's not any family members?

15          **MS. RUCKART:** These are people who were identified  
16          from the DMDC data ^ our data center. The Marines  
17          who were at the base between '75 and about --

18          **MR. ENSMINGER:** 'Seventy-five and '85.

19          **MS. RUCKART:** 'Seventy-five to '87, and the deaths  
20          occurring from '79 to 2008 because the NDI, National  
21          Death Index, wasn't in operation until '79, but the  
22          Marines had to start their service in '75 anyway,  
23          so...

24          **DR. BOVE:** What we have is this. We were focused on  
25          those, we have data from the DMDC for active duty

1 from '75 to '87, middle of '87. We wanted to focus  
2 primarily on those who started their service in '75  
3 because we don't have information on how long they  
4 served before that, but we do know it started in  
5 '75. However, since we have data on people who  
6 started before '75, we'll look at their mortality,  
7 too.

8 So the figures are near 43,000. It includes  
9 people who started before '75 but were on base at  
10 Camp Lejeune anytime between '75 and '87, similarly  
11 for Pendleton. And the civilian workers, we have  
12 data since December '72.

13 Again, we wanted to focus on those who started  
14 work after that because we don't know how long  
15 people in the database in '72, how long they had  
16 worked before that. But since we have data for all  
17 those people we're looking at that as well. So we  
18 focus more on a smaller group of it but not much  
19 smaller.

20 But we have data on all. We'll look at the  
21 data for all. So how many do we have? We have  
22 something like 215,000 active duty Marines from 1975  
23 to '85 plus an additional for '86 and '87, which is  
24 probably 120,000.

25 **MR. ENSMINGER:** Use the terminology Marines and

1 sailors, okay?

2 **DR. BOVE:** Marines and sailors, okay. We have  
3 something like close to 250,000 Marines and sailors  
4 from both Pendleton and Lejeune.

5 **DR. PORTIER:** I'll be back in a bit; I have another  
6 meeting I have to attend to.

7 **DR. BOVE:** If you add the civilian workers to both  
8 it's about 250,000 each. So we have about 500,000  
9 people in the mortality study. So it's a huge  
10 study. Even though it's a young cohort, it's a huge  
11 study, and we have quite a bit of statistical power  
12 for that study.

13 The drawback is that cancers that don't lead to  
14 death, you can't pick up. Cancers that are  
15 extremely rare like male breast cancer you can't  
16 pick up. But you can pick up kidney cancer, non-  
17 Hodgkin's lymphoma, leukemia, bladder cancer, liver  
18 cancer, all the key cancers that have been related  
19 to TCE and PCE and benzene and vinyl chloride. So  
20 you do have that ability in this mortality study.

21 So there are pros and cons and plusses and  
22 minuses. And one of the problems, as I was saying  
23 before, we were talking about vapor intrusion and  
24 how that might bias the study. The way that biases  
25 the study is that people we think aren't exposed may

1 have been exposed to vapor intrusion. So we're  
2 calling them unexposed, but they actually had some  
3 exposure. It makes it harder to see an effect,  
4 drives your risk estimates down towards no effect.

5 So that's one source of what we call exposure  
6 misclassification bias. That's the technical term  
7 for what I'm talking about. But there are other  
8 sources in this study. They're probably worse than  
9 that, and that includes, what we have in the  
10 mortality study is just the unit that they were  
11 with.

12 And we're using that unit code to tell us  
13 whether they were at Lejeune or Pendleton. But the  
14 unit may be stationed at Camp Lejeune but the person  
15 may be deployed overseas, taking training at another  
16 part of the base. So that to me is the bigger  
17 source of a problem with the mortality study because  
18 all we have is computerized data from the DMDC, and  
19 we have their unit code, and we have their  
20 occupation code. But we don't know if the person  
21 actually physically was at the base. That's a major  
22 problem.

23 The second major problem with the mortality  
24 study is that we may think people are unexposed  
25 because they are either barracked, they're not

1           barracked at main side, or they may live in family  
2           housing that wasn't ^ contaminated drinking water  
3           for some parts of Holcomb Boulevard, for example.

4           On the other hand they may be out in the field  
5           and getting drinking water from a water buffalo  
6           filled with Hadnot Point water. So vapor intrusion  
7           is like that. It's like that kind of a problem.

8           And the only way -- this happens in all epi  
9           studies. This is not unusual for Lejeune. Lejeune  
10          is difficult but other studies are just as  
11          difficult. And the way around that is to have a  
12          large number of people so that even though your risk  
13          estimate is lower than it should be, you still have  
14          confidence in that risk number. And you realize  
15          you're probably underestimating the effect, but yet  
16          you're still seeing an effect.

17          That's why I think I'm pretty optimistic about  
18          the mortality study is because so many, so large a  
19          sample, that even though the risk estimate may be  
20          pushed down towards one, will still give us enough  
21          of a signal to tell us if there's something  
22          happening. So that's how that works.

23          **MR. FONTELLA:** Jim Fontella. So you have ten  
24          percent that you know of of the deaths within that  
25          certain --

1           **MS. RUCKART:** Well, let me say something. All of  
2 these people's records were searched for. The first  
3 step was to take all 500,000 or so people and  
4 determine if they were dead or alive. Out of those  
5 500,000 people, we've identified about 43,000 are  
6 dead, and there's a group of unknowns I'll tell you  
7 about in a minute. But all of the other people are  
8 presumed to be alive, so we know that they're not  
9 dead.

10          **MR. FONTELLA:** But the question is that number,  
11 43,000, in your opinion already do you see anything  
12 abnormal about that? Is that a normal --

13          **MS. RUCKART:** We don't know anything about the  
14 deaths. The contractor has just identified. What  
15 they did is they used the vital status databases to  
16 determine who was alive or dead. And they're going  
17 to send those that they have good reason to believe  
18 are deceased plus those group of unknowns, that's  
19 people whose vital status they couldn't find out if  
20 they were dead or alive so there's no records to  
21 tell them.

22                 They first started out with about 60,000 people  
23 whose vital status was unknown. That's a lot.  
24 That's a lot more than they thought. So they ended  
25 up going to a locator firm and trying to see if

1           there was any information, any records to show the  
2           people were alive or recently dead. And they were  
3           able to whittle that number down to 6,000. That's  
4           great.

5           That means that they assume the other 54,000 --  
6           well, out of those 50,000, about 3,000 they realized  
7           were deceased. The other 50-some thousand or 40-  
8           some thousand, they realized were alive or good  
9           reason to believe they're alive. Six thousand are  
10          still in this unknown area. That's great. That's  
11          not that many to have to search in the NDI, the  
12          National Death Index.

13          So they're going to take the 43,000 who they  
14          know are dead. They don't know the reason why  
15          they're dead. They just know they're dead, and  
16          they're going to look for the 6,000 who they don't  
17          know if they're alive or dead. Send all those names  
18          and see what we get back. For the 43,000 that are  
19          dead we're expecting to get back their cause of  
20          death, and that's what we're going to be analyzing.  
21          For the 6,000 who we don't know we'll either get  
22          back no information or we'll get back their cause of  
23          death.

24          **MR. PARTAIN:** Perri and Frank, with the 43,000 dead  
25          and the 6,000 unknown you're going to get back

1 information, their death certificates. As you well  
2 know, death certificates are notoriously, they don't  
3 completely show everything. For example, somebody  
4 who has breast cancer, they survive the breast  
5 cancer and end up dying from complications --

6 **MS. RUCKART:** We're not actually getting death  
7 certificates. We're getting the information from  
8 the National Death Index so we're going to be  
9 getting the secondary causes, underlying causes.  
10 We're not just going to get like what you're saying,  
11 cause of death. If somebody has lung cancer, and  
12 they die of heart disease, underlying causes of  
13 death.

14 **DR. BOVE:** The approximate cause of death.

15 **MR. PARTAIN:** The approximate cause of death and  
16 then a secondary. Okay, because that's going --

17 **DR. BOVE:** -- cause of death information. We're  
18 getting that from NDI.

19 **MR. PARTAIN:** And you'll be able to discern that  
20 with the information that you get from NDI.

21 **DR. DAVIS:** And it also has most frequent  
22 occupation. The National Death Index does have  
23 occupational information in it. I helped to set it  
24 up a long time ago and at least it was supposed to.

25 **DR. BOVE:** I'm not convinced that it does, but we

1 have occupation codes from the DMDC database.

2 That's the information we'll be using to determine  
3 their occupation at the base.

4 **DR. DAVIS:** Well, the occupation at the base may not  
5 be that relevant to what they were doing for 20  
6 years later on.

7 **DR. BOVE:** Well, no, but not -- that's also true of  
8 any information on the death certificate, the  
9 deceased's occupation. But my understanding from  
10 the DMDC, or what we're asking for, is cause of  
11 death.

12 **DR. DAVIS:** And you're not asking for anything about  
13 occupation at all?

14 **DR. BOVE:** I'm not aware that they have information  
15 about occupation.

16 **MR. STALLARD:** They might have an MOS.

17 **DR. DAVIS:** Well, for the military they'll have an  
18 MOS, but I'm talking about -

19 Dick Clapp, are you on the line?

20 **MR. STALLARD:** Well, wait a minute. This is a point  
21 of clarification because I've turned off the thing  
22 because of the feedback, so they can hear us, but  
23 they can't respond right now. So we're going to try  
24 to work that out so that we don't have that  
25 distraction here. Let me turn it on and then --

1           **DR. DAVIS:** Well, the specific question on the  
2           National Death Index, which I have not looked at,  
3           frankly, in some time, but it was supposed to have  
4           occupation. And so I'm asking Dick Clapp, if you're  
5           on the line, if you can tell us whether or not the  
6           National Death Index currently has most usual  
7           occupation on it.

8           **DR. CLAPP (by Telephone):** No, I don't think it  
9           does, Devra. I think it's something that NIOSH does  
10          separately or individual states do separately, but  
11          they don't keep it on the NDI. It would have been a  
12          good idea or it was a good idea.

13          **DR. DAVIS:** Yeah, thanks.

14          **MR. FONTELLA:** Jim Fontella. Now, when I had my  
15          breast cancer, okay, I was on chemo. I developed an  
16          infection in my chest when I was on chemo. That  
17          nearly killed me. After that, about a year later,  
18          when they were installing a port, they put it in my  
19          arm instead of my chest, that developed a blood clot  
20          and my whole arm swelled up like the size of my leg  
21          below and then my chest and my neck had swelled up,  
22          and I was on like Heparin for seven straight days  
23          and I was on Coumadin for about year, maybe even two  
24          years. I can't even remember. But that could have  
25          also killed me. Now, if somebody dies of blood

1 clots, when you talk about secondary information,  
2 would know in your --

3 **DR. BOVE:** No, it's just causes of death. And so --

4 **MR. FONTELLA:** That's an issue there, too.

5 **DR. BOVE:** Yeah, that's the limitation. I just said  
6 there are pros and cons to a mortality study. The  
7 pros are the data's available, that you can do these  
8 studies rather easily. The cons are that you really  
9 want to get an incidence. You want to get at the  
10 fact that you had a breast cancer even though it  
11 didn't kill you.

12 To get to incidence what we, there are several  
13 approaches. One is, of course, through the health  
14 survey. The second approach is something we've been  
15 talking about and will try to pursue. Once the  
16 health survey, the survey part is over, and we  
17 convince the military to fund us, and that is  
18 something that hasn't been done before in this  
19 country.

20 We do not have a national cancer registry, but  
21 to use all 50 states, or most of them, to do a data  
22 linkage cancer study. There have been attempts to  
23 use subsets of like say 20 states. The Gulf War  
24 Cancer Incident Study used something like 20 states  
25 roughly, plus or minus.

1           And there have been other studies, occupational  
2 cancer, occupational studies, that have used three,  
3 four, five, six cancer registries surrounding the  
4 area of the industry. But no one has used all 50  
5 states or even close to that in a cancer incidence  
6 study except for, I think there was one study that  
7 looked at elderly cancers for some kind of health  
8 service activity. I think, but they did get  
9 identifiers.

10           And we're trying to figure out a way to do  
11 this, mostly without getting personal identifiers to  
12 make it easier for that to happen. But as I said,  
13 it's never been done before. It's going to require  
14 a lot of work, money and so on. But we want to --  
15 I've been bringing this up over and over again at  
16 CAP meetings and in my agency as well.

17           But I think the feeling is we have to finish,  
18 let's get the survey, at least a portion of it done.  
19 We still have to verify the diseases we get reported  
20 from each survey. But I think I can make a stronger  
21 case for us to start moving in this other direction  
22 to look at cancer incidence once the survey's done  
23 so I'm going to be pushing that. I hope to get your  
24 support on that, too, but I think that that's going  
25 to be the best way in the end because I have my

1           doubts about the survey.

2           I have doubts about surveys in general because  
3           of possible participation. It's not so much  
4           participation. I'm going to discuss this with the  
5           expert panel, but there's something called selection  
6           bias or non-response bias, which is not just lack of  
7           or a problem with participation, but participation  
8           amongst particular types of people. Those people  
9           who are exposed and have a disease of interest or  
10          those people who don't participate that don't have a  
11          disease or unexposed or some combination of that,  
12          that bias is discussed. Participation rate by  
13          itself is not a bias for this kind of study. It is  
14          a bias for Gallup and...

15          **MR. PARTAIN:** Frank, I want to interrupt here a  
16          second because I want to make sure because I'm  
17          confused here. When you have somebody showing a  
18          death certificate saying blood clots but they had a  
19          cancer but when you get the results back it says  
20          blood clots, which we're, you know, that's not what  
21          you're looking for, are you then going to take an  
22          individual's cause of death with one of the 43,000  
23          and try to determine whether there were any  
24          underlying health conditions that may have  
25          contributed?

1           **DR. BOVE:** Not in the mortality study. The  
2 mortality study just uses the information on the  
3 death certificate. So if he had a breast cancer but  
4 died because he was run over by a truck and maybe  
5 had heart disease on top of that, that might have,  
6 but --

7           **MR. PARTAIN:** ^ the truck but died of heart disease.

8           **DR. BOVE:** Whatever. It has to be related to the  
9 death itself. In particular, if you had a cancer  
10 and you're in remission or you've been cured, the  
11 only way you get at those is through a cancer  
12 incidence study.

13          **MR. PARTAIN:** Which you're not doing.

14          **DR. BOVE:** As I said, one way we're trying to do  
15 this, because we are mandated to do a survey. We  
16 thought we'd turn the survey into a study. Why do a  
17 survey; it has no scientific validity. So we  
18 thought we'd try to make a study out of it, and so  
19 that's what we're doing.

20                 But again, as I said, all these studies have  
21 limitations. The one about the mortality study's  
22 limitation is doesn't get an incidence. You have to  
23 die from it. And then there are problems, as you  
24 well know, with the death certificate. Sometimes  
25 the information is not very good. We all have that

1           problem in any mortality study.

2           **MR. PARTAIN:** But is there any way you guys can go  
3           and try to clarify it? Like if you've got an  
4           ambiguous, if you had an ambiguous death certificate  
5           just to go try to find out?

6           **MS. RUCKART:** We're not getting death certificates  
7           though. We're just getting a file back from the NDI  
8           that's going to be what they pull from the death  
9           certificate. We're not actually going to see death  
10          certificates. So we're just getting a file with  
11          causes of death listed in our file.

12          **DR. BOVE:** This is how all mortality studies are  
13          done. This is the limitation.

14          **MR. STALLARD:** Before we go forward, Dr. Clapp and  
15          Sandy?

16          **MS. BRIDGES (by Telephone):** Yes.

17          **MR. STALLARD:** You're still on the line, right?

18          **MS. BRIDGES (by Telephone):** Yes, I am.

19          **MR. STALLARD:** Is there anybody else on the phone?

20          **DR. CLAPP (by Telephone):** I am, too.

21          **MR. STALLARD:** Is there anyone else on the phone?  
22          (no response)

23          **MR. STALLARD:** I'm going to put you all in silent  
24          mode because we're having some unexplained voices  
25          from outer space or something. I don't know. But

1           it's a distraction here so we'll bring you back on  
2           the line if you have any questions that you wish to  
3           pose, okay?

4           **DR. CLAPP (by Telephone):** All right.

5           **MR. STALLARD:** Thank you.

6                       We're going to take a pause and I'm going to  
7           get back and like ten minutes from now I'll bring  
8           them back.

9           **MS. RUCKART:** So I think we pretty much covered the  
10          mortality study. Are there any additional questions  
11          about that?

12          **MR. BYRON:** Yes, sorry, I might have missed  
13          something. What are the years for that study?

14          **MS. RUCKART:** The deaths are going to be occurring  
15          from 1979 to 2008. And the Marines and the sailors  
16          who were on base -- the civilian workers. Well, the  
17          Marines and sailors from '75 to '87, the civilians  
18          from '72 to '87.

19          **DR. DAVIS:** You completed '87?

20          **MS. RUCKART:** Well, we're going to focus mainly on  
21          '85, but we're collecting it through '87. We may do  
22          additional analyses.

23          **MR. BYRON:** The average age would be my age. I  
24          graduated high school in '75. The younger they are,  
25          the more it will tell. That's what I was getting

1 at. How old is this group of individuals? They  
2 could be older than me, probably not younger than  
3 me.

4 **DR. DAVIS:** Do you have an SMR?

5 **DR. BOVE:** SMR?

6 **DR. DAVIS:** Do you know what the expected death rate  
7 is in this population and what the rate is that you  
8 observed?

9 **MS. RUCKART:** Well, we're going to wait for the  
10 cause of death. I don't believe we've calculated an  
11 overall cause. So don't know what the causes are.  
12 We just know about 43,000 plus 6,000 unknown, that's  
13 just based on the vital status search. We have to  
14 wait to get back the causes of death. And I believe  
15 that is going to, that search process is going on  
16 now and will be completed in the --

17 **DR. DAVIS:** Maybe I didn't make myself clear. If  
18 you have all cause mortality, I mean, you know what  
19 the, in a population of size X, you would understand  
20 that you would expect Y number of deaths over Z  
21 time. And I'm asking you can you answer, do you  
22 know what the answer to that is now?

23 **DR. BOVE:** No. No, we don't, no. Ten percent is  
24 probably in line actually, but we're going to wait  
25 and find out first of all who's from Pendleton and

1           who's from Lejeune and then beyond that we're going  
2           to do the study. And we'll do SMRs based on the  
3           drinking water contamination, based on where they  
4           were stationed, and then we'll do direct comparisons  
5           to solve.

6           We have a whole analysis planned, but we want  
7           to wait until we have the exposure information,  
8           which we will have roughly by the same time we can  
9           get the cause of death information. So it dovetails  
10          nicely.

11         **DR. DAVIS:** Do you know if you have complete, how  
12         complete your ascertainment is? In other words, if  
13         a population was a total of a million, you have one  
14         percent of that.

15         **DR. BOVE:** It's as good as the NDI is.

16         **MR. STALLARD:** And what is SMR?

17         **DR. BOVE:** Standardized Mortality Ratio. But the,  
18         what we have for everyone is their social security  
19         number and date of birth. With those two pieces of  
20         information you can get good information from the  
21         NDI. It's better than most situations.

22                 And you also can get good vital statistics  
23         information from the Social Security Administration  
24         who we will miss, however, because NDI doesn't cover  
25         outside the country, deaths outside the country.

1           And we'll also miss, the Social Security  
2           Administration will probably miss people, actually  
3           it has information on some people outside the  
4           country but it will be spotty, might have a problem  
5           there.

6           The other problem will be -- and this happens  
7           with any mortality study. There will be people we  
8           will not be able to determine whether they're alive  
9           or dead because they're outside the system. They're  
10          homeless. I think the prison population gets picked  
11          up, but the homeless may not get picked up. So  
12          those are some of the issues that, again, we face in  
13          any study. This is not unusual for any.

14          **MS. RUCKART:** But for the unknowns we have whittled  
15          it down to about 6,000 and that's, you know, a very  
16          manageable number and some of those will come back  
17          probably as deceased, so the total unknowns is going  
18          to be less than 6,000 out of 500,000.

19          **DR. BOVE:** Our main concern goes back to that issue  
20          I mentioned earlier, is exposure misclassification  
21          bias, which means we say people are exposed when  
22          they're not or we say they're exposed, unexposed  
23          when they are. Or we screw up in terms of how high  
24          they're exposure was. And that, again, is a  
25          problem. It does bias the study towards finding

1 nothing, and that's a problem with any of these  
2 kinds of studies.

3 It's just there's noise in these studies.  
4 There's nothing we can do about it. We try to  
5 eliminate it as much as possible. And by doing the  
6 extensive water modeling we're doing, we're trying  
7 to minimize some of that noise.

8 If we followed, for example with the NRC set,  
9 which is just use exposed versus unexposed, we're  
10 grouping together people with widely different  
11 exposures into one group. That is an enormous  
12 exposure misclassification bias, and that's why they  
13 -- well, I guess I'll stop there. That's why I  
14 suggested it, recommended it, but that's why we're  
15 doing the water modeling.

16 But I want to wait. And I know the case  
17 control study's been sitting there for awhile. I  
18 know you're frustrated by that. But I want to wait  
19 until we get the water modeling results because we  
20 absolutely need that to make the case if there's a  
21 connection.

22 **DR. DAVIS:** I have another, a couple suggestions,  
23 one of which is that you should absolutely look at  
24 the average age of diagnosis as, for example, if you  
25 had a group of ten multiple myelomas that were

1 diagnosed under age 45, you'd have something really  
2 interesting. If you look at age of diagnosis for  
3 the kinds of causes of death that might be just a  
4 little bit unusual and that may give you yet another  
5 indication as well.

6 **MR. PARTAIN:** Because in another bias your problem  
7 with mortality studies is that when you look at  
8 cancers, cancer today is a lot more survivable than  
9 it was five, ten, 15, 20 years ago. Is that correct  
10 a reason?

11 **DR. BOVE:** Oh, yeah.

12 **MR. STALLARD:** I'm going to check in with Dr. Clapp.

13 **DR. BOVE:** Actually, we did something like that in  
14 the first version of this small for gestational age  
15 study where we found affected mothers who were older  
16 than 35 who were exposed to PCE for example. So we  
17 do something similar in all these studies. We'll  
18 look for those kinds of age exposure interactions.

19 **MR. BYRON:** This is Jeff. That 43,000, did you say  
20 that was roughly out of half a million?

21 **DR. BOVE:** Yeah, it's about ten percent.

22 **MR. STALLARD:** Dr. Clapp, we have you again on  
23 speaker. Is there anything you'd like to contribute  
24 or question?

25 **DR. CLAPP (by Telephone):** Well, no, I agree with

1           what Frank has been saying about the great  
2           limitations of the mortality study and the problems  
3           of exposure misclassification. Those are common  
4           problems. I've done these kinds of studies myself,  
5           and we still have found some things factually in  
6           Viet Nam veterans. So it's not like a hopeless  
7           exercise. I think it's a very worthwhile study to  
8           be doing.

9           As far as the, Mike asked a question about the  
10          survivability of cancer these days. I mean it  
11          depends on the cancer. Some types of cancer are not  
12          particularly more survivable now than they were ten,  
13          15, 20 years ago. Like lung cancer is not, probably  
14          non-Hodgkin's lymphoma and kidney cancer are not  
15          that different these days. And breast cancer in  
16          women at least is more survivable now than it was.  
17          So there's no simple answer to Mike's question. I  
18          think overall survival has improved somewhat, but it  
19          depends quite a bit on which type of cancer you're  
20          talking about.

21          **MR. STALLARD:** Thank you.

22          **MR. PARTAIN:** On that note, Frank, will we be able  
23          to delineate what type of cancers, the NDI's going  
24          to give you what type cancers they had, right?

25          **MS. RUCKART:** Yes.

1           **MR. PARTAIN:** So in our group if we have a spike in  
2 kidney cancer deaths, that would be something of  
3 interest?

4           **DR. BOVE:** Oh, yeah.

5           **HEALTH SURVEY**

6           **MS. RUCKART:** I think everyone feels comfortable on  
7 the mortality study. We'll move on to the health  
8 survey. So it was mentioned before that our letters  
9 are revised now to more specifically mention the  
10 drinking water contamination in Camp Lejeune.

11                   Because of that we had to go back to OMB. So  
12 we did have approval for our older materials that  
13 came in November, but since we revised them in  
14 January, we had to get back to OMB, and we have not  
15 gotten approval for the revised materials. So we  
16 cannot start sending out the survey until we get OMB  
17 approval.

18                   So now it's the beginning of April. Our  
19 current plan is that we would start the mailings in  
20 May, again, contingent on OMB approval. Should we  
21 get that very soon, the plan is to start the  
22 mailings in May.

23                   I think I may have mentioned this before. It's  
24 going to be a wave process. The contractor cannot  
25 send out, you know, 300,000-plus surveys at once and

1 manage the responses. So there are six waves, and  
2 it's a six-month process.

3 So if we start in May, the last surveys will go  
4 out in September. Each wave though takes about ten  
5 weeks. So because, you know, we have the initial  
6 contact, and we have repeated attempts to get  
7 participation. And the waves will be three weeks  
8 apart.

9 So meaning the first wave that goes out May 1<sup>st</sup>,  
10 then the people in the second wave toward the end of  
11 May, they will get their first letter, maybe  
12 overlapping in that sense, but some people's waves  
13 will be finishing up as some other people's are  
14 starting.

15 And we've built in a little extra time at the  
16 end for catch up. You know, like if they get some  
17 new addresses for people or some stragglers and  
18 things like that. But the data collection would end  
19 in about October.

20 So we had our health survey expert panel  
21 meeting on March 8<sup>th</sup>. Unfortunately, we couldn't  
22 have it in January. But the meeting was very, very  
23 successful. We have, we're preparing some summary  
24 notes from the meeting. They have been reviewed by  
25 us, and we sent them back out for the panel members'

1 concurrence, and we gave them about a month to  
2 review it.

3 So by the end of the month we'll have that  
4 finalized. Or we've given them till the end of the  
5 month to give us any comments they have on the  
6 summary notes, and then we'll be finalizing it. It  
7 shouldn't take that long for us to finalize it here  
8 at the agency and then we can share it and post it  
9 on the web, but just to let you know the overall  
10 sense is there was a lot of support for the health  
11 survey. A lot of support for continuing on to the  
12 next phase, the medical records confirmation not  
13 contingent upon any magic number for participation  
14 rates. You know, the overall feeling was that there  
15 really is no number that you could say it has to be  
16 this or we can't go on.

17 So the general feeling was they're supportive  
18 of moving forward regardless of the rate. We're  
19 putting a lot of time and resources into this health  
20 survey. Let's take it to completion and do the  
21 medical records.

22 One thing that came out of the panel is the  
23 panelists are wondering if there's anything further  
24 we could do to promote the survey. So everyone's  
25 going to be receiving their individual study

1 invitation letter and the follow-up material. But  
2 is there something more that we could do to really  
3 express the urgency here and the importance of this.

4 So this is kind of a fine line because you  
5 can't do any other initial recruitment. That would  
6 have to go back, anything that's seen as recruitment  
7 material would have to go back and get OMB and IRB  
8 approval, and you see how long it's taking to get  
9 the re-approval of our one change to the letter  
10 here.

11 So what we are doing is we are engaging with  
12 BAH, ^, I think you're all familiar with them, and  
13 they're going to help us develop a marketing  
14 strategy. This will be something general so it  
15 won't be construed as recruiting material. It's  
16 something to spread the word: Hey, these surveys  
17 are going to be coming out. When you receive yours,  
18 please don't throw it away as junk mail. Please  
19 open this. This is important. Also, the materials  
20 would really stress the importance of Camp Pendleton  
21 because our materials are just sort of general.  
22 We're talking about ^.

23 These materials will let Camp Pendleton know  
24 it's very important that you participate. You're  
25 the comparison. We know you weren't affected, but

1 we still need your help. You're an important piece  
2 here.

3 So we will also want to talk with you. We know  
4 that you have your website and you have your  
5 channel. We want to again just engage with you and  
6 make sure -- I know you're going to do this -- put  
7 it on your website. Encourage people to fill out  
8 the ^ quickly. I know we talked about this before.

9 **MR. BYRON:** Why not put it on a billboard on 75?

10 **MS. RUCKART:** So, you know, we want to talk to you a  
11 little bit more and see if you have any other ideas.  
12 We haven't gotten back from BAH exactly what they  
13 want to put out in press releases, but they're going  
14 to be developing some materials for us.

15 So as I said, it's going to be sort of a  
16 general plea, but we might have just targeted areas  
17 like specific publications that Marines or retired  
18 Marines read or areas where they reside. So  
19 targeted in that sense but general in the sense that  
20 it can't be viewed as really recruiting individual  
21 people.

22 **MS. BLAKELY:** I have one. Mary Blakely from the  
23 CAP. What about public health systems? Is there  
24 any way you could post notices in those places?

25 **MS. RUCKART:** What do you mean?

1           **MS. BLAKELY:** Like where people go when they can't  
2 afford healthcare.

3           **MR. ENSMINGER:** Well, VA hospitals is a prime  
4 example.

5           **MR. BYRON:** How about just a public health notice in  
6 a commercial form?

7           **MS. RUCKART:** Okay, that brings up something. Our  
8 branch chief has requested that we put something out  
9 in the MMWR, that's the Morbidity and Mortality  
10 Weekly Report. That's a publication that is not  
11 intended for the public. Mainly it's going to  
12 providers and nurses and things like this, so all  
13 those people would see it. And then also this  
14 publication sometimes gets picked up by the press.  
15 So it gives us like two avenues to really reach out.  
16 I think that's getting at what you're saying.

17           **MR. ENSMINGER:** Brad, Brad, what would it take to  
18 get the VA to put a posting to advertise this in VA  
19 hospitals?

20           **MR. FLOHR:** I don't know. I can't really answer  
21 that question. I'd have to talk with the people in  
22 Veterans' Health Administration and see what  
23 they're, if there's any provisions or, like I said.

24           **MR. PARTAIN:** Can we make a formal request that  
25 ATSDR send a letter to the VA asking that this

1 information be posted at the VA clinics?

2 **MR. ENSMINGER:** It would require making up a very  
3 tactful neat poster that they can put up. You know,  
4 not something with magic marker or cardboard.

5 **MS. RUCKART:** Well also, as part of this strategy it  
6 does have to ^ the ^ and the Marines and have their  
7 help in promoting as well. I guess we could have  
8 another ^ from the VA, you know, from the VA to  
9 military family and ask them for their ideas on...

10 **MR. ENSMINGER:** Well, Perri, I've got another idea  
11 and we could have a placard attached and made up for  
12 the end, at the end of documentary about the health  
13 survey, that people are going to be receiving these,  
14 and they need to fill them out and return them.

15 **MS. RUCKART:** I mean, anything that you all can do -  
16 -

17 **MR. ENSMINGER:** Because this thing's going to end up  
18 on HBO or A&E or something.

19 **MR. BYRON:** This is Jeff. We'll do whatever we can  
20 do, but I want to make sure you guys are doing  
21 whatever you can do. Like I said, CDC puts out  
22 public health notices all the time. I see  
23 commercials on TV.

24 **DR. BOVE:** Yeah, but we're working with the --

25 **MR. BYRON:** Well, I mean, will you ask to see if

1           there'll be a commercial on TV to say to U.S.  
2           Marines that served at Camp Lejeune and Camp  
3           Pendleton participate in this study? Because you do  
4           ask people to get vaccinations and stuff, I know  
5           that, and flu shots.

6           **MS. RUCKART:** BAH is going to send us their draft  
7           plan this week, not any material but just their  
8           general approach. So we'll see what they get back,  
9           and we're going to have a call with them Friday, and  
10          we can bring these things up. Nothing has really  
11          been decided. We just had kind of like a kick-off  
12          meeting last week.

13          **MR. PARTAIN:** This, I think, is a golden opportunity  
14          for the Marine Corps to show their concern for the  
15          health, safety and welfare of the Marines and their  
16          family members by engaging and promoting this  
17          through, you know, they've had ^ on the interstate.  
18          When I drive I see billboards for the Marines, join  
19          the Marine Corps, what have you.

20                 They certainly should be able to fund some  
21          billboards, some public service announcements on the  
22          TV and not just advertise in newspapers. You know,  
23          get something like a billboard that's permanent  
24          where people can see it and put it in Florida where  
25          a lot of people live and get it on TV. Make a

1 public health service announcement. You've been  
2 saying this for quite some time. Live up to what  
3 you're saying now.

4 **MR. BYRON:** This is Jeff again. I'll be honest with  
5 you. I don't want the Marine Corps putting it out.  
6 I want the Marine Corps to pay for it for you. I  
7 want the CDC to put it out because I've just been  
8 back stabbed too many times, okay?

9 **MS. RUCKART:** But I want to say one thing. You  
10 know, this is a new idea for us. It was just put  
11 forth by the panel a month ago. We're exploring it,  
12 but there isn't a budget for this. We did not  
13 request a budget so we're somewhat limited. For  
14 some reason we're able to work with BAH, our  
15 communications office had a contract with them, but  
16 I'm not really sure what kind of funds are available  
17 for like TV newscasts and things like that.

18 **MR. BYRON:** If we'll get you a billboard for a  
19 month, will you put up the income?

20 **DR. DAVIS:** The Marine Corps, as you know,  
21 advertises all over for recruiting. They have a  
22 huge advertising budget, and it would not --

23 **MR. PARTAIN:** That's for recruiting.

24 **DR. DAVIS:** I understand, but this is recruiting.  
25 This is just recruiting for a study. And I also

1 know that in terms of the new social marketing you  
2 could certainly get Rachel to probably do a You Tube  
3 trailer for you. And you can certainly put it at  
4 the very end of the documentary. But you can give  
5 it to CDC to post on their website. Right? The  
6 trailer which simply says we're looking for --

7 **DR. BOVE:** I don't know if we can do that or not,  
8 but send it to us anyway.

9 **MS. RUCKART:** Yeah, I mean, they are, BAH is aware  
10 that social media is a good way to reach people, and  
11 I'm sure that's part of their plan, right?

12 **MR. STALLARD:** Okay, so how is this moving forward  
13 with recruiting? Is it working with BAH?

14 **MS. RUCKART:** Yes, Booz Allen Hamilton. And funny  
15 enough, some of the people who are assigned to this  
16 are also people that have worked on the registry.

17 **DR. BOVE:** Really.

18 **MR. BYRON:** Booz Allen Hamilton has made so much  
19 money in this. Maybe they should contribute the  
20 funds to get this done.

21 **MR. STALLARD:** So are they going to have a  
22 communication plan, a strategy that can be shared  
23 with the CAP?

24 **MS. RUCKART:** Well, they're sharing with us this  
25 week, and we're, I mean, they're supposed to send it

1 to us tomorrow. And we're going to have a call on  
2 it Friday, and I don't know what they're going to  
3 send but it's going to be quickly because they want  
4 to time this, whatever materials are produced, with  
5 the mailings of the health surveys. So if the  
6 health survey does in fact go out in May, then any  
7 of these ways to publicize will be happening in May.  
8 We're on a really short turnaround here.

9 **MR. FLOHR:** Hey, Jeff, how about the direct  
10 approach? These surveys are going to Marines,  
11 right?

12 **MR. BYRON:** Yes.

13 **MR. FLOHR:** As I understand Marines are taught to do  
14 as their told, right?

15 **MR. BYRON:** Yes.

16 **MR. FLOHR:** So why don't you just start the survey  
17 bold letters, Marine, fill this out and send it in?

18 **MR. BYRON:** I agree. And the thing should be that  
19 you're still providing service. You want to tout  
20 this that the veteran is still serving his country.  
21 I feel I'm serving my country right now. I feel  
22 just as much a patriot today as the day I joined the  
23 Marine Corps. Because the only way to effect real  
24 change in a country is be involved as all these guys  
25 are.

1           **MS. RUCKART:** That's one thing when we had our  
2           initial meeting with BAH, and we're talking about  
3           messages. The message is help your Marine Corps  
4           family. You know, like once a Marine always a  
5           Marine. You're not active, but you're helping your  
6           -- especially for Pendleton. You weren't affected  
7           if you weren't at Lejeune, but you're helping your  
8           Marine Corps family.

9           **MR. BYRON:** I'm sorry. We need that terminology  
10          just for a simple fact that we've kind of had the  
11          fox in the hen house when they sent out their  
12          letters to registrants about the NRC findings as far  
13          as the levels that were experienced at Camp Lejeune  
14          aren't high enough to even kill rats. Well, it's  
15          killed plenty of people. But because of that  
16          misinformation I think you're right. It has to be  
17          touted the right way. You have to play on their  
18          sensitivity as far as patriotism to their fellow  
19          Marines and countrymen.

20          **DR. DAVIS:** Are you using focus groups to come up  
21          with the best way to reach people? Because that  
22          would make the most sense, you know?

23          **MS. RUCKART:** Well, I think when you do that you're  
24          kind of walking that fine line with the OMB and you  
25          can't interview more than so many people or your

1 materials have to be vetted as you know.

2 **DR. DAVIS:** Even a focus group with nine, that's the  
3 rule.

4 **DR. BOVE:** We were told, we were actually during the  
5 expert panel meeting they said why weren't you doing  
6 the focus groups, and we didn't plan for that. At  
7 one point we were talking about doing a pilot and  
8 then that, we got negative feedback from Congress on  
9 the pilot for good and bad reasons. And so we're  
10 not doing focus groups. We're not doing a pilot.  
11 We're launching right into the survey using the  
12 standard methodology for survey research.

13 So it's not like we need to pilot that. But we  
14 can't do a focus group at this point or a pilot even  
15 or anything else without going through OMB. And we  
16 haven't gotten OMB approval yet for the change we  
17 made recently so we've been pushing and pushing to  
18 get approval from them. That's holding things up so  
19 that's the situation.

20 **CANCER INCIDENCE OPTIONS**

21 One other thing that we were talking about that  
22 came up at the last CAP meeting was you want to have  
23 some idea of how many cancers or whatever we might  
24 see if there's a hundred percent participation in  
25 the survey. I think that was the request because

1           you want to have some sense of how many, something  
2           to compare with what you get here and from your  
3           website.

4           And the problem with doing any of this is that  
5           we don't know where the denominator is. We don't  
6           know what the size of the population is. I once  
7           said it was half a million to a million people  
8           possibly exposed doing a back-of-the-envelope kind  
9           of calculation. The Marine Corps actually did a  
10          more formal calculation and came up with roughly the  
11          same thing which means that we really don't know is  
12          the bottom line, so anywhere between a half million  
13          and a million.

14          But we don't know the ages. You can make  
15          guesses as to what the age distribution is of all  
16          these people. So given with all that in mind I'm  
17          going to hand out a couple of things here, and I  
18          don't know if we'll have time to go through with  
19          everything. And we can ask questions later.  
20          Another time we can go over this again at another  
21          CAP meeting. We're running out of time.

22          But the first thing I'm handing out, the first  
23          two things I'm handing out are the materials we  
24          handed out to -- there's two things here -- we  
25          handed out to our expert panel to give them a sense

1 of what the statistical power of this survey looks  
2 like with different participation rates.

3 This is also something the Marine Corps wanted  
4 to see. They wanted to see the power calculations  
5 for both the mortality and the health survey last  
6 year or a year and a half ago I guess, and so we did  
7 this for them as well, but we primarily wanted to  
8 give this to the expert panel so they have some  
9 handle on the situation.

10 There's a one-pager. On one side it said  
11 method of calculation on it. Can you all see that?  
12 Because I don't have, I have a different copy in  
13 front of me. It's on the back of the first page or  
14 the front of the first page.

15 Now this is just how we did it. We used  
16 incidence rates from almost all 50 state cancer  
17 registries that are in CDC's database. And based on  
18 these national rates we made assumptions as to how  
19 old the people were when they started at Camp  
20 Lejeune and how they progressed over time into  
21 different age groups.

22 And as they moved from one age group to the  
23 next, they changed their risk of cancer, in this  
24 case kidney cancer so you just see an example. And  
25 there you see a number of cases of kidney cancer in

1 each age group it could be estimated by this  
2 approach and you get a bottom line of, say, 58  
3 cases. And then to get the risk you just put the 58  
4 over the total number in this cohort here.

5 This cohort was 28,000 Marines and so you get a  
6 risk of 2.1 per thousand. So that's the approach  
7 I've been using, but I'm trying to figure out how  
8 many male breast cancers to expect or how many  
9 kidney cancers to expect in the survey. And even in  
10 the mortality study I've done a similar approach.

11 **MS. SIMMONS:** Probably an ignorant question.

12 **DR. BOVE:** Go ahead.

13 **MS. SIMMONS:** Is what you're saying is between the  
14 ages of 30 and ages of 52, the way you calculated it  
15 would be, you would expect 2.1 cases? Is that  
16 right?

17 **DR. BOVE:** 2.1 per thousand.

18 **DR. DAVIS:** For all the ages.

19 **DR. BOVE:** So just simply added up the number you  
20 see in the last column. All those cases are added  
21 up. That equals 58, and there are 28,000, and  
22 that's a simple risk. So that's just a simple...

23 And in the front page, actually I did this the  
24 second thing. The first thing I did was the longer  
25 thing I sent to you were comparisons between

1           Pendleton and Lejeune with different participation  
2 rates, and you can look through it. I start off  
3 with 25 percent participation rate because that was  
4 the World Trade Center survey that was published.

5           They published it with a 25 percent  
6 participation rate which I was kind of shocked that  
7 they would even publish a study with that low a  
8 participation rate. Actually, it was worse than  
9 that. The comparison was 12 percent, but they  
10 published it.

11           So I said all right, let's see. If we get that  
12 poor a participation rate, what other relevant risks  
13 we could detect with any statistical power. And you  
14 see that it's not bad even with that low  
15 participation rate. Well, we're hoping for higher  
16 so I went to 30, 40 and 50 percent. Fifty percent,  
17 if we get that high, we're doing real well.

18           As I said to you, I don't know if all of you  
19 heard this, but the U.S. Census last year, the  
20 mailed portion of it, had a 63 percent participation  
21 rate. We're required to fill that out. Now they  
22 got higher participation rates once they went door-  
23 to-door, but the initial mailed survey which is  
24 similar to what we're doing, 63 percent.

25           So I think if we get up to 50 that's a huge

1 success. If we got anything above 50, it's  
2 terrific. So that was the state of comparison  
3 between Pendleton and Lejeune.

4 I thought that a better approach might be to  
5 split Lejeune into three parts, people parts: the  
6 high exposure group, one third of them; a medium  
7 exposure group and a low no exposure group just to  
8 figure this out. And see what would happen if you  
9 compare the high group with the low group at  
10 different participation rates. So that's that one-  
11 pager.

12 Turn it over. You see different participation  
13 rates. And this is the one that the expert panel  
14 focused on because this is really the main analysis  
15 we would be doing. So we want Pendleton in the  
16 study, and we also want to be able to directly  
17 compare among the Lejeune people, the Lejeune  
18 sailors and Marines and civilian workers who were  
19 supposedly at different levels.

20 As you can see, at the 20 percent participation  
21 rate it gets harder to, you have to get pretty high  
22 differences but beyond that you start doing pretty  
23 good. And so the expert panel saw this. I think  
24 they felt that there wasn't really a, most of them  
25 felt there wasn't any one participation rate that

1 would be a bar from proceeding to the second part of  
2 the study.

3 One panel member saw the 20 percent and sort of  
4 latched onto that figure and said, well, why don't  
5 you try to at least get 20 percent. But I think  
6 that's because I had ten percent in the exhibit. So  
7 that's what we handed out to them.

8 And the last thing I'm going to hand out to you  
9 -- this is the more problematic thing, but I'm going  
10 to give it to you anyway. Do what you want with it.  
11 Just trying to give you some sense of how many I  
12 expect, how many cases I expect, and I'm doing this  
13 in a couple of different ways. This is complicated,  
14 confusing, it's confusing to me actually but let me  
15 see if I can work it out.

16 The first thing you see the cancers along the  
17 side. That's similar to the previous thing I gave  
18 you. The first column is how I did risk. So those  
19 numbers are the same as the previous.

20 **DR. DAVIS:** Right. This is a truncated age group,  
21 30 to 59.

22 **DR. BOVE:** Hold off a second. Yeah, yeah. It's  
23 truncated because what I'm doing, I'm using a ten --  
24 I forgot to mention this -- there's a ten-year lag.  
25 So you start Camp Lejeune at 19 let's say. And I

1 don't count the first ten years. You know, it takes  
2 a certain amount of time for the cancer to get  
3 initiated and start. So there's a ten-year lag in  
4 all this.

5 Let me go quickly through this, okay? So the  
6 first column is what I did earlier. That's my risk  
7 estimate. The second column is the SEER prevalence  
8 rate for all ages for this cancer. SEER has, in  
9 this case it's nine registries: San Francisco,  
10 Connecticut, Detroit, Hawaii, Idaho, New Mexico,  
11 Seattle, Utah and Atlanta, plus two initial areas:  
12 LA and San Jose/Monterey. So that's what they are  
13 using.

14 I use almost all 50 state cancer registries in  
15 my risk estimate. Their problem was estimates just  
16 based on just those registries so it's going to be  
17 different. It's all ages besides including kids all  
18 the way up to people who are 90 years old. So it's  
19 an adjusted all age prevalence.

20 The next column has expected prevalence. And  
21 this, I didn't know what to do here because all ages  
22 didn't make any sense. So I picked the prevalence  
23 for the 50-to-60 year age range in the SEER  
24 prevalence just, I could have picked 60-to-70, but I  
25 thought 50-60 is roughly the age group we're talking

1 about.

2 The way SEER does this, and why my number --  
3 like for example, kidney cancer. I think there's a  
4 2.1 per thousand, and their expected prevalence is  
5 1.5, so it's lower. It's pretty much lower across  
6 the board. With their prevalence they just count  
7 one cancer. If you had two cancers, they only count  
8 the first one you had. I don't do that. If you had  
9 two cancers, you had two cancers. So that's the  
10 first difference right off the bat between what I do  
11 and what they do.

12 Second, I think mine's more defensible in that  
13 these are the published rates so there you go. So I  
14 included them. So given that there are 250,000 in  
15 the Lejeune survey cohort roughly, roughly, so  
16 250,000 just to make it easy. I think it's more  
17 like 242, 243 thousand, but I use round numbers.

18 If you use the SEER prevalence for the 50-to-60  
19 year olds, you'd expect 275 kidney cancers. And if  
20 you use my best guess then you get 440 for everyone  
21 in the survey. So there's a difference. Mine are  
22 higher. I think mine's better, but you see why.

23 And then finally, I use 800,000 as my best  
24 guess at how many people might have been exposed at  
25 Lejeune, that's between 100,000 and a million. And

1           for this, this is based on all the SEER rates. So  
2           it's based on the SEER prevalence all age rates  
3           which, I think, are too low. So if you want to go  
4           down to male breast cancer, for example, based on  
5           the SEER prevalence and 800,000 --

6           Well actually, I didn't do 800,000. For that I  
7           assumed that there are 700,000 males and 100,000  
8           females in this cohort roughly. You get 56 male  
9           breast cancers. If you use my figures, you get  
10          slightly higher. Or, no, actually, no, you get  
11          lower. You get lower. You get roughly around the  
12          same because the difference isn't that big and it  
13          doesn't include in situ cases which would add a  
14          little more to that.

15          So do with it what you want. These figures --  
16          I have draft written on them. It's an exercise. I  
17          don't think it's that helpful, but if you find it  
18          helpful, that's fine. The more important stuff was  
19          the statistical power calculations which I handed  
20          out earlier which showed that the study does have  
21          good power even at low participation rates and so I  
22          think it's possible to find something in these  
23          studies if there's not too much bias, which none of  
24          these calculations take into account because you  
25          can't in these kind of calculations.

1           The same is true for the mortality study so I  
2 think because you have such large numbers that we  
3 have a chance to find something. Now we talked  
4 about the limitations of the mortality study. The  
5 limitations of the health survey are this bias issue  
6 which will always come up because people always  
7 think that the people who were sick and were exposed  
8 will participate more than anybody else and then  
9 bias the results. So we're going to hear those  
10 charges against, you know...

11           We do have to verify the outcomes. That's  
12 difficult. It's time consuming. We may, as in the  
13 birth defects study, we may find that we can't  
14 verify some of the cases because there's no medical  
15 records that are available no matter what we do to  
16 confirm them. That will probably happen here, too.  
17 There'll probably be underreporting of people who  
18 are, for example, from Pendleton, that not only low  
19 participation, but since they don't have any  
20 exposure, they may not remember all the diseases and  
21 report them. This is a problem with other surveys.  
22 It's not just this survey.

23           So for all the plusses and minuses, which I say  
24 there are also plusses and minuses for the health  
25 survey. So just so you're aware of this.

1           **MR. STALLARD:** Any questions?

2           **MR. ENSMINGER:** I don't like this idea of using this  
3 health survey as a cancer incidence rate study.  
4 It's going to take too damn long. By the time you  
5 get all the data back, and then it's a self-  
6 reporting survey, and then you've got to verify all  
7 that stuff. I mean, you're talking five years.

8           **DR. BOVE:** No, no, not that bad.

9           **MR. ENSMINGER:** Well excuse me, damn it. I mean,  
10 how long have you been at Camp Lejeune now?

11          **DR. BOVE:** A lot of the time consuming part was the  
12 water model. So let me go over the timeline. This  
13 is changing a little bit, but we hope to finish the  
14 collection of the survey by November. Then we have  
15 to move to the second phase. Because of our  
16 contract, which we're trying to work with our  
17 contracts people to work out a better arrangement,  
18 we can't start --

19          **MS. RUCKART:** The first phase, began in September  
20 2010, is 18 months. That ends in March. However,  
21 if they need to take longer than March, that's fine.  
22 We'll get a no-cost extension. What that means is  
23 the second phase cannot start before March. It may  
24 start later if the health survey ^ are delayed, if  
25 we can't start in May or we can't start in June. If

1 we can't start in time to have them finish  
2 everything up by March, you know, because after the  
3 survey data collection ends, there's some tasks they  
4 need to do. They need to clean up the data and get  
5 it in the format that's usable to us. So they have  
6 till March. If they do not do that by March --

7 **DR. BOVE:** Jerry, just to finish. We're planning to  
8 be finished with the entire study including  
9 verifying all the outcomes by the end of 2013.  
10 It'll probably be a little bit, sometime in 2013,  
11 middle-to-end. So it's not five years, but it is,  
12 does take a long time.

13 To do a cancer data linkage effort, so it's not  
14 easy either. One study that looked at 20 cancer  
15 registries, we're going to try to look at twice that  
16 many. They looked at 20. They spent 400 hours just  
17 to try to work out arrangements of all the cancer  
18 registries and two or three of them they never  
19 worked out an arrangement.

20 And now we're more than doubling the number of  
21 cancer registries. So that study's not going to be  
22 easy to do or quick to do because there's no  
23 national registry. That's just the reality. That  
24 doesn't mean we shouldn't pursue it, but it will  
25 take time, too.

1           **MR. ENSMINGER:** I mean, if our government and our  
2 president actually got up and said that his goal was  
3 to defeat cancer within his lifetime, well, by damn,  
4 if you're serious about that, then why not create a  
5 national cancer registry where researchers, who have  
6 a right and the need to know, can go and collect  
7 this data and do these damn studies without having  
8 to go through these individual state registries,  
9 which are, this is a crock of crap.

10           I'm serious. I mean, this is idiotic. Why  
11 doesn't somebody in the federal government require  
12 these states to report to one national cancer  
13 registry?

14           **DR. BOVE:** Well, they do report in that they report  
15 figures to CDC.

16           **MR. ENSMINGER:** No, I'm talking about everything.

17           **DR. BOVE:** But if you want to do a study --

18           **MR. ENSMINGER:** Like a tumor board.

19           **DR. BOVE:** If you want to do a study, you have to  
20 work with each cancer registry.

21           **DR. PORTIER:** Well, it just so happens we have  
22 something called the Environmental Public Health  
23 Tracking Network that we're putting together here at  
24 NCEH. And what that network is going to do, it's  
25 not just for cancer but for a broad spectrum of

1 diseases. Have the states report back to us from  
2 which we're building one huge database.

3 It's not a classic cancer registry in the sense  
4 that it does time trends as well. But nonetheless,  
5 it's an attempt to go in the right direction, and if  
6 we can get that network to become national -- we're  
7 now in about 28 or so states. If we get that  
8 network to go national and do all 50 states, then it  
9 will be the closest thing we've got to a national  
10 cancer registry.

11 **MR. ENSMINGER:** Yeah, and you'll have people out  
12 there saying oh, this is socialism and, you know,  
13 idiots. My point about the cohort that you've got  
14 with the mortality study, which is the information  
15 that's coming out of the DMDC, the damn Defense  
16 Manpower Data Center, I think that that same cohort  
17 you should do a cancer incidence rate study on that  
18 cohort.

19 This stuff about using the damn health survey,  
20 I mean -- I went through this before you walked in,  
21 Dr. Portier -- that's a self-reporting survey which  
22 is going to throw up red flags for people. Number  
23 two, once you collect the data then you've got to go  
24 back and verify all of it through medical records.  
25 This 1975-to-1987 group you could do a down and

1           dirty, quick cancer incidence rate of those people  
2           that were there at Lejeune during that period of  
3           time.

4           **DR. BOVE:** That's exactly what we're thinking of  
5           doing. Since we have social security number, social  
6           security number and date of birth on all of them.  
7           Name, we have some civilian workers', some periods  
8           of time where the name wasn't there or a full name  
9           wasn't there, and there are short periods of time  
10          when that was true for the Marines and sailors. But  
11          date of birth and social security number, that's  
12          sufficient to link with a cancer registry.

13                 Even with the tracking you still have to work  
14                 all 50 states individually to get this information.  
15                 The one option that the VA used in their Gulf War  
16                 study was to provide the information to the  
17                 registries and then get back information that was  
18                 without personal identifiers, but enough information  
19                 so you could do an analysis.

20                 And so that would be a possible way to go  
21                 because some cancer registries by law in their state  
22                 cannot release data on anybody unless there's a  
23                 consent form along with it or a medical release form  
24                 somehow get sent. That's true of a couple of states  
25                 we've been told that. So that's not true of all the

1 states. Other states have other reasons why they  
2 don't want to participate, like New Jersey for some  
3 reason didn't participate in the Gulf War study,  
4 didn't participate in this Pittsburgh research study  
5 that was done. They've had a change of  
6 administration apparently and maybe they're more  
7 cooperative, but New Jersey is just one example.  
8 There are other states that will cooperate or not  
9 depending on who's there.

10 So again, the only way around this is to try  
11 this approach that the VA did. Before we do  
12 anything we do want to finish at least the survey  
13 portion of the health survey because this would  
14 require asking the Navy and Marine Corps for  
15 additional funds. You have to make a case --

16 **MR. ENSMINGER:** That's my next question. Is how  
17 much more above and beyond would this cost?

18 **DR. BOVE:** We'd have to price that out. It has not  
19 been done before to this extent. The Gulf War used  
20 20 states. We're talking much more than that so I  
21 don't know the answer. We've had some people look  
22 into it and go on. But I still think that we need  
23 to make a case, I think that internally we're not  
24 focused on this, and I want to hear feedback.  
25 That's why I bring it up because we need to get some

1 feedback from you. It sounds like you do want us to  
2 pursue this.

3 **MR. ENSMINGER:** Yes, I do. I think it's the  
4 quickest and most reliable way to get an idea of how  
5 many cancers and whether you have an elevated cancer  
6 rate.

7 **DR. BOVE:** It's not necessarily the quickest but --

8 **MR. PARTAIN:** And you also have another group, too -  
9 I'll bring it up. I've said it before -- the in  
10 utero population. You've got 16,000 identified  
11 there that were most at risk.

12 **DR. BOVE:** That's more difficult because we don't  
13 have social security number on most of them. We do  
14 have date of birth and we have the name. The name  
15 may have changed, but we do have date of birth and a  
16 name.

17 **MR. PARTAIN:** But you still have the information  
18 from the contactor did the original survey in 2001?  
19 They called somebody.

20 **MS. RUCKART:** Yeah, we have that information, but  
21 that's ten or so years old. But the current  
22 contractor is searching for those people as far as  
23 the current health survey. They are included. So  
24 the health survey does include a small sample of  
25 dependents that we did have information on.

1           **MR. PARTAIN:** But once again, we have a group that's  
2 identified that is the most at risk, that is the  
3 least studied throughout the health --

4           **DR. BOVE:** And they're part of the survey.

5           **MR. PARTAIN:** They need to be studied. They need to  
6 be looked at.

7           **DR. BOVE:** They're part of the survey.

8           **MR. PARTAIN:** But the cancer incidence I'm convinced  
9 is going to show something, at least from what I'm  
10 hearing out there with people contacting us through  
11 the website. I mean, the kids who were born there,  
12 they're seeing it and somebody needs to look into  
13 it, and it's just not happening right now.

14          **MR. BYRON:** And it's not just the cancers either.

15          **MR. PARTAIN:** We had a conversation about that.

16          **MR. BYRON:** It's not just the cancers either.

17          **DR. BOVE:** Well, the survey, the survey deals with  
18 the cancer incidence, cancer registries it would  
19 have to be focused on.

20          **MR. BYRON:** I want to bring up one thing before I  
21 forget it, and it may be a little off track, but it  
22 definitely applies here, too. I've seen commercials  
23 on TV that says that the autism rate in the civilian  
24 community is one in 110 children. And I'm also  
25 seeing that it's one in 87 in the military

1 community. You have not seen that? I'd like to  
2 propose to you --

3 **DR. BOVE:** Can you get --

4 **MR. BYRON:** -- to look into this --

5 **DR. BOVE:** Can you provide that? Where did you hear  
6 that?

7 **MR. BYRON:** We've seen it in commercials and seen  
8 people on TV speaking about autism.

9 **DR. BOVE:** No, the one in 87?

10 **MR. BYRON:** One in 87 with the military. I'll try  
11 to find that information and get it to you. But you  
12 also hear it's one in 110 outside the military. I  
13 don't know what's causing it, but I'd like you to  
14 pursue that also if you could, Brad, or if there's  
15 any information.

16 **MR. FLOHR:** I cannot.

17 **MR. BYRON:** There's nothing you can do there?

18 **MR. FLOHR:** No.

19 **DR. DAVIS:** Where do the 16,000 kids come from?

20 **DR. BOVE:** We were talking about this at lunch. We  
21 did this survey that determined, that identified  
22 birth defects. We contacted 12,500 parents so  
23 there's 12,500 children and 12,500 parents.

24 **MR. PARTAIN:** Sixteen thousand I thought was the  
25 total number. Twelve thousand five hundred was the

1 participation rate.

2 **MS. RUCKART:** We don't know the total number because  
3 there's no information on the number of births that  
4 occurred after the parent transferred from the base.  
5 So we estimate that the total number of births  
6 during 1968, when the birth certificates began to be  
7 computerized, until 1985, when the main portion of  
8 the contamination ended, is about 16- to 17,000. We  
9 don't have the exact number for ^ data.

10 **DR. DAVIS:** But that's only going to give you the  
11 number of babies for which that information is.  
12 It's not any follow-up to adults or to people like  
13 Mike, for example.

14 **MS. RUCKART:** Right, that's why we're saying we are  
15 trying to locate all the children and families that  
16 were included in our previous survey and study so  
17 that we can include them in the health survey.  
18 We're trying to trace them and locate them so that's  
19 the ability --

20 **DR. BOVE:** Again, we thought there may be 16,000 to  
21 17,000 births, but we don't really know. But we did  
22 contact 12,500 roughly. And so we're including all  
23 those people, the parents and the child, in the  
24 survey if we can get their current address just like  
25 the DMDC people, same procedure.

1           The problem is that with the DMDC we have,  
2           again, social security number, date of birth for  
3           everybody. With the survey we have date of birth  
4           for everybody. We've got social security number  
5           only for the person who responded to the survey  
6           which is half time was the mother, half the time was  
7           the father. We don't have it for the child.

8           **MR. PARTAIN:** You can use that to track down the  
9           child. I mean, usually my mother knew where I'm at.

10          **DR. BOVE:** Believe me, we use the best locating firm  
11          to get current address for all the people in the  
12          survey not just dependents but all of them.

13          **MR. PARTAIN:** Real quick. On this chart, Frank, the  
14          800,000 is for one year's --

15          **DR. BOVE:** I'm sorry. Which chart?

16          **MR. PARTAIN:** On the one where you have the current,  
17          the incidence rates, the last one you gave us. Is  
18          that four years when you're estimating that  
19          population for the '50s through '85?

20          **DR. DAVIS:** Do you mean what age groups?

21          **MR. PARTAIN:** No, you said that equals 800,000.  
22          It's the far right column.

23          **DR. BOVE:** Eight hundred thousand is what we  
24          estimated between '55 and '85.

25          **MR. PARTAIN:** Okay, so that's between year '55 and

1 '85?

2 **DR. BOVE:** Yeah. Again, I did a back-of-the-  
3 envelope calculation years ago between half a  
4 million and a million people exposed during those  
5 peak years simply by looking at how many people were  
6 there from '75 to '85 and roughly multiplying by  
7 three with the idea that during the Viet Nam War  
8 period, there'd be much more. So that's how I came  
9 up with mine.

10 Scott Williams then went back and with whatever  
11 information he had tried to cobble together an  
12 estimate because he thought mine was off the wall.  
13 His estimate was the same thing. So with a little  
14 bit better information than I had we came up with  
15 the same range. Which means to me that neither of  
16 us have good information as to how many people were  
17 there. That's what it tells me.

18 **MR. PARTAIN:** But as far as this chart goes you're  
19 looking between '55 and '85 roughly 800,000. And I  
20 realize this is not in stone or any scientific  
21 thing. If I'm reading this right, between those  
22 years the 800,000 exposed, you're expecting about  
23 536 kidney cancer cases.

24 **DR. BOVE:** Yeah, using the SEER age-adjusted,  
25 looking at all ages age-adjusted prevalence.

1           **DR. DAVIS:** For SEER in what year?

2           **DR. BOVE:** The SEER rate is in 2010. But with an  
3 entrance to NEXUS, so they look at one year and they  
4 look at how many people have the cancer who are  
5 still alive in that year. It takes some account of  
6 people who might have died before that and if they  
7 got the cancer all the way back to the start of the  
8 cancer registry for seven or eight or nine cancer  
9 registries; I can't remember which.

10          **MR. FONTELLA:** Jim Fontella. Don't the incidence  
11 rates change through the years? Like from what I  
12 saw in one chart from the incidence rates it showed  
13 like 0.8 breast cancer in 1963, and it went up to  
14 like 1.3 in 1996.

15          **DR. BOVE:** Yeah, the incidence rates change by --

16          **MR. FONTELLA:** Was it an average you took is what  
17 I'm saying with that year that you took?

18          **DR. BOVE:** The way I calculated risk, you saw how I  
19 did it. I looked at the incidence rates. I used  
20 the incidence rate age-specific incidence rates for  
21 each cancer from the 1999-2005 data for all 50 state  
22 cancer registries. That's where I got my risk  
23 estimate.

24                       Where SEER gets its prevalence estimate was it  
25 cast a number of people with that cancer in seven

1 registries in two other areas, nine areas, who were  
2 alive in 2007. Different age groups so that I  
3 picked a 50-to-60 age group. I could have picked  
4 the 60-to-69. It would have been a little higher,  
5 but I picked 50-to-59 is sort of where those people  
6 are right now. So that's why I picked that one.

7 As I said my risk estimates are higher for a  
8 couple of reasons. One is first of all it's based  
9 on more cancer registries so I think it's better.  
10 But, secondly, if you had more than one cancer, they  
11 only count the first cancer in the SEER rate. I  
12 don't. My estimates are based on cancer rates for  
13 that cancer. If you have other cancers, you're  
14 included in that incidence rate.

15 So there are differences, but I didn't want you  
16 to put too much weight on this thing. You asked me  
17 to do this last time, and I thought I would do it  
18 even though I know we don't have a real firm  
19 denominator. We don't know the age distribution of  
20 the population so I did a whole bunch of guesses.  
21 But you wanted something so this is the best I could  
22 do, and I don't know if it's helpful. What I think  
23 is helpful is the other stuff I handed out which  
24 gave you the power calculated, the minimum relative  
25 risk we can detect with decent power, and I think

1           that that shows you these studies have the power to  
2           detect them.

3           **MR. STALLARD:** One important document that we'll see  
4           in retrospect once the study is completed.

5           **DR. BOVE:** Yeah, right, right.

6           **MR. PARTAIN:** Well, even with this chart here, I  
7           mean, you've got 56 males with breast cancer between  
8           '55 and '85. We've got 70 that we know of.

9           **DR. BOVE:** Yeah, this doesn't include in situ so add  
10          about 15 more.

11          **MR. PARTAIN:** Okay.

12          **DR. BOVE:** But again, you haven't identified all the  
13          --

14          **MR. PARTAIN:** Yeah, I'm not saying --

15          **DR. BOVE:** -- these numbers are based on a lot of  
16          assumptions so between the two, take it for what  
17          it's worth. I mean, I'm just giving you some  
18          ballpark feeling for this. That's the best we can  
19          do.

20          **MR. PARTAIN:** I was going to say, if we're seeing  
21          this then what's the next step? What do you, like  
22          just using the male breast cancer as an example  
23          because we know we've got this.

24          **DR. BOVE:** I don't want to use this for anything  
25          really. For male breast cancer -

1           If we have a few minutes.

2       **MR. STALLARD:** We do.

3       **DR. BOVE:** I'll just go quickly over --

4       **MS. RUCKART:** We can talk about it at the next  
5 meeting. People are getting ready to go.

6       **DR. BOVE:** I did go over some of the ways we could  
7 deal with male breast cancer at the last meeting I  
8 think.

9       **PLANNING NEXT MEETING AND FORUM IN NC**

10       **MS. RUCKART:** So Jim Masone just joined us. He is  
11 primarily setting up our meeting.

12           So if you'll approach the table and you can  
13 talk about it. You could share any updates you have  
14 and then we can talk about your input in planning  
15 the forum.

16       **MR. FLOHR:** Folks, I need to get to the airport.  
17 I'll look forward to seeing you in Wilmington.  
18 Thanks for the opportunity to be here again and I'm  
19 sure we'll be talking to you about future meetings  
20 and get-togethers. And thanks again. I'll see you  
21 soon.

22       **MR. STALLARD:** Please, go ahead.

23       **MR. PARTAIN:** Brad, one quick question. At the  
24 Wilmington meeting, assuming we get this planned and  
25 it happens and stuff, is it possible that the VA,

1           there may be because it is near Camp Lejeune and a  
2           significant veteran population in the area, there is  
3           a good possibility that we may get a lot of people  
4           that want to talk or ask questions of the VA. Is  
5           there any way you guys can have staff up or perhaps  
6           have a presence there to be able to answer those  
7           questions if it happens?

8           **MR. FLOHR:** It's certainly a possibility. We do  
9           forums. We can try to get someone from, of course,  
10          the regional office in Winston-Salem to send some  
11          people up to specifically answer questions.

12          **MR. PARTAIN:** Can we go ahead and make that a  
13          request on behalf of the CAP? Do you think we can  
14          do that?

15          **MR. FLOHR:** Sure.

16          **MR. PARTAIN:** Because I know, you know, I hate to  
17          see you get swarmed by a thousand people with  
18          questions. You'll probably end up looking like me.  
19          If you could make that a formal request, I'd  
20          appreciate it.

21          **MR. FLOHR:** Okay.

22          **MR. STALLARD:** Thank you. We can add that to the  
23          meeting planning agenda.

24                 Thank you for joining us. We're delighted that  
25                 we were able to see you in person.

1           **DR. DAVIS:** Thank you.

2           **MR. STALLARD:** Okay. Can we have our attention now  
3 focused on the speaker? Let's talk about the  
4 planning for the Wilmington meeting.

5           **MR. MASONE:** Good afternoon. My name is Jim Masone.  
6 I work in the office of the Director ATSDR, and I'm  
7 here to brief you and answer any questions about the  
8 ^ forum, the next CAP meeting. I think in terms of  
9 the schedule right now is to have -- and this is  
10 fairly current -- we have negotiated dates with the  
11 University of North Carolina in Wilmington, and  
12 we'll be meeting in the Burney Center on campus  
13 there. It's the newest, as far as I can tell it's  
14 the newest meeting facility that they have on  
15 campus.

16           We have the Burney Center, we have July 20<sup>th</sup>, we  
17 are planning to have the CAP meeting same schedule  
18 as we typically have from nine in the morning until  
19 three in the afternoon. Then we'll have a couple  
20 hours break and then in the evening we're planning  
21 on having a forum from five o'clock until  
22 approximately eight o'clock in the evening. Then  
23 that will also be in the Burney Center probably in a  
24 different room in the same center. For you folks  
25 who will be traveling and may not have a lot of

1 transportation, there are food venues adjacent to  
2 the Burney Center so you won't go without dinner or  
3 lunch that day. But we do have the space scheduled  
4 and we're planning on having it July 20th.

5 **MR. ENSMINGER:** How many seats are available in this  
6 place where they're talking about holding the public  
7 meeting?

8 **MR. MASONE:** Good question, sir. We've reserved 100  
9 spaces for the CAP meeting, and we scheduled -- and  
10 we can increase that if you think that that's going  
11 to be necessary.

12 **MR. ENSMINGER:** Yeah, I do.

13 **MS. RUCKART:** That's just the CAP meeting.

14 **MR. PARTAIN:** How many for the forum?

15 **MR. MASONE:** For the annual forum I think we have  
16 500.

17 **MR. ENSMINGER:** Only 500 spaces, seats?

18 **MR. MASONE:** Yes, sir. That's what we're talking  
19 about right now.

20 **MR. ENSMINGER:** I think you're way low-balling it  
21 for the CAP meeting.

22 **DR. DAVIS:** Yeah, if it's there I would agree that  
23 you're likely to get a lot more people particularly  
24 if you're going to be publicizing it. You might  
25 want to think about having a larger space.

1           **MR. MASONE:** I think we can arrange that. So the  
2 way we're planning is to set up something, we'll  
3 have approximately 25 people at the table. Is that  
4 reasonable?

5           **MS. RUCKART:** Twenty.

6           **MR. MASONE:** Okay, well, we're planning on being set  
7 up in a U-shape like this and with chairs set up  
8 auditorium style, probably something along these  
9 lines behind the actual CAP meeting space. That's  
10 for the CAP. And then for the forum, we're planning  
11 on having a dais in the front of the auditorium set  
12 up where everyone else would be sitting theater  
13 style for the forum. As far as I can tell it's not  
14 going to be in the auditorium. I think y'all had it  
15 last time --

16           **MR. ENSMINGER:** It was in Keenan Auditorium.

17           **MR. MASONE:** Yeah, thank you.

18                         They said that they felt like that was probably  
19 not the best venue. So they recommended the Burney  
20 Center.

21           **MR. PARTAIN:** Burney?

22           **MR. MASONE:** Burney Center, B-U-R-N-E-Y.

23           **MR. ENSMINGER:** Now what's your name again?

24           **MR. MASONE:** My name is Masone, M-A-S-O-N-E. My  
25 first name is Jim.

1           **MR. ENSMINGER:** And what's your e-mail address, Jim?  
2           What's your e-mail address?

3           **MR. MASONE:** My e-mail address is J-M-A-S-O-N-E-at-  
4           C-D-C-dot-G-O-V.

5           **MR. PARTAIN:** Now if for some reason we get  
6           feedback, because we'll start talking about this in  
7           our community, if for some reason we get feedback  
8           that there's going to be a lot more people showing  
9           up than we're thinking here --

10          **MR. ENSMINGER:** That's why I wanted his contact  
11          information.

12          **MR. PARTAIN:** -- do we have any potential plan to  
13          revisit -- there's a lot that's going to be  
14          happening in the press and everything.

15          **MR. MASONE:** That would be wonderful. If you could  
16          let us know as soon as possible. They're making  
17          space for us. Apparently, there are some competing  
18          parties there at the university, and we, as an  
19          outside group, don't. We're unfortunately at the  
20          lowest priority of the scheduling space, but I think  
21          they're making particular allowances for us.

22                 That being said I'd like for us to be sure and  
23          be respectful of that. So if you can give me an  
24          idea as soon as possible that would be helpful for  
25          us.

1           **DR. BOVE:** Let me ask the CAP members. Does five to  
2 eight make sense for a public forum or six to nine  
3 or do you have any --

4           **MR. ENSMINGER:** Five's a little too early. You  
5 know, people that are working, and they want to come  
6 home and have dinner. They want to get ready and  
7 then travel to the venue.

8           **DR. BOVE:** I forget when we --

9           **MR. ENSMINGER:** It was like seven to nine.

10          **DR. BOVE:** It was that late. I know we had got  
11 there just in time to plan --

12          **MR. STALLARD:** For the CAP meeting itself?

13          **MS. RUCKART:** No, for the forum.

14          **DR. BOVE:** I think it probably was seven to nine.

15          **MR. ENSMINGER:** Yep.

16          **DR. BOVE:** It took every bit of those two hours,  
17 too, because there were a whole lot of questions we  
18 had to answer the next day we couldn't just at the  
19 forum. So I think it has to be later than five.

20          **MR. MASONE:** That's fine.

21          **DR. BOVE:** Is six too early still?

22          **MR. ENSMINGER:** That's still too early. I mean,  
23 seven to nine.

24          **MR. PARTAIN:** Six-thirty, seven to nine.

25          **MS. RUCKART:** Six-thirty, then why not 6:30?

1           **MR. PARTAIN:** Six-thirty is okay.

2           **DR. BOVE:** I do think we're going to need more than  
3 two hours possibly.

4           **MR. ENSMINGER:** Well, I have a recommendation as  
5 well.

6           **DR. BOVE:** Go ahead.

7           **MR. ENSMINGER:** When people come to this thing, when  
8 they're coming in, we need people at the doors  
9 handing out a question sheet. If they have  
10 questions, they can sit down, and they can write  
11 their questions out and turn them in at the end of  
12 the thing. If their question cannot be addressed  
13 during the meeting, then they can be responded to  
14 later.

15           **MR. MASONE:** What we have arranged, Frank, is we  
16 have it set, there will be microphones in the house.  
17 People can step up to the microphones and make their  
18 presentation because we do plan to have it streamed.  
19 We want to make sure we catch it all, catch all the  
20 audio. So that's the way we have it set up right  
21 now. But to your point if there are questions we  
22 can't answer, I should say they can't answer in the  
23 course of the forum --

24           **MR. STALLARD:** Not everybody wants to step up to a  
25 public microphone. And so to honor that

1 introspection, let's say, I think we have to have a  
2 vehicle where if they want to fill out questions  
3 that we can capture.

4 **DR. BOVE:** That went pretty well at the last forum.  
5 We may need your help in collecting those. I don't  
6 know how much staff from ATSDR is going up to this  
7 forum.

8 **MR. ENSMINGER:** Just put a box.

9 **DR. BOVE:** Put a box to collect them, okay, just to  
10 put a box, but we do need to --

11 **MR. ENSMINGER:** And announce it.

12 **MS. RUCKART:** Are you thinking of like community  
13 ambassadors to help us?

14 **MR. BYRON:** We can contract that out.

15 **MR. PARTAIN:** What about with this getting an idea  
16 of how many people are going to participate? I'm  
17 envisioning more. Maybe I'm optimistic, but we had  
18 an informational meeting down in Tampa that Jerry  
19 and I conducted with a little bit of press  
20 notification beforehand, and we put 250 people in a  
21 room with not much effort. And that's in Tampa,  
22 Florida, and we're going to right next to Camp  
23 Lejeune.

24 What about you guys setting up something on the  
25 web or e-mail address to where people who want to

1 attend this can send their contact information  
2 saying I want to be there so we can start generating  
3 some counts to get an idea of how many people are  
4 going to show up? The last thing I want to see is  
5 have a bunch of people show up and nowhere to put  
6 them and be turned away. Get an e-mail address or  
7 get people saying if you want to go to this, e-mail  
8 us here so that way you guys can see because  
9 somebody's got to do the count because otherwise it  
10 gets all messed up.

11 **MR. STALLARD:** Mary Ann.

12 **MS. SIMMONS:** I wasn't at it last time, this forum,  
13 so can you describe what this was?

14 **MR. ENSMINGER:** It was put on by the Wilmington Star  
15 newspaper. They had representatives from ATSDR.  
16 They had a toxicologist from North Carolina State.  
17 What's his name? Jerry LeBlanc (ph). And I was  
18 there, and they gave, every person spoke and gave a,  
19 Morris went over the water modeling. Frank was  
20 going over the studies and whatnot. And the Marine  
21 Corps refused to participate. They had an observer  
22 there.

23 **MR. STALLARD:** So that's the forum part. So this is  
24 the first time that we're doing the CAP in  
25 conjunction with that, right?

1           **MR. PARTAIN:** Yeah, and to make it official, we  
2 would also as a CAP --

3           **MR. ENSMINGER:** Well, I mean, the last one was put  
4 on by the Wilmington Star News, and this is the  
5 first time that the CDC is putting on a --

6           **MS. SIMMONS:** Did you participate last time?

7           **DR. BOVE:** Yeah, I gave reports, and I gave a  
8 presentation.

9           **MR. PARTAIN:** And to make it official from the CAP -  
10 - I think everybody will agree with me -- we would  
11 like to officially invite the United States Marine  
12 Corps to participate in the CAP meeting next meeting  
13 and have a representative there for the community.

14           **MR. STALLARD:** I'd like for us to talk seriously  
15 about the kind of flow of the agenda. We're going  
16 to be in a public forum in the home territory of  
17 Camp Lejeune. For me, personally, if I'm  
18 considering that I think that it would be helpful to  
19 have Jerry give a presentation about all the work  
20 that the CAP has done to give a background and  
21 context for people so that they understand.

22           **MS. RUCKART:** At the CAP meeting or at the public  
23 forum?

24           **MR. STALLARD:** Probably both because the same people  
25 who are going to be at the CAP meeting are going to

1           be at the forum. And so from that point on -- Five  
2           hundred people is a lot in the audience, and I think  
3           we have to manage the communication. And it's going  
4           to be a different dynamic than this. So I'm asking  
5           for your help that in doing an agenda, we need to be  
6           thinking as a unified CAP that we're presenting an  
7           image to the public that we operate and have been  
8           working together. Here's our history. There's the  
9           things we've accomplished, and then we can get to  
10          the meat of whatever it is we want to talk, but we  
11          have to set the stage. Think about that.

12         **MR. PARTAIN:** An hour and 15 minutes is the perfect  
13         vehicle to do that, and it's called "Semper Fi,  
14         Always Faithful".

15         **MR. STALLARD:** And if we want to show that --

16         **MR. PARTAIN:** That would be a great opportunity  
17         because it shows everything we've been going  
18         through, our trips to Washington, our CAP meetings,  
19         on everything that's been going on --

20         **MR. ENSMINGER:** If you're going to do that, then  
21         you're going to have to do that separately, early.

22         **DR. BOVE:** Yeah, yeah, that's what I'm thinking.  
23         Then it makes sense to have that like at five and  
24         then follow that up. I still think that you're  
25         absolutely right. One of the CAP members should

1 give a short presentation for as long as they need  
2 to take actually. The CAP, what it is, what it's  
3 done.

4 **MR. STALLARD:** And what it's not done or what the  
5 challenges are still that are facing the barriers.  
6 I mean, what we have to show in my view there's been  
7 tremendous, there's been progress and there remain  
8 challenges. And this is what collectively we've  
9 been able to do, and this is what collectively we're  
10 trying to solve. So you guys can draw straws.

11 So it's unanimous. Jerry has just been  
12 nominated and ratified. So but we'll continue to  
13 work that out. I'm sure there's going to be a lot  
14 of dialogue between now and then or some dialogue I  
15 would hope in terms of agenda building and  
16 organizing.

17 And who's going to see if that, if it can be  
18 shown, "Semper Fi"?

19 **MR. PARTAIN:** I will.

20 **MS. RUCKART:** Then you would need to get there  
21 earlier? I mean, we have to iron this out because  
22 it's going to be more cases for running a movie.

23 **MR. STALLARD:** Like projection for one thing.

24 **MR. ENSMINGER:** The second film festival will be  
25 over by that time, too, so Silver Dock in D.C. or

1 Silver Spring, Maryland, that's going to be shown  
2 there. There are different environmental groups  
3 that want to get separate screenings of the movie  
4 for Capitol Hill, specifically congressional staff.  
5 So July, well, this is in July. It shouldn't be too  
6 much of a problem to get a screening at that  
7 meeting, before that meeting. I'll check on it. I  
8 mean, I can't say that for sure, but I'll have to  
9 check with the producer.

10 **MR. MASONE:** Please let me know in terms of the  
11 timing, the space and AV requirements as soon as  
12 possible, because we do have to pay on an hourly  
13 basis so we do have considerations for planning  
14 purposes. So if you could let me know as soon as  
15 possible that would be helpful.

16 At some point we are going to be locked into a  
17 contract where we have to pay for it in advance. So  
18 once we have done that, made those arrangements,  
19 we're going to be pretty much locked in, so if you  
20 could let us know as soon as possible it would be  
21 helpful.

22 **MS. RUCKART:** When you say as soon as possible, can  
23 we set a date then that means?

24 **MR. ENSMINGER:** Yeah, what's your drop dead date,  
25 Jim?

1           **MR. MASONE:** I don't know that, and I'm afraid to  
2           commit to that right now because I'm not, I wanted  
3           to negotiate with, we'll find out from you folks  
4           what -- here's what we need to do.

5           **MS. RUCKART:** Why don't you later this week give me  
6           your absolute deadline, and I'll communicate it to  
7           the CAP.

8           **MR. MASONE:** Okay, very good, thank you.

9           **MR. STALLARD:** So that's the CAP agenda that we're  
10          going to work on. In terms of the open public forum  
11          who organizes the flow of that, speakers and this  
12          and that?

13          **MR. ENSMINGER:** ATSDR.

14          **DR. BOVE:** Again, the CAP member to speak about the  
15          CAP, and Morris will talk about the water modeling,  
16          and I will talk about the studies.

17          **MR. STALLARD:** Are any congressional people going to  
18          be there?

19          **DR. BOVE:** Huh?

20          **MR. STALLARD:** Any congressional people?

21          **MS. RUCKART:** Probably in the audience.

22          **MR. ENSMINGER:** I think the whole, I think the  
23          entire CAP ought to be present for --

24          **MR. PARTAIN:** With the lodging and stuff you've got  
25          I'm assuming we're going to be there two nights?

1 I'm assuming because it's a special event.

2 **MR. STALLARD:** Yes. I mean, for instance, if we  
3 were doing a presentation we'd want to show some of  
4 the, you know, when we do introductions here, it's  
5 your name and CAP member, but we have Dr. Dick Clapp  
6 who is expert in X-Y and Z. You know, to sort of,  
7 who are the people that are here representing these  
8 interests to give a little bit more depth to just a  
9 name.

10 **MR. PARTAIN:** Well, one of the things I'd like to  
11 see at the CAP meeting, too, as far as when you talk  
12 about the community coming in and everything, most  
13 people are visual these days. It would be good to  
14 have some of the blow-up maps of contamination  
15 plumes, water distribution centers, you know, where,  
16 you know, you could do a street map showing where  
17 buildings were located, where people lived, the  
18 street names. Have them on the walls so people can  
19 see and interact.

20 **MR. STALLARD:** That animation that Morris showed us  
21 today.

22 **DR. BOVE:** Morris has all those maps.

23 **MR. PARTAIN:** I mean that would be good to have out  
24 there in like around the chamber so people can see  
25 that because those are the frequent questions we

1 get. They want to know what was where, how bad, my  
2 neighborhood, how do I find out where I lived,  
3 where's such-and-such street, and the Hadnot Point -  
4 -

5 **MR. ENSMINGER:** I disagree. I don't think they  
6 ought to be in the meeting area. They should be, if  
7 there's a lobby for this building, that's where  
8 those easels and those maps should be, out in the  
9 lobby. Because you're going to have people going up  
10 there with other people, and they're going to be  
11 conversing. And if you have that in the same hall  
12 as where you're having the meeting --

13 **MR. PARTAIN:** Get them up on the wall or something.

14 **MR. ENSMINGER:** Not on the wall. Put easels up.

15 **MR. STALLARD:** They also need something to take  
16 away, reading material or follow-up information, who  
17 can they contact, stuff like that.

18 **MR. PARTAIN:** Including reading material and  
19 participating completion dates. What you all are  
20 doing as ATSDR.

21 **MR. STALLARD:** Appropriate reading material.

22 **MS. SIMMONS:** I'd hand out all the presentations.

23 **MR. STALLARD:** What?

24 **MS. SIMMONS:** We do meetings like this a lot. I'd  
25 hand out copies of all the presentations. That

1 would be one handout to take away.

2 **MR. STALLARD:** So maybe what we need between now and  
3 then is make a list of presentations and commit to  
4 who's going to do those, and then handouts and what  
5 those would be so that we can have that printed well  
6 in advance for that. I'm sure you guys do this all  
7 time. I'm just thinking extemporaneously.

8 So we're agreed we're all going to Wilmington,  
9 right?

10 **MR. ENSMINGER:** Yeah, down to the River Walk.

11 **MR. BYRON:** How's the surfing?

12 **DR. PORTIER:** Wilmington in July is about as hot as  
13 you can get.

14 **MR. ENSMINGER:** Yeah, but the River Walk's nice. In  
15 the evenings go down on the River Walk.

16 **MR. STALLARD:** Do I need to make any administrative  
17 things? You all turn in your vouchers, send them  
18 in, do what you're supposed to do. There's always  
19 that.

20 **MR. ENSMINGER:** I notice this envelope that they  
21 handed out they've got a cover letter in there about  
22 filling out our travel and then mailing it back in.

23 **MS. RUCKART:** This is what our secretary has given  
24 to me so I guess this, this is what the secretary  
25 gave to me.

1           **MR. ENSMINGER:** Since I've been on the CAP since  
2           2005, I've never mailed anything. I've sent it back  
3           electronically, and it's always sufficed.

4           **MS. RUCKART:** It's a new secretary.

5           **MR. PARTAIN:** Can you clarify because I don't have a  
6           large amount of wealth to wait for my reimbursement.  
7           I either mail PDF. I scan PDF and mail it to, e-  
8           mail it in. As we know snail mail takes awhile.  
9           Can we make sure that there's email?

10                   And also speaking of e-mail, there was some  
11           change with the e-mail. I'm not getting all the e-  
12           mails.

13           **MS. RUCKART:** Our servers are migrated and this is  
14           what's happened and I have let them know, the way  
15           the e-mail addresses showed up, I have no control  
16           over that. It's a behind-the-scenes thing, and I  
17           brought it to their attention. And their response  
18           was I need to notify every person that they should  
19           not, they should look for us in their junk mail.  
20           And my response was if somebody e-mails me, and I e-  
21           mail them back, I have no other way to get in touch  
22           with them than to e-mail them back. If it goes to  
23           their junk mail, how else can I e-mail them to tell  
24           them to check your junk mail.

25           **MR. PARTAIN:** I'm not even getting them --

1           **MR. ENSMINGER:** No, no, no, when you hit reply like  
2           when responding back to those e-mails, and I hit  
3           reply all, ATSDR's e-mail address comes back with  
4           this word in parentheses right after ATSDR, target.  
5           And when I send it, it says it's an undeliverable  
6           address. Where the hell's the word target come  
7           from?

8           **MR. PARTAIN:** The old saying if it ain't broke,  
9           don't fix it. Well, someone fixed something that  
10          wasn't broke.

11          **MS. RUCKART:** The agencies are having a lot of e-  
12          mail problems since they migrated us, and I told  
13          them we're having a problem, and their response was  
14          I need to tell everybody to make sure it didn't go  
15          to their spam folder. And I'm saying how am I going  
16          to do that if, I mean, this is a public mailbox.  
17          Anyone can e-mail me. I cannot know who's going to  
18          e-mail me to contact them. Basically, after  
19          bouncing around the answer is --

20          **DR. BOVE:** The easy solution would be just, I'll e-  
21          mail you from my account and you can e-mail me.

22          **MR. ENSMINGER:** No, what I do, I delete the e-mail  
23          address that they send it on, then I go back into my  
24          contact list and put the old address on it and send  
25          it, and it's fine.

1           **MR. PARTAIN:** As far as addresses, who do we send  
2           them to?

3           **MS. RUCKART:** Well, I have to get the new  
4           secretary's e-mail address. I don't know what her  
5           e-mail address is.

6           **MR. STALLARD:** We're wrapping it up. Dr. Portier,  
7           any closing comments? Thank you.

8           **DR. PORTIER:** Thank you all for being here. Thanks  
9           for the ideas and suggestions of ways that we can  
10          improve what we're doing. Thanks a lot.

11          **MR. STALLARD:** Everybody safe journey home. This  
12          concludes our meeting.

13          (Whereupon, the meeting was adjourned at 3:20 p.m.)  
14  
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**CERTIFICATE OF COURT REPORTER****STATE OF GEORGIA****COUNTY OF FULTON**

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of April 5, 2011; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither relation nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 1st day of May, 2011.

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**STEVEN RAY GREEN, CCR, CVR-CM, PNSC**  
**CERTIFIED MERIT COURT REPORTER**  
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