

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Agency for Toxic Substances and Disease Registry

convenes the

FIRST MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

FEBRUARY 1, 2006

The verbatim transcript of the
Meeting of the Camp Lejeune Community Assistance
Panel held at the ATSDR, 1825 Century Boulevard,
Atlanta, Georgia, on February 1, 2006.

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February 1, 2006

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TRANSCRIPT LEGEND

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

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

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

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

-- "^" represents inaudible or unintelligible speech or speaker failure, usually failure to use a microphone.

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

(alphabetically)

BOVE, FRANK, ScD, ATSDR
BRIDGES, SANDRA, COMMUNITY MEMBER
BYRON, JEFF, COMMUNITY MEMBER
CLAPP, RICHARD, SCD, MPH, PROFESSOR
DYER, TERRY, COMMUNITY MEMBER
ENSMINGER, JERRY, COMMUNITY MEMBER
FISHER, JEFFREY, PH.D., SCIENTIFIC EXPERT
MARTIN, DAVE, COMMUNITY MEMBER
MCCALL, DENITA, COMMUNITY MEMBER
ROSSITER, SHANNON, MPH, ATSDR
RUCKART, PERRI, MPH, ATSDR
STALLARD, CHRISTOPHER, CDC, FACILITATOR
TOWNSEND, TOM, COMMUNITY MEMBER

P R O C E E D I N G S

(9:15 a.m.)

WELCOME AND OPENING COMMENTS

1 **MR. STALLARD:** We are still missing one panel member, yet
2 we are hopeful that she will join us as soon as possible.

3 Welcome everyone to the first Camp Lejeune Community
4 Assistance Panel. My name is Christopher Stallard. I am
5 facilitating this session today. We're going to start
6 off with a welcome from Dr. Howard Frumkin, the Director
7 of NCEH/ATSDR and then I'm going to inform you all on
8 guidelines and setting expectations for this meeting.

9 **DR. FRUMKIN:** Good morning, everybody. Welcome to
10 Atlanta for those of you who are visiting from out of
11 town. I'm the Director of NCEH/ATSDR as you just heard.
12 Some of you may be familiar with ATSDR, the Agency for
13 Toxic Substances and Disease Registry. That agency has
14 now partially consolidated with a sister agency here at
15 the CDC called the National Center for Environmental
16 Health. Hence the long name, NCEH/ATSDR, and again, my
17 name's Howard Frumkin.

18 I've been the director here for about four months so
19 this is relatively new to me. One of the very important
20 places that I've learned about since becoming Director is
21 the Camp Lejeune site. It's an extremely important site
22 to this agency. And I'm delighted that you're all here

1 to begin moving us forward, continue moving us forward in
2 addressing the health concerns at this site.

3 Before getting into anything procedural, I just want
4 to say on my personal behalf, and I think on behalf of
5 everybody in this agency, how sorry I am at the suffering
6 and the pain that has gone on in the community in
7 connection with exposures there in connection with
8 illnesses. We don't forget, I don't forget, and I think
9 everybody in this agency doesn't forget that behind all
10 of the epidemiologic studies, behind all of the legal
11 maneuverings and administrative discussions, there are
12 people. And when people are suffering, we care very
13 deeply. And so I hope we can all remember that the
14 center of our concerns as we move forward together.

15 The Community Assistance Panel is a very important
16 asset to us. It's important because we care very much
17 about working with the communities where we're active.
18 And so a situation like Camp Lejeune where you represent
19 a community that's been affected, and I know that some of
20 the most important leading voices in the community are
21 here today, it's extremely beneficial for us to work with
22 you together to do our work as well as we can.

23 I expect that as the day goes forward and as the
24 months move on, we will talk together about the need for
25 scientific investigations and other health interventions

1 in the community, and I think that your community
2 perspective together with the expertise of professionals
3 in this community will help us reach the best decisions
4 we can reach together. We are very, very prepared to
5 listen, prepared to change course if necessary to reach
6 the best decision.

7 I want to thank each and every one of you for being
8 here today, giving your time. I know that members of
9 your community are grateful to you for doing this, as
10 grateful as we are. I also want to thank Dick Clapp and
11 Jeff Fisher who are our outside experts and will be here
12 from Boston and the University of Georgia, respectively,
13 who will be helping you with some of the technical
14 material you need to deal with today.

15 And if I can do anything at all to help move this
16 process forward and to help ease your time here, I'll be
17 very happy to try to do that. I'm being very quick
18 because I have a 9:30 that I have to get to. Are there
19 any questions or comments that anybody wants to share
20 before I run away?

21 **MR. ENSMINGER:** I have something I'd like to discuss with
22 you later, sir.

23 **DR. FRUMKIN:** Okay.

24 Thank you all, best wishes for a successful meeting.
25 Thank you for being here.

1 **MR. STALLARD:** To start this process I think it would be
2 a good idea if we just briefly introduce ourselves to one
3 another, your name and perhaps your affiliation on this
4 panel.

5 **DR. BOVE:** My name is Frank Bove, Senior Epidemiologist
6 in Health Studies at ATSDR. Camp Lejeune activities.

7 **MR. BYRON:** My name is Jeff Byron. I'm from Cincinnati,
8 Ohio. I'm a CAP member, and I have a website called "The
9 Few, the Proud and the Forgotten."

10 **MS. BRIDGES:** Sandra Bridges, Charlotte, North Carolina,
11 member of CAP.

12 **MS. RUCKART:** Perri Ruckart, Principal Investigator,
13 ATSDR, Camp Lejeune Study.

14 **MR. ENSMINGER:** I'm Jerry Ensminger. I'm a Camp Lejeune,
15 North Carolina, CAP member.

16 **DR. CLAPP:** I'm Dick Clapp. I work at Boston University
17 School of Public Health, but I'm an expert for the CAP.

18 **DR. FISHER:** Jeff Fisher from College of Public Health,
19 University of Georgia, just a few miles away from here,
20 and I'm a professor and department head.

21 **MS. DYER:** I'm Terry Dyer. I'm from Wilmington, North
22 Carolina. My sister, Karen Strand, and I started the
23 website, "The Water Survivors."

24 **MR. MARTIN:** I'm David Martin from Black Mountain, North
25 Carolina. I'm also with Water Survivors.

1 **MS. ROSSITER:** I'm Shannon Rossiter. I'm an
2 epidemiologist in the Division of Health Studies, and I'm
3 working on the Camp Lejeune project.

4 **MS. McCALL:** Good morning, my name is Denita McCall. I'm
5 from Littleton, Colorado, and I'm a member of the CAP for
6 the staff.

7 **MR. STALLARD:** All right, I'm sure that many of you have
8 received quite a bit of read-ahead material, but just to
9 be sure that we're all on --

10 **MR. TOWNSEND (by telephone):** Can I interrupt?

11 **MR. STALLARD:** Yes, please, Tom. And we have Tom.

12 **MR. TOWNSEND (by telephone):** Yes, I'm on the line.
13 Could you turn up the volume or put the mike closer? I
14 cannot get you on video, and I can barely hear you.

15 **MR. STALLARD:** We'll do what we can. Go ahead, Tom, we
16 can hear you though, real well.

17 **MR. TOWNSEND (by telephone):** Yeah, the telephone works,
18 but the video is --

19 **MR. STALLARD:** Would you take a moment and introduce
20 yourself for us, please?

21 **MR. TOWNSEND (by telephone):** I'm Tom Townsend. I'm a
22 CAP member and have been involved in this since about
23 1999, and I live in Idaho. And it's snowing here.

24 **MR. STALLARD:** It must be very early. Welcome, Tom,
25 we'll attempt to do what we can to resolve the visual

1 hang up.

2 **MR. TOWNSEND (by telephone):** I can hear you now, thank
3 you.

CHARGE TO THE GROUP (GOALS, EXPECTATIONS, PROCEDURES)
CHRISTOPHER STALLARD

4 **MR. STALLARD:** The objectives of this meeting are to
5 obtain recommendations from the CAP members on the
6 feasibility of conducting specific studies at the base.
7 Secondly, it is to receive CAP recommendations concerning
8 the prioritization of those studies identified. It's
9 very important that we understand that this is a process.

10 This is the first in a series of meetings until we
11 achieve our objectives. So it is ongoing and evolving.
12 Since it is ongoing and evolving, and we are going to be
13 together for a number of sessions, it is important to
14 establish at the outset guiding principles to govern our
15 interaction. I'm going to go over this list, but I
16 encourage you if you have something else to add here,
17 please feel free to do so.

18 First of all, we are grateful to have an audience
19 here; however, the audience may not participate during
20 the discussions, zero discussions. Your role is to
21 listen and observe during the formal part of the meeting.

22 Respect: one speaker at a time, please. This is a
23 future oriented assembly. We're looking to identify the
24 studies that are feasible and to prioritize them. This

1 is not a forum for a review of the past, zero personal
2 attacks.

3 I say this for those of you who have microphones,
4 please leave them in the room or turn them off because
5 they will pick up if you leave the room, for instance to
6 the rest room or have a little caucus, it will be
7 broadcast.

8 We are to seek consensus so that what that means is
9 so that we all understand is that I can live with what
10 the group is saying. If you feel so adamantly opposed,
11 then you need to say that, and we'll have to figure out
12 as a group how to address your issues. But our goal is
13 consensus.

14 This is for everyone in the room, please. Turn your
15 cell phones onto silent, stun or vibrate, the audience as
16 well. And probably most important, start on time,
17 please, and end on time. That is our goal for all future
18 meetings and this one as well. Is there anything else
19 that members of the Panel would like to offer in terms of
20 guiding principles?

21 **MR. ENSMINGER:** Yes, I have a brief statement that I'd
22 like to make before this thing gets started. I know you
23 said you don't want to bring up anything about the past,
24 but I think some of the things that have brought us to
25 this point need to be brought out. And I've prepared a

1 brief statement, and I'd like to read it.

2 **MR. STALLARD:** Okay, is there anything about guiding
3 principles -- you will have time, Jerry, to read that
4 statement very shortly as soon as I go through the
5 administrivia, you're up, okay?

6 Anything else to add to this?

7 (no response)

8 **MR. STALLARD:** Here are some administrative notes for
9 you. The rest rooms and the location, those of you who
10 are here, it's a maze. It's out toward the front guard
11 desk to the left down that hallway just past the
12 elevators. Lunch is between 12:00 and 1:00. It's a
13 working lunch for the Panel. When you came in, you
14 should have received a lunch menu. We ask that you make
15 your selections by the break so that we can ensure it's
16 delivered on time.

17 This session is being web cast, I think, Tom. At
18 least he's getting it telephonically, and it's being
19 archived which means that at least the video proceedings
20 even if it's not being reached by Tom will be archived
21 and available. We have one member via phone. Please
22 keep that in mind.

23 Tom, I'll work with you as best I can when you have
24 to have something to say.

25 **MR. TOWNSEND (by telephone):** I hear you very well.

1 **MR. STALLARD:** Good.

2 And we have a court reporter here.

3 The role of the facilitator, my role, is to
4 acknowledge the speakers, to redirect and focus on
5 objectives where it appears that we may not be going
6 toward the objectives, mitigate communication barriers,
7 to summarize or otherwise clarify for understanding. If
8 I can understand it, then that helps me to see that the
9 group understands it. And I am as well your time
10 manager.

11 So Jerry, right after this will be your opportunity
12 to make your presentation.

13 This is an exercise right now to find out from each
14 of the members what is it that you want to achieve during
15 this meeting and future CAP meetings, and what you want
16 to avoid. So it's a blank sheet. I need some feedback
17 here. What do you want to achieve?

18 **MR. ENSMINGER:** Do you want it right now?

19 **MR. STALLARD:** Yeah, I want you to say what you hope to
20 achieve in this meeting.

21 **MR. BYRON:** I want to see further studies on the children
22 who were born prior to the ^ base housing and the adults.

23 **MR. STALLARD:** That's getting further studies on
24 children?

25 **MR. BYRON:** Yes.

1 **MR. STALLARD:** That's getting more into the substance of
2 what you're going to be discussing, but I've got it.

3 **MR. ENSMINGER:** Well, and seeing how this is one of the
4 largest contaminations that's taken place as far as
5 actually documented level of contaminants in the drinking
6 water, I think it would be the moral obligation of the
7 people that were responsible to notify everybody that was
8 exposed to this stuff.

9 **MR. STALLARD:** Okay, what else?

10 **MS. DYER:** I think it would be beneficial to know and
11 talk a little bit about how, where the monies come from,
12 how they're divided, so as far as like studies go, and
13 what different areas go to like advertising, doing the
14 notification, you know, that sort of thing. Is it, the
15 monies that you've been given, is it specifically divided
16 for different areas? And if not, how we can accomplish
17 that so that we can get some of these things like
18 notification done.

19 **MR. STALLARD:** Okay, Terry, I have that as financing,
20 resourcing of studies, how is it divided and allocated.

21 **MS. DYER:** Right, and maybe even the different people
22 within this organization that are working on it, you
23 know. Who better is it that we need to be in contact
24 with, and...

25 **MR. STALLARD:** Who to work with at where?

1 **MS. DYER:** Here, at the ATSDR.

2 **MR. STALLARD:** At the ATSDR.

3 **MR. BYRON:** Byron again. I'd like to know the national
4 statistics on the illnesses that have been, that are
5 being studied in the current in utero study. I'd also
6 like to know the mortality rate of the 103, how many are
7 actually surviving at this time. How it compares to the
8 national average.

9 **MR. STALLARD:** Okay, let me make sure I've got this. The
10 national statistics of the current in utero studies and
11 what was the second one?

12 **MR. BYRON:** Mortality rate of the 103 children, how many
13 are still surviving and what that national average
14 represents. What that average represents compared to the
15 national average.

16 **MR. MARTIN:** David Martin, I'd like to see if there's any
17 way we could figure out how to get some of these people
18 who've been exposed, who are suffering from illnesses,
19 some help as quickly as possible. We have people out
20 there that have never been able to work in their life
21 because of some of these devastating illnesses, people
22 that are sick or receiving treatment at this time with no
23 sources of income and no insurance to cover it. We have
24 to do something quickly to get these people some help.

25 **MR. STALLARD:** How to get help for those affected

1 quickly. Does that capture it? Okay, thank you, Dave.

2 **MS. DYER:** One more thing, I'd like to see some paperwork
3 on other bases across the country that have had, maybe
4 they're Superfund sites going back as far as you've got
5 paperwork for, like chemicals, that sort of thing, and
6 what the studies that the ATSDR has on them. I'd like to
7 see paperwork with that so that we can compare it to what
8 happened at Lejeune.

9 **MR. STALLARD:** Can I ask you all to speak more directly
10 into the microphones?

11 **MS. McCALL:** And I would really like to emphasize the
12 importance of notification. This has to be our first and
13 foremost job. As a CAP member I feel that my
14 responsibility in representing the community is to inform
15 the community. I can't represent anyone in the community
16 without them knowing that somebody is representing them.
17 Does that make any sense?

18 I mean, this really is just -- I can't get past the
19 notification issue until, you know, we get some kind of
20 an organized way to let people know. I think that's
21 probably one of the most important things we need to
22 achieve in this first meeting is to figure out how to
23 notify, and start notifying, people.

24 **MR. TOWNSEND (by telephone):** I've got a couple of items
25 I'd like to get ^ perhaps some of them ^ first would be

1 communicate the exposure detail for all people, all
2 persons, childs (sic), wives, service people that lived
3 at Camp Lejeune and I would say that for the time period
4 ^ 1968^. I lived there 30 years before then.

5 The second is to continue and expedite the water
6 modeling process. I think that's critical for us to
7 provide a credible scientific connection between the
8 known contaminants and what we've got in our tap water in
9 our house.

10 Third is for the ATSDR to work with the Department
11 of Defense and the Department of Veterans Affairs. I
12 believe somebody mentioned that there are a lot of
13 veterans that are unable to work because of adverse
14 effects of their contamination. And the last thing is I
15 would hope that ATSDR records for the past be made
16 available to the FOIA. I have been continually looking
17 for records from ATSDR, and I have been skipped for the
18 last five years on this subject. That's the end of the
19 initial things.

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

21 Now just so I'm sure that I captured it all, Tom,
22 continued communicating exposure details to all who lived
23 at Camp Lejeune. Is that what you wish to achieve?

24 **MR. TOWNSEND (by telephone):** (no response)

25 **MR. STALLARD:** All right, Tom, communicate exposure

1 details to all who lived at Camp Lejeune time frame open.

2 **MR. TOWNSEND (by telephone):** Time frame of ^.

3 **MR. STALLARD:** Right, continue to expedite water
4 modeling, continue and expedite water modeling.

5 **MR. TOWNSEND (by telephone):** Right and try to expedite
6 the analysis of the water.

7 **MR. STALLARD:** And ATSDR, DOD and VA work together, and
8 ATSDR records of the past be made available to FOIA.

9 Anything else that you hope to achieve in this CAP
10 forum? Anything that we need to avoid?

11 **MS. BRIDGES:** I think the studies for the children, that
12 were done on the children, were only done for specific
13 birth defects or cancer. I think that should be expanded
14 to other handicaps that these had and had to live with.

15 **MR. STALLARD:** Let me make sure I've got that. Expand
16 studies on birth defects and other --

17 **MS. BRIDGES:** Not just the ones that you were looking for
18 that the, that had been studied before at different
19 contamination sites. All of the birth defects are
20 affected by different -- what we drank as well as our
21 genes and, you know. But there were different things
22 other than cancer, leukemia or death.

23 **MR. STALLARD:** Okay.

24 **MR. BYRON:** Those items, the illnesses and the cancers,
25 the birth defects and cancers, is that based on the Dover

1 study over in Massachusetts? Is that where we came up
2 with this?

3 **MR. STALLARD:** I guess that's out of scope right now,
4 thank you.

5 This helps us to understand as a group what the
6 expectations are, some of the expectations are that we
7 can see how we might achieve those and be clear in terms
8 of what things we may or may not be able to achieve in
9 this process.

10 Yes, Jeff.

11 **DR. FISHER:** I have a question of the CAP members. What
12 they might expect from the two people here that are
13 called experts to help them.

14 **MR. BYRON:** I think guidance more than anything. We're
15 none of us that I know of, none of us that I know of are
16 professionals in the epidemiology field so we're looking
17 for your guidance as we did the previous panel as to
18 what's the proper way to conduct these studies,
19 feasibility studies, risk assessments, whatever, I mean.
20 I think we're looking for your expertise in that matter
21 to kind of guide us along.

22 **MS. DYER:** Well, also in that and as a part of the
23 achievement, I, with talking to the rest of the CAP
24 members last night, we really feel like that we can leave
25 here with work that's going to be done before the next

1 time. I mean, we've got suggestions that we're ready to
2 go with, and we know that you have been a part of other
3 studies. And so in that, you should be able to help us.
4 Is this feasible? Can you do this before the next
5 meeting? That sort of thing.

6 **MR. ENSMINGER:** You know, while we're talking about
7 achievements, you know, an in utero study was done on
8 military children that lived aboard the base, the mothers
9 lived aboard, the parents lived aboard the base. An
10 ATSDR statement back at that time was that they wanted to
11 study the most susceptible population group which would
12 have been fetuses.

13 The civilian employees of Camp Lejeune, the women of
14 childbearing years were completely left out of that
15 previous study. Those women, who's to say how much of
16 these chemicals, especially in the levels that were in
17 that water, that those civilian babies were born to those
18 civilian employees weren't harmed. I mean, these people
19 were completely left out of this thing.

20 **MR. STALLARD:** That, I believe is going to come into
21 again talking about what are the studies that are
22 feasible and then the priority of those studies.

23 Are there any other achieves or avoids?

24 (no response)

25 **MR. STALLARD:** All right, Jerry, would you give us your

1 opening comments, please?

2 **MR. ENSMINGER:** Once again, I'm Jerry Ensminger. I'm a
3 CAP member.

4 It has been a long hard fight that has brought us
5 all to this point in the Camp Lejeune water contamination
6 situation. I would like to thank everyone that has been
7 involved in our plight for getting us to this juncture.
8 Early on in this situation representatives of the United
9 States Marine Corps, Department of the Navy, and DOD
10 manipulated other agencies through the lack of
11 cooperation to downright intimidation to keep the lid on
12 the truth.

13 Thanks to the media some truly concerned people on
14 Capitol Hill and many of us seated here today that lid
15 has been blown off. Previously, the United States Marine
16 Corps, Department of the Navy, and DOD had a large voice
17 in the decisions that were made on what studies would be
18 conducted on the affected community. There have been
19 disparities in exposed population groups, levels and
20 dates of exposure. There have been many incidences of
21 misinformation, disinformation and downright withholding
22 of information concerning this contamination incident,
23 but we have endured.

24 Look around you today. DOD agencies do not have a
25 seat at this table. It is time for us to ensure that all

1 of the disenfranchised population groups who were exposed
2 to this contamination at Camp Lejeune receive the long
3 overdue answers to their questions. It is time for the
4 Department of Defense to live up to their own call of
5 support for the people who defend this nation no matter
6 when they served.

7 The formation of the expert panel of February 2005
8 and this Community Advisory Panel or CAP is an attempt by
9 ATSDR to usher in a new era of trust and cooperation. I,
10 as a member of this affected community, applaud these
11 efforts. While this Community Advisory Panel has been
12 formed to explore further studies on exposed populations
13 at Camp Lejeune, none of our recommendations will amount
14 to a proverbial hill of beans without the cooperation of
15 DOD agencies.

16 DOD holds the key to the information that is
17 required to help rectify this wrong. The question is
18 will you cooperate? You know, we spoke earlier about
19 notification of people. I brought that up which I
20 thought, feel is extremely important. I think it's
21 morally required.

22 You know, you have to put yourself in the shoes of
23 people who have been harmed. I lost a child. My
24 daughter was conceived while we lived in one of the
25 affected housing areas. She was six years old. She was

1 diagnosed leukemia. I watched that child go through hell
2 for two and a half years before she died. I wondered
3 after the shock of her diagnosis wore off, I began to do
4 what any human being does. I began to wonder why. Why
5 this happened.

6 All through her illness, through her death, after
7 her death for 14 and a half years I wondered what
8 happened to my child. I looked in my family history, her
9 mother's family history. No other kids had ever been
10 diagnosed with leukemia. By a stroke of luck I heard a
11 news report on local TV in North Carolina when the public
12 health assessment came out for Camp Lejeune. And the
13 reporter -- I was walking from the kitchen to the living
14 room with a plate of food to eat dinner while I was
15 watching the news.

16 And while I was walking in the living room, the
17 reporter said the chemicals that were found at Camp
18 Lejeune's drinking water between the years of 1968 and
19 1985 have been known to cause childhood cancer, primarily
20 leukemia. I dropped my plate. It was like God opened
21 the sky up and gave me an answer that I had been looking
22 for for 14 and a half years. How many other people are
23 out there looking for that answer? And I vowed at that
24 time if I did nothing else through this thing, I would
25 try to give those people that answer.

1 That's all I have, thank you.

2 **MR. STALLARD:** Thank you, Jerry.

3 Perri, this is your opportunity.

4 **MR. TOWNSEND (by telephone):** (inaudible)

5 **MS. RUCKART:** Tom, did you have a question?

6 **MR. STALLARD:** Go ahead, Tom. Speak up.

7 **MR. TOWNSEND (by telephone):** I listened very intently to
8 what Jerry had to say. We have worked together for the
9 past four or five years. Jerry started out earlier than
10 I did, and then I, my family was not made aware of the
11 situation until 1999 when the ^ survey began. We lost a
12 child in 1967 ^ chemical exposure. So I have a very
13 definite ^ , but it's very difficult.

14 I completely go along with the ^, I hope ATSDR ^ of
15 adverse effects ^. It may not be ^ . When I say
16 communicate with ^ personnel, I mean every man, woman and
17 child ^. As far as I'm concerned ^ on the base three or
18 four times a week, still it may not be the same as ^ my
19 child living ^. And I am deeply aggravated with the
20 Defense Department ^ for failing to notify these people
21 that they were being poisoned. I just can't believe that
22 you could send Marines to fight in North Viet Nam and
23 Korea ^ and then expose them to this whatever else is
24 going on without some kind of remorse.

25 I want the CAP members to know that Jerry Ensminger

1 and I petitioned the Department of Justice. We want a
2 thorough investigation ^ violate ^ ^ law. It took two
3 years to do this, and it did not go to a grand jury. So
4 unfortunately, there was no criminal action. ^ ^ laws in
5 place that had been enacted by the Congress of the United
6 States. ^ And the Department of Justice does not run
7 criminal investigations. ^ We spent two years of looking,
8 and we got some pretty good indications ^. I just want
9 to ^.

10 **MR. STALLARD:** Thank you, Tom. For some reason you were
11 turned down a little bit. We're trying to fix that so,
12 we did hear you. The Panel members all heard you speak,
13 correct?

14 **THE COURT REPORTER:** I couldn't hear. It won't be in the
15 record.

16 **MR. STALLARD:** Okay. Thank you for sharing your stories.
17 Now we're going to move on toward our objective of
18 looking at which studies to get an overview of what's
19 been done that we may start working toward the future on
20 what studies are the most feasible.

21 Perri.

OVERVIEW OF ATSDR ACTIVITIES AT CAMP LEJEUNE
PERRI RUCKART

22 **MS. RUCKART:** Thank you. Earlier this morning I gave
23 everyone a revised presentation that was Fed Ex'd to you
24 about a month ago. This is basically the same except

1 we've updated some of the numbers because we've been
2 working very hard on this, and we had some changes.

3 So the first several slides just talk about our past
4 activities, and I think most people are fairly familiar
5 with that so I'd like to start with just where we are
6 with the current study unless there are any questions
7 about our past activities. So I'm going to be starting
8 with the slide, "Current ATSDR Epidemiological Study."
9 It's after the slide "1998 ATSDR Study on Adverse
10 Pregnancy Outcomes."

11 So as everyone here knows we're in the process of
12 conducting the study which we've called Exposure to
13 Volatile Organic Compounds in Drinking Water and Specific
14 Birth Defects and Childhood Cancers. It's a case-control
15 study. It's a multi-step process, and the first part of
16 that involved a literature search which helped us to
17 focus on the specific birth defects and childhood cancers
18 that we could attempt to focus on. There was a question
19 before us that was it based on just one study, and it was
20 not. It was based on a review of many studies that have
21 been conducted.

22 So you can see on the next slide listed outcomes
23 that seemed plausible to investigate further. And as a
24 result of that we conducted a telephone survey. The
25 reason why the telephone survey was necessary was because

1 as everyone, I believe, knows, there's no central place,
2 no database or anything, where we can just go to and say
3 who lived at Camp Lejeune and who had these things we're
4 looking for. We have to just be very creative and come
5 up with a way to identify everyone who was potentially
6 involved here.

7 So the way we did this was to call everyone that we
8 knew that lived there at that time based on I believe
9 this was births during that time, and then asking, all
10 those folks that we talked to, do you know of anybody
11 else who lived at Camp Lejeune and was pregnant during
12 that time. We also had a media campaign, and we tried to
13 identify all the people.

14 And the objective of the survey was to determine if
15 we could go ahead further --

16 **MR. STALLARD:** Perri, excuse me just a moment. We've had
17 a request for some copies that people could follow along,
18 and you all have all the copies. So is there someone who
19 could give me one copy that we could quickly go -- as
20 long as you can still read along somewhere, hold on just
21 a moment.

22 **MS. RUCKART:** Do you want me to stop?

23 **MR. STALLARD:** I do for just a moment if you would. This
24 would be a perfect time for a five-minute reprieve, and
25 take this time to fill out your lunch and then everyone

1 will be...

2 (Whereupon, a break was taken.)

3 **MR. STALLARD:** Please take your seats. Let's resume.

4 **MS. RUCKART:** Okay, we're going to have to go ahead and
5 get back started up here. I've just been told by our
6 facilities manager here that we do need to speak very
7 loudly and into the microphones so they can be sure to
8 pick it up. So please keep that in mind.

9 Also, I've been requested to mention to you that we
10 will need the lunch orders in as well as the money so we
11 can place our order and be sure to have that on time.
12 There's a woman with a pink plaid jacket. She'll be
13 coordinating that. Her name's Carolyn Harris, so please
14 be sure to see her if you haven't already done so.

15 So to pick up where I was before, we're talking
16 about the telephone survey, why it was necessary to do
17 that so we could conduct the study. So the objective of
18 the survey was to determine whether we could conduct a
19 study to make sure that we could find and identify a
20 large enough group of people to consider further
21 studying. And could we actually find and verify that
22 there were conditions, adverse health conditions that we
23 could further study. And would there be enough numbers
24 to actually conduct a study.

25 As part of that effort, we determined that, well, we

1 surveyed the births that occurred on and off base. So
2 the only requirement was that the mother was pregnant at
3 any time during 1968 to '85, and we estimated that to be
4 about 16- to 17,000 births. We had a pretty good handle
5 on the number of births that occurred on base. But as I
6 mentioned before, those births off base -- it was sort of
7 like an unknown number. Just anecdotal information from
8 the on-base hospital suggested that maybe three to four
9 thousand births occurred off base.

10 So as you know, we had, we took some steps to try to
11 find those people, one, word of mouth and people that we
12 were talking to as part of the survey asking them did you
13 have any neighbors, did you know of anybody else who was
14 pregnant with you on the base but maybe moved off base
15 before child birth. And we had a media campaign.

16 So we were able to survey the parents of 12,598
17 children, and we estimate this to be an overall
18 participation rate of 74 or 80 percent depending on
19 whether you think there are 16,000 or 17,000 births.
20 That's how we came up with that range of participation.

21 So what have we determined that we can study. There
22 were sufficient numbers of reported cases of neural tube
23 defects, oral cleft defects and childhood hematopoietic
24 cancers and that includes the non-Hodgkin's lymphoma and
25 the childhood leukemia. So we had 106 reported cases:

1 35 neural tube defects, 42 oral cleft defects, and the 29
2 cancers.

3 So we randomly picked about 800 controls from the
4 survey population. These are the children who didn't
5 have an adverse condition reported. We over sampled just
6 to ensure that we had 10:1 ratio control cases. Maybe
7 Dr. Clapp will talk about that later. It's just kind of
8 like something you do in terms of sampling and to have
9 adequate numbers for analysis, and we'll get into that
10 later. And we didn't match. Possibly again, Dr. Clapp
11 can discuss that with his technical terms.

12 So we conducted detailed interviews in the spring of
13 2005, so just about a year ago, to the parents of these
14 identified cases and the controls to obtain just more
15 specific information on maternal water consumption habits
16 such as how much water they drank and different other
17 water use activities like showering or bathing or washing
18 children, I'm sorry, bathing children, and the
19 residential history. Of course, that's very important to
20 find out where they were living during the pregnancy and
21 just other risk factors such as medical history,
22 pregnancy history of the mother, work details, things
23 like that.

24 And we attempted to interview all of the confirmed
25 and pending cases and controls. And what we mean by

1 pending is if we couldn't get information one way or the
2 other, any medical records or some kind of report to show
3 that the child had a reported condition or not, we just
4 called that pending meaning sort of like this open kind
5 of case.

6 So where are we now? So we've been working very,
7 very hard to just find a final disposition for all of the
8 reported cases. And by that I mean, yes, we can confirm
9 they have what was reported. No, they did not have the
10 condition reported. We have medical records that prove
11 or show otherwise if they have something else, just not
12 what was reported. They were ineligible and in a minute
13 I'll tell you what we mean by that. They refused or
14 they're pending which we discussed what that means.

15 So in terms of why somebody would be ineligible, a
16 reason for that would be that it was determined they were
17 not actually carried in utero on the base, or they were
18 born outside of our time frame here for the study of 1968
19 to '85. They were diagnosed with cancer after age 20,
20 and they were adopted; therefore, not carried in utero on
21 the base.

22 So where are we now with the numbers that this data
23 is hot off the presses, is current as of yesterday. We
24 have confirmed 56 of the reported cases as having the
25 condition reported during the survey. That's 53 percent.

1 Forty-one cases were confirmed to not have the reported
2 condition, were ineligible or refused. And out of that
3 number 29 have been confirmed as not having the reported
4 condition. And we have nine children who are still
5 pending, and a little bit later I'm going to go into some
6 more details about our efforts to confirm the pendings
7 and just some specifics about each of these nine children
8 so you can really see our efforts and what's going on
9 here.

10 I would like to point out though while I said that
11 we do have 56 confirmed cases, only 53 of these confirmed
12 cases were interviewed. The three that were confirmed
13 and not interviewed include two cases of neural tube
14 defects and one cleft. It's very unfortunate these
15 people are just not locatable.

16 We worked with a contractor to conduct the
17 interviews, and they have a lot of resources available to
18 them to try to locate people. And they've done extensive
19 searching and we could not find them. And we also worked
20 with the military to see if they could provide some
21 information to help locate these people, and it's just
22 not possible. So unfortunately, you know, we're not
23 going to be able to do an extensive analyses including
24 these three people because we don't have the detailed
25 information that we collected during the interview.

1 So I just want to talk now about each of the three
2 case groups. The number that was reported and where we
3 stand now, where they fall into those categories. For
4 the neural tube defects, we had 16 confirmed having
5 neural tube defects. As mentioned, we couldn't interview
6 two of those.

7 **MR. STALLARD:** Jeff, do you have a question?

8 **DR. FISHER:** I have a question. The people you can't
9 find, they don't pay income tax in the United States? Or
10 how far did you go to try to find people?

11 **MS. RUCKART:** I don't have all of those details because
12 it was mainly by the contractor. I know they have done
13 extensive searching. They've done paid searches and all
14 of those things. I don't know why they couldn't find
15 them.

16 **DR. BOVE:** Many of these people are scattered all across
17 the country.

18 **MS. RUCKART:** Or the world.

19 **MR. STALLARD:** Thank you. Please proceed.

20 **MS. RUCKART:** So out of these reported neural tube
21 defects we were able to confirm 16 of them; however, we
22 could only interview 14 of them. And we have confirmed
23 that 12 did not have a neural tube defect, two were
24 ineligible, two refused, and three are still pending.

25 Out of the oral cleft defects, we've confirmed 24

1 as, yes, having the oral cleft defect, 11 as not being
2 the oral cleft, three refusing to participate and four
3 are still pending. As for the hematopoietic cancers, we
4 have 16 confirmed as, yes, they have that condition, six
5 confirmed as not having the condition, three ineligible,
6 two refused and two still pending.

7 So I just wanted to talk about our extensive
8 verification efforts, kind of an overview, and then I'm
9 going to go case-by-case for these 9 pending and you can
10 see where we are. We have made numerous attempts. It
11 started with trying to obtain birth and death
12 certificates and records from medical providers. We also
13 searched for records at the National Personnel Records
14 Center in St. Louis. That's where the military records
15 would go.

16 We decided when we couldn't come up with anything
17 with those methods that we would contact the children who
18 had reports of spina bifida and oral cleft to see if they
19 would go to a current medical provider and see if the
20 doctor could look at them today and say, yes, you have
21 evidence that you had, have had a neural tube defect or
22 an oral cleft.

23 And finally, we sent registered letters to these
24 pending cases. We sent them with a return receipt so we
25 can verify that they did receive the letter; they had to

1 sign it, urging them to please help us, to please visit
2 the medical provider or give us any records that they
3 have so we could confirm their condition and have them be
4 part of the study.

5 I would like to mention that as leading up to this
6 numerous phone calls have been made where we've had
7 contact with these people sometimes or not. It wasn't
8 like we just sent a letter. We did actually call them
9 several times and try to talk to them and explain the
10 importance of this process.

11 With these nine cases, we've had one oral cleft.
12 We've had extensive efforts to locate the parents. They
13 just were not locatable, but that doesn't mean that we
14 still don't want to confirm them. We still would, and we
15 can maybe do some limited analyses with them if we can
16 just confirm they have the condition. So we obtained
17 their birth certificate from Onslow County and no health
18 information was provided.

19 We were told by the County that this birth was in
20 1985, I should mention, and we were told that the health
21 information was not available. They had destroyed it. I
22 guess, they enter it into a database, and after that they
23 destroy the hard copies, and there was nothing provided
24 to us electronically to suggest any health information on
25 the oral cleft, and therefore, the record's destroyed.

1 We can't look at a hard copy.

2 We have a case reported of neural tube defect,
3 specifically spina bifida. This child was born in 1973.
4 The family does not have any records. We offered the
5 child the opportunity to go to a current doctor, and we
6 talked to this person and they seemed like they wanted to
7 cooperate, but they never made the appointment and
8 several follow-up phone calls have not been answered.

9 Again, they got the registered letter and they just
10 did not want to follow back up with us. We obtained
11 their birth certificate from Onslow County. Because they
12 were born before 1978, health information is not
13 available. They only have to keep it for a certain
14 amount of time; I think 20 years, and it's just not
15 available.

16 I should also mention that there comes a point when
17 we've called these people so many times and sent them
18 letters where we just really can't call them any more.
19 We have some standards here that we need to go by. Our
20 studies are reviewed by an IRB, Institutional Review
21 Board, and it places limits on how many attempts you can
22 make before it sort of is bordering on harassment. And
23 we've made like the maximum number of attempts where the
24 person doesn't respond. There's only so much we can do
25 at that point.

1 We have another case of neural tube defect, also
2 spina bifida. The child was born in 1971.
3 Unfortunately, this child is deceased, and their birth
4 and death certificates don't mention anything about a
5 neural tube defect. The cause of death as listed on the
6 death certificate is hydrocephalous. So we have found
7 out where this child was born. It's a hospital in Texas,
8 and we're now trying to contact that hospital to see if
9 they may still have some information, some records, and
10 we'll just have to wait and see what happens with that
11 effort.

12 We have a case of non-Hodgkin's lymphoma. The child
13 was born in 1972. The family does not have any records,
14 and the mother states the child is going through a very
15 difficult time. This child is going through, well, I
16 don't know, going through a messy divorce. And she can't
17 get the child to make a doctor's appointment, and she
18 won't provide any information on where we can, any
19 contact information for us to call this person ourselves,
20 and just the regular searches like we mentioned before,
21 didn't yield any contact information for this person.
22 We're at the point now where we can't contact the mother
23 anymore. We contacted her many times, and she's
24 basically said she's done all she can do, and we can't
25 call her again.

1 So based on the information she provided me, telling
2 me about her child was going through a messy divorce, and
3 we know where the parent lives, which doesn't mean we
4 know where the child lives, but we're again, just trying
5 to pull out all the stops here, we've been in contact
6 with that state's divorce records area to see if we could
7 just glean some information from the divorce record,
8 maybe get an address or something to actually contact the
9 child.

10 Again, we can't call the mother anymore or the
11 father. And the divorce records in that state didn't
12 produce any information, and we are in the process of now
13 trying another paid people search. We'll have to see if
14 that yields anything useful.

15 We have another case of an oral cleft. This child
16 was born in 1971. In further talking with the mother,
17 she says the child had a deviated septum, almost a
18 harelip. We requested that the child have a medical
19 visit now, and there's been no response after several
20 follow-up phone calls to see if they will schedule the
21 appointment. We have obtained a birth certificate from
22 Onslow County. Again, since this child was born before
23 1978, there are no records available any more.

24 We have another oral cleft born in 1977. The family
25 has no records. The parents want the child contacted

1 directly. This child is now, you know, an adult, over 18
2 years. We have made several attempts to contact him,
3 phone calls, e-mails, and there's just no response on his
4 part. Again, he was born before 1978 so there's no
5 information on the birth certificate from Onslow County.

6 We have another oral cleft born in 1980. This child
7 is unfortunately deceased. Some records that the family
8 had were unreadable due to age, and other records that
9 they provided to use did not mention the cleft defect.
10 And those records that were unreadable are no longer
11 available from the hospital. In further talking with the
12 father, he states that that child's palate was high, but
13 intact.

14 So we have received some birth certificate
15 information -- this is from South Carolina. No
16 congenital malformations or anomalies were noted. The
17 death certificate lists cardiac arrest and aspiration as
18 the cause of death and notes the history of cerebral
19 palsy and meningitis with seizures. The autopsy also
20 does not note the oral cleft.

21 Through our contacts with the National Personnel
22 Records Center in St. Louis, they told us that the
23 records are being held elsewhere as a result of
24 malpractice suits. So we can't view them. With this
25 child we just don't know with the cerebral palsy, and the

1 child, of course, had cleft palate. Maybe possibly there
2 was some confusion when CP was noted. It was cerebral
3 palsy or cleft palate. We can't confirm it. It could be
4 cerebral palsy. We just have to leave it open or
5 pending. We can't say one way or the other at this
6 point.

7 We have a leukemia. This child was born in 1969.
8 Unfortunately, this child is also deceased. The parents
9 won't answer our calls. Basically, they live with an
10 adult son, and he will not put them on the phone for us.
11 The hospital no longer has this child's records. The
12 cause of death is listed on the death certificate as
13 aplastic anemia. It could be leukemia. We just, it may
14 be, we just at this point can't say. We don't have the
15 records.

16 We are not willing to just put this one aside yet.
17 We have a few more things we are trying to do to confirm
18 it because we feel it's very likely it will end up to be
19 leukemia. So we are trying to see if the hospital can
20 tell us about the doctor that treated this child.

21 Now the hospital doesn't have the records. But if
22 we can find out who the doctor is, it may be possible
23 that the doctor kept his own personal records, and we
24 might be able to get the information that way. So we're
25 going that route because, you know, we really want to do

1 our best to confirm every possible case especially one
2 that looks very likely like this one.

3 And then our final pending case is a neural tube
4 defect. It was reported as an anencephaly. Now
5 anencephaly is absence of the brain. If you are born
6 that way, you would not live. So this child was born in
7 1985. This father has said that he will mail us records,
8 and we never received them. We've made numerous follow-
9 up calls in an attempt to get them and have not gotten a
10 response.

11 Now the thing with this particular child is, we did
12 obtain the birth certificate from Onslow County. And
13 again, there are no, we're told that the health
14 information was not available. It's been destroyed
15 because it's been about 20 years old now.

16 Now we also requested the death certificate from
17 Onslow County because if this child was born with
18 anencephaly, and they were born in Onslow County, most
19 likely the child would have died in Onslow County because
20 he would have died very shortly after birth.

21 And we were told that Onslow County didn't have a
22 death certificate which may suggest that this person is
23 not dead. And if they're not dead, they didn't have
24 anencephaly. So... Also, according to their birth
25 certificate their APGAR score was normal which is not

1 consistent with someone with anencephaly. Again, since
2 we can't confirm one way or the other, we're not going to
3 close it out as a no, we're just going to have to keep it
4 pending because we just don't have any information.

5 So that's where we are with our verification
6 efforts. Wanted to show everybody that we are working
7 hard. We are trying and just to really give you a sense
8 of what is involved here. Now I'm just going to briefly
9 touch on a few other things.

10 Just briefly, I want to talk about the water
11 modeling from this. The Marines recently provided
12 additional documents related to the water modeling to
13 Morris Maslia. He's going through them now. He's asked
14 the Marines Headquarters to confirm that there are no
15 additional relevant documents. And they responded saying
16 they will attempt to comply with this request, but they
17 don't have the subject matter expertise to properly
18 determine the relevance of documents in all cases. So --

19 **MS. McCALL:** They just need to turn everything over, and
20 you guys decide the relevance because you guys are the
21 experts.

22 **MS. RUCKART:** I believe we'll have to talk about that
23 later.

24 So I just wanted to let everyone know that we are
25 obviously still proceeding with the water modeling and

1 having all the information definitely that is key to
2 progressing with that.

3 So just to kind of go over our timeline, Morris is
4 to provide the water modeling results and data to us in
5 early 2007, so approximately a year from now. And at
6 that point we will integrate what he gives into our
7 analysis and finalize our report. And that will be done
8 by the end, or we're anticipating if everything goes
9 according to schedule, which hopefully it will, by the
10 end of 2007.

11 I wanted to mention that we can't undertake any new
12 studies till we have the water modeling results. That is
13 what's going to give us the exposure information, and the
14 exposure obviously is key here. And at that point we can
15 also re-analyze the 1998 study on small for gestational
16 age. It has come to our attention that there may have
17 been some inaccuracies with that exposure data so we want
18 to revisit that.

19 **MS. McCALL:** I'm sorry, but I don't know why we couldn't
20 simultaneously do health studies along with the water
21 modeling. That was one of the recommendations from the
22 expert panel was that these need to both be parallel.

23 **MS. RUCKART:** Right, well, this effort right now having
24 the CAP is starting that effort to talk about what may be
25 feasible and prioritize. So we are starting that effort.

1 I just mean we actually couldn't do a study until we get
2 those exposure ^. That is a key piece of information.
3 But we obviously are moving forward. We're here today.

4 **MR. MARTIN:** Regarding the water modeling, you say early
5 2007. Is that to complete all three phases of it, the
6 Hadnot Point, Tarawa Terrace and Holcomb Boulevard?

7 **MS. DYER:** That's what I wanted to ask Morris. I talked
8 to you about it. If that's okay, I can go ahead and ask
9 him now.

10 When you and I --

11 **MR. STALLARD:** As we continue on, I'd like to encourage
12 the panel members to jot down those things that come to
13 mind in these overviews and --

14 **MR. TOWNSEND (by telephone):** (inaudible)

15 **MR. STALLARD:** Hold on, Tom, just a minute please.

16 I'd like to encourage the panel members during these
17 presentation parts which is to give us all a foundation
18 and an overview, to jot down those things that you want
19 to bring up that are relative to moving forward in terms
20 of how we're going to conduct future studies and which
21 ones are feasible and allow some dialogue where it's
22 appropriate, okay?

23 **MS. DYER:** Thank you.

24 And Morris, this will help us in the future so
25 that's why I'm asking now. In several of our phone

1 conversations one thing that you said was that the, we
2 had a year for Tarawa Terrace, and that year at the time,
3 I think it's 1958. And so if we've got a year that the
4 chemicals, that the contamination started then in Tarawa
5 Terrace, that gives a group of people, it gives us a
6 year. And so why can't we -- and you had talked about
7 possibly being able to release the information for Tarawa
8 Terrace because the wells have been, you kept them kind
9 of separate all along. And so if we've got the
10 information, the year that it started, that gives us a
11 place to go.

12 **MR. MASLIA:** Let me -- there are several parts to your
13 question and if I can very briefly separate them out so
14 we're all on the same page I think that, for those of you
15 who have not been in this process for that long, I think
16 it will be, it'll help you out. And if I don't answer
17 exactly what you're telling me, ask it again, and I'll be
18 happy to answer it.

19 We made the, an approach standpoint decision early
20 on about the, as the complexity of this project evolved,
21 that we would try the water modeling, and attempt to
22 water modeling an area where we thought we would have the
23 best success in having a scientifically defensible end
24 product and information for the epidemiologic study.
25 That turned out to be Tarawa Terrace for a couple of

1 reasons.

2 Number one, primarily there is one contaminant,
3 being PCE or perc, and I say primarily because they're
4 all derivatives primarily. We also primarily knew what
5 the source was. The source which was a dry cleaning
6 facility. So from that standpoint we could save some
7 effort and time and try to rule out investigative work,
8 detective work, and trying to understand what all the
9 ABCs of chemicals were there.

10 And so we've modeled that, and because -- without
11 getting into details; we did this previously, the water
12 modeling panel -- because of modeling considerations,
13 hydrogeologic considerations, we were able to isolate the
14 Tarawa Terrace area and develop a ground water flow
15 model-type transport in that area. In doing so, while we
16 have not publicly released specific information, we have
17 briefed the Marine Corps as is our responsibility to do,
18 to work with them.

19 And in August of 2005, we briefed them and told them
20 at that time our best estimate was contamination at five
21 parts per billion at Tarawa Terrace well since May of
22 1960. That's what we reported to General Kelley and his
23 staff at that time. We also told the Marine Corps -- and
24 for those of you who were there at our water modeling
25 panel -- that it was a very strong recommendation, and we

1 are following up on that from our expert panels.

2 Number one, go back and do additional data discovery
3 to see if that would impact our modeling assumptions.
4 And also number two and three, do extensive sensitivity
5 analyses and uncertainty analyses. So we could feel
6 confident on the solutions and answers that we provide to
7 the epi studies as far as what the concentration of
8 ground water was at various months that we were modeling
9 as well as at various locations.

10 And we are currently doing that right now. So that
11 is why we have not put anything in writing because that
12 can change, and when we put something in a report in
13 writing, as I'm sure it's been discussed here previously,
14 from the epi standpoint and from our standpoint it will
15 need to be reviewed by a peer panel or an outside panel
16 of experts. And so we are still, and as I think was
17 mentioned by Perri, we have received additional or more
18 recent information, and we are modifying some tables and
19 some charts and some things of that nature based on
20 recently received information.

21 So I'd like to stick right now to answer you is 1960
22 is a very good estimate, but I am not ready, or the
23 agency is not ready to commit that to writing because we
24 are conducting the additional analyses that our Panel
25 recommended so we can be as assured as we can with what

1 the uncertainty is and what the range, what the range of
2 date possible dates may be for the first level of
3 concentration, five parts per billion PCE as well.

4 The second, I think if I recall, the second part or
5 an additional part of your question is the other areas.
6 We are currently now working through the hydrogeology and
7 developing, modeling the ground water for the Hadnot
8 Point and Holcomb Boulevard areas. Because of the size
9 of those areas and the size of the computational
10 equipment that we have, we have subdivided those into two
11 additional ground water models.

12 Does that answer?

13 **MS. DYER:** No, a little.

14 **MR. STALLARD:** Excuse me, Tom's trying to, let's give him
15 the opportunity. Tom?

16 **MR. TOWNSEND (by telephone):** I presume that was Perri
17 talking, Perri Ruckart.

18 **MR. STALLARD:** Perri was talking and then she was
19 followed by Morris.

20 **MR. TOWNSEND (by telephone):** Yeah, I recognize their
21 voices. I think, I don't know why ATSDR promulgated the
22 number of cohorts involved because the final statistic
23 that I have that I got from the state of North Carolina
24 shows that there was 33,456 children born in the naval
25 hospital between '68 and '85, and 17,211 at Onslow

1 Memorial Hospital for a total of 50,727, and we're
2 talking about 12,000 people that were contacted. And
3 that doesn't seem to me to be a big, big bite. I just
4 throw that out, and I'm not going to fight about it, but
5 I think that we have been marginalized.

6 **MR. STALLARD:** Thank you, Tom.

7 **MR. TOWNSEND (by telephone):** Point two --

8 **MR. STALLARD:** Thank you, Tom. We have, as you recall,
9 earlier on we have already identified the need to look at
10 further studies on children and if that entails expanding
11 the cohort, that's what this Panel is about to talk about
12 and deliberate then.

13 **MR. TOWNSEND (by telephone):** Okay, well, I, some of the
14 Panel has only been around for a certain period of time.
15 The rest of us have been around trying to work on it for
16 the last seven or eight years. And I would say that
17 making cleft lips and cleft palates major objects of
18 decision making is rather miniscule because they weren't
19 doing this in Viet Nam on the hospital ship. Why not
20 some emphasis on terminal illnesses of children? And the
21 last thing is there's plenty of fetal death data in
22 Onslow County. I have it. And what does ATSDR do? I
23 mean they've been doing? They ^ and largely minimalize ^
24 data concerning Camp Lejeune ^.

25 **MR. STALLARD:** Thank you, Tom. I'd like to let Perri

1 finish her presentation and then just please try to
2 consolidate your comments that we may also have time for
3 Dr. Clapp and Dr. Fisher is going to be leaving at 12:00,
4 and we'd like to hear from him as well, okay?

5 **DR. FISHER:** Since Morris is still here, can I ask a
6 question?

7 **MR. STALLARD:** Yes, you may.

8 **DR. FISHER:** For trichloroethylene, have you worked with
9 that yet?

10 **MR. MASLIA:** TCE, we're working with that at Hadnot
11 Point, and obviously from PCE, the derivative DCE and
12 TCE, we actually have ongoing analysis to one of our co-
13 operators that do some much more sophisticated, they can
14 transport from a PCE to DCE.

15 **DR. FISHER:** So you're going all the way to vinyl
16 chloride?

17 **MR. MASLIA:** As an additional analysis, not as the
18 primary analysis as to when as well. That's classified
19 as that what our Panel was doing initial sensitivity
20 analyses. That's specifically one of the areas that we
21 interpreted as what they meant by that. So we are doing
22 that at Tarawa Terrace.

23 **MR. STALLARD:** Perri, while we have Morris here, I'm
24 going to have any other questions of him asked that we
25 may -- from this and see if you want to --

1 **MS. DYER:** Morris, you didn't answer my question. That's
2 why I wanted to finish up with you, okay? Can we be
3 given Tarawa Terrace data before the Hadnot Point is done
4 so that we can go ahead and do a study on Tarawa Terrace?
5 We had talked about that at one point, that you had
6 always divided these studies. So can we go ahead and
7 have -- instead of waiting till 2007 -- have the data
8 from TT so that we can run with it? And if you're saying
9 1960, are you guys kind of going above that or are you
10 tending to look with this new information a little bit
11 earlier than that?

12 **MR. MASLIA:** Well, we will be putting out reports
13 specifically from the Tarawa Terrace area when those
14 reports are cleared by ATSDR. We are currently working
15 on them, and they will be released publicly.

16 **MS. DYER:** Okay, so it will be before the 2007?

17 **MR. MASLIA:** Yes.

18 **MS. DYER:** Thank you.

19 **MR. MARTIN:** My question is kind of along the same lines.
20 I was concerned or do you have enough with your
21 preliminary studies at this point as far as a population
22 estimate or the number of residences or quarters in the
23 Tarawa Terrace area that were actually affected that
24 would make it feasible to move forward with notification
25 of people that primarily came from Tarawa Terrace?

1 **MR. MASLIA:** That would really be outside the water
2 modeling part and more the exposure. We will be
3 providing the epidemiologists the time and concentration
4 of water delivered.

5 **MR. MARTIN:** Okay, I'm concerned also with the water
6 modeling. The way I understand it is you're trying to
7 determine how much water went to an individual residence
8 per gallon per day. Is that correct? Is there any
9 consideration to the --

10 **MR. MASLIA:** That is not correct.

11 **MR. MARTIN:** Okay.

12 **MR. MASLIA:** Based on, again, the recommendation of the
13 water modeling panel, no, at this point, based on the
14 recommendations and then from the water modeling expert
15 panel that we had in March, the recommendation was to use
16 a much more, what we call simple mixing model, and to
17 determine the concentration of the mixed water, the water
18 derived at the treatment plant, from both contaminated
19 wells and non-contaminated wells at Tarawa Terrace.

20 At this point, short of knowing any additional
21 information, or having any additional informational
22 interconnections that's the approach we're taking.
23 That's what we'll be providing to the epidemiologists,
24 what's the concentration of the delivered water from the
25 treatment plant by month and by year.

1 **MR. MARTIN:** And there again I apologize, it's not real
2 clear to me exactly how the study is effective and all,
3 but does it take in any consideration as far as
4 environmental exposure, the creeks, the new river channel
5 that came through there? You know, because we were eight
6 year old kids. We were always in the creek. We were
7 always fishing, and we ate the flounder and the crabs and
8 everything that came out of the water as well.

9 **DR. BOVE:** This is not actually a question for him.

10 **MR. MARTIN:** Okay.

11 **MR. MASLIA:** Outside the water modeling aspect.

12 **MR. MARTIN:** Thank you.

13 **MS. RUCKART:** I think that I would wrap up now with my
14 presentation, just a few more things I wanted to add.

15 One of the CAP members requested that I discuss the
16 annual plan of work, APOW, that we provide to the DOD.
17 So as far as the APOW, we did put in a request for funds
18 to computerize the housing records. There are
19 approximately 90,000 -- I'll say to completely
20 computerize the housing records. There are about 90,000
21 hard copy records that have information on housing areas
22 for Camp Lejeune. And the only records computerized to
23 date are from the 1998 study. That's approximately 15
24 percent of these 90,000 records. So we've asked for some
25 funds to undertake that effort.

1 And we have also asked for funds so we can explore
2 military and navy databases to identify people and health
3 information. And we've also asked for money to fund the
4 CAP meetings. DOD has provided funds to pay for this CAP
5 meeting. We've requested additional funds to support
6 subsequent CAP meetings and so far we haven't gotten a
7 response on that.

8 **MR. BYRON:** How long ago did you request that?

9 **MS. RUCKART:** Have to ask Linnet. October? October
10 2005.

11 **MS. DYER:** Is there anyone here that has any kind of
12 knowledge as to their approval or disapproval of this?
13 Is that why? Do you know? I mean, what is their stance
14 on the CAP? Are they going to work with us? Are they
15 glad that we're here? Are they going to continue? I
16 mean, it would be nice to know what the Marine Corps or
17 the DOD's feel about this is so that --

18 **MS. RUCKART:** I can't answer that question.

19 **MS. DYER:** It would be nice to know because that helps to
20 know if we're going to be able to plan a future or not.
21 So we need to know that.

22 **MR. STALLARD:** Do we have that? Would the court reporter
23 need to know level of commitment?

24 **MS. DYER:** Level of commitment with the DOD. Are they
25 going to continue funding? Are they wanting to work with

1 us with the CAP? I mean, this was, we've heard that they
2 wanted to work with us, and if they want to work with us
3 then they need to provide the funds to be able to get us
4 here and to do this job. We're committed, and we want to
5 know how much their commitment is to us.

6 **MR. STALLARD:** Frank, do you have anything on that?

7 **DR. BOVE:** We're waiting to hear ourselves.

8 **MR. MARTIN:** I think there again we need to restate as we
9 did in Washington that we're here in the spirit of
10 cooperation. We want to do whatever we can possibly do
11 to help the ATSDR or whoever else requests us for
12 information. We want to provide everything we can, but
13 we'd like to expedite some things and get them moving
14 forward. We've met; we've talked; we all knew the water
15 was contaminated; we all know people are sick. So we
16 need to move on.

17 **MR. STALLARD:** I'd like to talk at some point in terms of
18 what you envision DOD participation in this CAP process.
19 I think that might need to be clearly laid out so that
20 there's a clear understanding and expectation of who's
21 doing what with whom and the level of commitment that
22 we're asking for.

23 Perri, are you finished with your presentation?

24 **MS. RUCKART:** (no audible response)

25 **MR. STALLARD:** If it's all right, we're going to move

1 right on into Dr. Clapp's overview and presentation to
2 give us the basics of epidemiology I take it, 101 or
3 something along those lines.

EPIDEMIOLOGY OVERVIEW
RICHARD CLAPP

4 **DR. CLAPP:** I know we're running way behind schedule so
5 what I thought I would do, I thought I'd just hit three
6 points. What kind of epidemiology studies are done in
7 situations like this, and I'll talk about three major
8 ones. And then what kind of answers can you get from
9 those kinds of epidemiology studies or not get from those
10 kinds of epidemiology studies. And then how do you
11 assess the feasibility of doing these major kinds of
12 studies.

13 And some of this you've already been talking about,
14 and I'm sure some of you have already heard this in
15 previous discussions. So I'll probably be repeating some
16 things maybe for emphasis or at least my own perspective
17 on some of these things, and also give some of my own
18 personal experiences.

19 And also, I only know a couple people in this room
20 so I should say a little more about myself than whatever
21 you have, one paragraph, whatever. I started getting
22 involved in situations like we're talking about here in
23 the 1970s because of Woburn, the child leukemia cluster
24 in Woburn, Massachusetts. We've all heard about it, all

1 seen the movie or read the book.

2 And so it was because of that child leukemia cluster
3 in a small part of a neighborhood, really of a small city
4 north of Boston, that was eventually traced to
5 trichloroethylene in the drinking water that I started
6 thinking, well, there's a lot to know and a lot to learn
7 and a lot to do in order to try to prevent this kind of
8 tragedy from happening to other children in other
9 communities.

10 So I started learning about it in the 1970s, and
11 then I worked at the state cancer registry. I was the
12 director of the state cancer registry in Massachusetts
13 where we looked at a lot of situations like this around
14 Massachusetts where there was drinking water contaminated
15 with in one case, perchloroethylene.

16 We've continued to look at the childhood leukemia
17 pattern in Woburn, Massachusetts. We wrote reports about
18 it. We testified in hearings about it. I was on a group
19 like this, and we call it the CAC, C-A-C, for the Woburn
20 citizens during the period when the ATSDR had funded a
21 follow-up study, what they call of follow-up case-control
22 study of childhood leukemia in Woburn.

23 And then I continued that work in my doctoral
24 dissertation where I looked at, among other things, Viet
25 Nam veterans in Massachusetts. What kind of cancers Viet

1 Nam veterans got. As a result of that study, I wound up
2 testifying in Congress actually. It was the Veterans'
3 Affairs Committee about cancer of Viet Nam veterans that
4 they ought to be compensated for.

5 So I come to this with some personal experience,
6 some pretty intense personal experience I guess. And
7 also, I think, some lessons that I've learned over the
8 years.

9 I should mention one other thing. I didn't meet
10 Morris Maslia ^ Township or in Toms River, New Jersey,
11 where he is doing a very similar model for the water
12 distribution from contaminated wells in that town as I
13 know you're aware of this because it's in various ATSDR
14 summaries and reports. But that is a, mind you, that was
15 a successful study, a case-control study of childhood
16 cancer, not just leukemia, in relation to water
17 contamination and other factors like where do people, you
18 know, get their fish, or do they swim in the river, and
19 that kind of thing.

20 There was a significant statistical association
21 between water, especially from one well field as modeled
22 by, or as it is called at ATSDR, and it was produced as a
23 public report. There was great media attention to it.
24 It was about six years ago. And so it can be done, I
25 guess, is what I'm saying. These things can be done.

1 They're expensive; they take a long time. There's plenty
2 of experience to draw on. And I think the people who are
3 doing this work at ATSDR are well aware of that prior
4 experience.

5 So I guess that's enough about -- or I should say I
6 teach environmental epidemiology. I teach this kind of
7 stuff. In fact, Morris co-edits a book about how you do
8 exposure assessment which we're going to use in courses
9 teaching this kind of what we call environmental
10 epidemiology. The key ways to do exposure assessment,
11 for example, environmental epidemiology studies.

12 So that's where I'm coming from on this. I've got a
13 fair amount of experience. I've worked with citizens'
14 groups, many more than I've just described, and had some
15 personal lessons that I think I've learned along the way.

16 So I would say briefly now there are generally three
17 kinds of studies that people do, scientists do in
18 response to citizens' concerns in a situation like this.
19 This is the way that Dr. David Ozonoff describes it.
20 David Ozonoff was on the science panel a year ago. He
21 was one of my mentors. He's my friend; he's my next door
22 neighbor at the offices where we work together. He's
23 actually a principal investigator on a grant from the
24 National Institute for Environmental Health Sciences
25 which I'm on, in terms of disclosure or whatever conflict

1 that is. ^ field and ^ the same thing.

2 And so I should say also Dr. Ozonoff describes a
3 public health disaster as something that is so bad that
4 even an epidemiologic study can pick it up. So that's
5 the sensitivity that we're talking about. These
6 epidemiologic studies are hard to do, and at the end of
7 it, you're not exactly sure you've really identified
8 exactly what was going on.

9 It's almost like it's the looking for your keys
10 under the lamppost because that's where the light is, but
11 that's not where your keys are. It's just you have to
12 look where you can. You have to look at the time period
13 that you have available, where you have available data,
14 or you have to look for health effects where there's
15 enough of them that you might actually see something as
16 opposed to something that's really rare, and you're not
17 likely to see it even in a large population.

18 There are three major types that are done. One is
19 when citizens are worried about a health problem that
20 they know they've had, -- and Jerry just described his
21 daughter's health problem he knows she had. And what
22 caused it is the question they ask. What caused that
23 health problem to happen to them or to their child? And
24 typically, that's answered with what's called a case-
25 control study where you look at diseases that have

1 happened.

2 And you ask back in time what were they exposed to
3 or what was their genetic family history, or what other
4 activities occurred besides the exposure that you think
5 may have caused it. And then you try to compare what
6 happened to the cases, to a group of controls who are,
7 say in this case, other children who didn't have that
8 disease but were in the same general area, and what were
9 they exposed to and see if there's some difference in
10 exposure between the cases and the controls.

11 That's the case-control study. That's what Perri's
12 talking about, and that's a very appropriate way to
13 approach this question of what happened. Why did this
14 happen to cause the disease that we know our children
15 have or if it's adults we know we have.

16 A second question that people ask is we know we were
17 exposed to something. What's going to happen to us? So
18 there the issue is the exposure's been documented. We
19 know there's something in our drinking water, or we know
20 there's something coming out of that plant down the
21 street. Or in the case of Viet Nam vets, we know we're
22 exposed to Agent Orange. What's going to happen to us?

23 And that is typically done by following people, a
24 group of people exposed to something, through time to see
25 what happens to them. And that's what's called a cohort

1 study. And usually it's a much larger study. If it's,
2 say for example, workers at a factory or at a company
3 that has factories all over the U.S. That can be a
4 cohort study of, say for example, DuPont workers.

5 DuPont Chemical has had cohort studies of DuPont
6 workers. And for those DuPont workers that worked in the
7 dye division, what diseases did they have? And you
8 follow people for years, sometimes ten or 20 years, and
9 famous cohort studies sometimes go on longer than the
10 investigators that started it. They outlive their
11 researchers.

12 And they're very expensive. They do involve tracing
13 people who move to other parts of the U.S. or even to
14 other countries, trace them. So you have to hire
15 companies like Equifax. That name was mentioned here
16 before, or Westat or some of these other contractors that
17 do have, you know, armies of people that will take, make
18 phone calls, will track down vital records or registry of
19 motor vehicle records in different states and try
20 identifying people to see that you can still contact them
21 as part of your cohort study.

22 It's a much bigger effort. It's a much more
23 expensive effort. Some people say it's for when you know
24 what the exposure is, but you're not sure what diseases
25 you might see from this exposure. It's the best way to

1 learn about a variety of diseases from a particular
2 exposure. But in any case it's the second method.

3 Often in community studies that's not appropriate
4 because people scatter, and also there may be communities
5 that are even larger than large companies in terms of
6 their size. So it becomes unwieldy and impossible to pay
7 for. It's too expensive to try to carry out a study like
8 that.

9 It doesn't mean it can't be done. There have been
10 cohort studies, and one famous one in England. People
11 lived around a nuclear weapons recycling plant it was
12 called or a nuclear materials recycling plant called
13 Winsgale (ph). And they looked at all the kids that were
14 born in that area, followed them wherever they went
15 throughout England and see how many of them got leukemia,
16 and a fair amount of them did because they were exposed
17 to this radioactive cloud that came out of the Winsgale
18 plant. So that was you could say a positive result from
19 an expensive and long-term cohort study.

20 And then a third type of study that typically
21 happens in communities is are we sicker than our
22 neighbors. The question is, okay, we think we probably
23 have some exposure. We think we're probably sicker than
24 we should be. But how do we know whether that's true if
25 we compare ourselves, can we compare ourselves to our

1 neighbors in the next town or the rest of the state?

2 And that's typically called, or that type of study
3 is called a prevalent study. It's a disease prevalence
4 study. It's not necessarily about a specific disease
5 like cancer. It might be about a variety of things like
6 asthma as well as birth defects as well as autoimmune
7 diseases like lupus. We want to know are those things
8 happening to us more than they are to our neighbors. And
9 that's, as I say, a prevalence study.

10 So those are the three types generally of community
11 environmental health studies that people have done over
12 the past 20 or 30 years. And then a couple of quick
13 things. What do we learn from these studies? What
14 answers can citizens get? And generally it's answers
15 about broad questions like is there an -- it's a term
16 that's used in epidemiology -- is there an association?
17 Some people say epidemiologists have a national flower,
18 and it's the hedge.

19 So we can say there's an association. What the
20 people want to know is that, what is an association?
21 Does that mean it causes something? The answer to that,
22 and often the epidemiologist, well, it's an association,
23 but we don't yet know whether that's a cause. There's a
24 lot of dancing around that happens. A link as opposed to
25 that's the cause.

1 So as I said an epidemiologist is trained to be
2 cautious about this kind of stuff. I've sort of ignored
3 some of that training myself, but I'll tell you most
4 epidemiologists, that is what you're taught to do is to
5 not leap to conclusions. So there's that unsatisfying
6 result from these studies.

7 And then for an individual person like Jerry's
8 daughter or Jerry. What caused my daughter to have her
9 disease that killed her? And that, the epidemiologic
10 study generally will not answer that. It will say there
11 was this association so this is a plausible link. But
12 it's the doctor that treated Jerry's daughter that says,
13 I've looked at this. I've known this family. I've
14 looked at all their family history -- and he's described
15 some of it. I know what medications she took, the ones I
16 that prescribed, the ones that somebody else or over the
17 counter. There's no other likely, there's nothing more
18 likely to explain that child's disease than this
19 exposure.

20 That's the causal statement, the medically plausible
21 or whatever to a reason -- It's used in court. It's
22 called to a reasonable degree of medical certainty. I,
23 the physician, think that Jerry's daughter was, got her
24 leukemia that killed her because of this exposure. And
25 that's not from an epidemiologic study. That's a

1 clinical statement.

2 Most doctors are unwilling to make a statement like
3 that for the same reasons as some of the epidemiologists,
4 but also because they would have to play God to know
5 that. They would have to have been inside the genes of
6 this child's -- this unfortunate event that happened to
7 this child in order to know for sure that that was the
8 cause.

9 But on the other hand some doctors can say to a
10 reasonable degree of medical probability. In other
11 words, if you weigh that it would be more that it did
12 cause it, and I'm willing to say that in court or to an
13 insurance company or whatever it is.

14 So that's the kind of difference between what an
15 epidemiologic study can tell you at the end of it all.
16 Or even what an epidemiologist, even good ones like the
17 ones involved in this study, will be able to say to you
18 definitively at the end of it. Well, there is an
19 association, and it meets the usual conventions of
20 statistically significant or not.

21 And then the last thing I want to say is something
22 about feasibility. I guess I've already said some of
23 this, but case-control studies are the most efficient
24 studies. And for a rare disease like a birth defect of
25 the heart, for example, or even childhood leukemia, that

1 is the most efficient way to go about trying to figure
2 out what happened. What was the association that is most
3 likely the explanation for this pattern of disease that
4 we see in this community.

5 And so it's the most feasible and part of the
6 feasibility is to see well, are the records available and
7 will people answer us when we call them up and ask a
8 questionnaire over the phone? Perri's been describing
9 that. That's been going on, and it seems like it's
10 feasible. And they're going ahead with it. And I
11 commend them for that.

12 For a cohort study there's a lot more that I think
13 I've implied that would tell you whether it was feasible
14 or not. I was actually part of an epidemiologic
15 feasibility study for DOE, EPA and the Nuclear Regulatory
16 Commission to see what populations you could study that
17 were exposed to low-level ionizing radiation, and whether
18 you could do a new study that would say how does that
19 affect people with this low dose.

20 So it's a very specific epidemiologic question, and
21 the feasibility study meant that we had to go to places
22 where there were first of all large numbers of people who
23 were exposed at low dose and that there were medical
24 records and exposure records available, if not all of
25 them, at least a very significant portion of them. And

1 then my role in this feasibility study actually was to
2 see are there cancer registries where these people
3 worked, state cancer registries so you could pick up the
4 cancers that occurred in this cohort.

5 So the feasibility study itself took three years.
6 We published it. It was a Journal article in the
7 American Journal of Public Health about it. There were
8 these two thick reports about it. And we did think it
9 was feasible. Actually, there were two groups that we
10 thought it was feasible to study that weren't already
11 being studied.

12 One was people who had worked at nuclear power
13 plants and all over the country actually that were
14 exposed that had badges that said what their exposure
15 was. And we recommended that at the end of that. And
16 I'm trying to remember what the other -- oh, the other
17 ones were actually cohorts of DOE workers and they were
18 already pretty much being studied.

19 So that process led us to believe that, you know,
20 there are ideal studies that we would love to do. They
21 would cost a fortune to do them, and we found that out
22 about these low-level exposures to ionizing radiation.
23 And so I think actually none of those that we recommended
24 are being done. Individual utilities have studied their
25 workers, and then there have been radiation Canadian

1 studies of nuclear power plant workers that have taught
2 us what we now know about low level ionizing radiation
3 which is if you do a study, you actually can see the risk
4 goes up practically above zero. You know, the dose
5 response is such that there is no safe dose for ionizing
6 radiation. That's what these big studies have taught.

7 I'll reserve judgment on whether a cohort study of
8 everyone who went through Camp Lejeune is feasible. I
9 think you'd have to find out a lot more about them in
10 order to say anything about that. So one last thing I'll
11 say before I stop is, and I really prefer to do this
12 interactively and answer questions.

13 There was a toxic waste site in central New Jersey
14 called the Lipari Landfill. And at one point it was the
15 number one, ranked number one on the Superfund list,
16 USEPA Superfund list, and that was because ^ was one of
17 these toxic waste dumps. The landfill was a dump where
18 chemical companies from all over New Jersey came and
19 unloaded their stuff. And it stayed in the ground and
20 went into the ground water, went into the rivers.

21 You know, people were affected if they swam in a
22 pond where there was a Girl Scout camp nearby. They were
23 affected if they ate fish from the rivers, et cetera.
24 And so there was lot of people affected. This was in
25 Glassboro and Mantua (ph) and several other towns in

1 central New Jersey. The Lipari Landfill site was number
2 one on the Superfund list because of the toxicity of the
3 chemicals and how many people were affected.

4 So they actually formed their own registry of people
5 that wanted to know, people who lived around the landfill
6 who wanted to know new information about what was learned
7 about exposures. So they formed their own, I would call
8 it a mailing list, but it was computerized. And the
9 organization was called LINK the Lipari Information
10 Network, had thousands of members and people voluntarily
11 joined up.

12 And there was a person who actually worked out of
13 the town hall who was the coordinator of this. They got
14 a grant from, I believe, a foundation. At one point they
15 had a grant from ATSDR to keep in touch with everybody.
16 They had a mailing list, and they put out a newsletter.
17 And so there was a lawsuit of people who lived around
18 this landfill filed against, you know, a hundred or so
19 polluters.

20 And as part of the lawsuit, the attorneys for the
21 plaintiffs asked us, me -- I worked at the time at a
22 public health consulting company called John Snow, Inc. -
23 - to do a health survey of the people that were in their
24 database. So we did, mailed it out. They had the
25 addresses. They were all computerized. It went to

1 several thousand people, and we got the results back. It
2 was all self-reported, so called self-reporting health
3 survey reports.

4 There were some very unusual findings in it which we
5 summarized and produced a report. And it so it was, I
6 would say -- and then we sent out the results of that
7 through the newsletter to everybody that had participated
8 or not. Those that had responded with a questionnaire in
9 the mail or just were interested in knowing what other
10 people said. And so that was a way of keeping in touch
11 with several thousand.

12 It wasn't 60,000 or even 20,000. It was four or
13 five thousand as I recall, somewhere in that range, of
14 people who lived around the Lipari Landfill dumpsite and
15 were members who had signed up with the LINK
16 organization. And some of them moved away, quite a ways
17 away. So it was a good way to keep in touch with them.

18 But it was I would say an informal, we didn't
19 publish this in a scientific journal. It was a report
20 that was reported back to the organization. It was used
21 as part of the negotiations in the lawsuit, but I don't
22 think it was the, by any means, the critical -- and they
23 did have a settlement with these responsible parties.
24 They weren't even potentially responsible. They were
25 responsible, and they paid money to the people that had

1 been exposed. And so that I just offer as another
2 method.

3 And I'm not necessarily recommending that you file a
4 lawsuit or even that you try to get a grant to do this
5 database, but it has been done at least in one other
6 community. I will stop with that.

7 **MR. STALLARD:** Thank you, Dr. Clapp, and thank you for
8 not hedging at all on that.

9 I have been asked by those up front that if you want
10 to eat lunch, there are five of you who have not
11 committed both with your votes and your wallets, so we
12 need that. So let's just take a few moments to do that
13 real quick.

14 Folks, can we take maybe just a few minutes? I'd
15 like to ask Dr. Fisher when we get back if he has
16 anything prior to his departure for a previous
17 commitment.

18 (Whereupon, a break was taken from 11:10 a.m. until
19 11:20 a.m.)

20 **MR. STALLARD:** Terry, you wanted to mention something
21 about the DOD connection, or do you want to do that -
22 -

23 **MS. DYER:** We're going to do that after lunch. I'm
24 going to have a statement from someone. So I'll be
25 able to read it after lunch.

1 **MR. STALLARD:** Okay, and just for those to know we
2 have members of DOD in the audience, and they would
3 like to affirm their commitment to this process. And
4 Terry will have some more after lunch.

5 Unfortunately, Dr. Fisher had a previously
6 scheduled commitment this afternoon and will have to
7 be leaving us shortly to make that commitment. So
8 we're going to use this time right now to hear
9 briefly from Dr. Fisher, and then we will open the
10 Panel for open interactive discussion.

11 **REMARKS BY DR. JEFFREY FISHER**

12 **DR. FISHER:** I'd like to say I'm very excited about
13 this opportunity to assist the CAP. It's a humbling
14 experience, very difficult task where science and
15 policy meet and how far can the science go. I'm not
16 an epidemiologist. You should know that. I'm a
17 token toxicologist, I guess. So my background and
18 what I do is much different than Dr. Clapp. For
19 example, the groundwater modeling perked my interest.
20 I do mathematical modeling only of chemicals in the
21 body. So I can contribute and have, I think,
22 important things to say, but on some of the epi I'm
23 not going to be real strong, so I want that to be
24 known.

25 I've worked with trichloroethylene though for

1 about 20 years in the laboratory, and I've
2 participated with the US EPA in the last five or six
3 years in their re-evaluation of trichloroethylene.
4 So I've been very close to trichloroethylene, and I
5 worked with NIOSH in Cincinnati on a dry cleaner
6 study and have done animal studies with
7 perchloroethylene. So I have some sense about the
8 database for perchloroethylene.

9 I've been involved in citizens' groups. This
10 isn't on my CV so even the citizens here may not know
11 this, but in Dayton, Ohio, where the Mound facility,
12 a DOE facility, I was helping out on trying to come
13 up with a soil cleanup standard for Plutonium-238 and
14 other chemicals that had contaminated a park and
15 onsite remediation.

16 So I've been involved in environmental
17 contamination issues scientifically as well as in the
18 public-related issues since about 1985. I have
19 several federal grants, one with trichloroethylene
20 through the Medical University of South Carolina
21 working with mathematical modeling of some of the
22 metabolites.

23 So that's a little background about me. I'm
24 close by so the trip is maybe easiest on me, 70 miles
25 away or less. I wanted to make, I guess, two or

1 three points that I heard two or three times from the
2 CAP about notification. My question to ATSDR -- I
3 don't expect an answer, but it's just a question.
4 Where do you stand on that? How robust is that
5 particular issue? I don't know. I'm not close to
6 this project yet. I was a year ago, and a little bit
7 more background, I had 30 seconds of fame on CNN.
8 That's how the people here found me out and called
9 me. So some of the people on this CAP I've talked to
10 over the last five years, I think twice a year, and
11 always had very good conversations. They ask every
12 difficult questions and very relevant questions.

13 But back to the three things I wanted to
14 mention before I go that just came to my mind as I'm
15 sitting here. First meeting, the notification issue,
16 an update from ATSDR on their epi work which looks
17 like it's a lot of work. My general question is how
18 does that body of work meet the needs and
19 expectations of the CAP based on what they said what
20 they would like to achieve. They mentioned they
21 would like to expand the end points, that kind of
22 question, a general, broad question. I don't have a
23 sense for that answer.

24 When a more technical issue -- and I think I
25 mentioned this on CNN -- in looking at a lot of

1 military sites, which I've looked at a lot of
2 databases with trichloroethylene, and I don't have
3 the background, but some of the drinking water or
4 some of the monitoring water I should say,
5 concentrations to me were extremely high, actually
6 approaching the limit of solubility depending on the
7 water characteristics.

8 And it's unusual to me to see so that perked my
9 interest in terms of what is their exposure, this
10 population. Historically, 50 parts per million even
11 100 parts per million you can see has occurred in the
12 '50, '60, '70s but not a thousand, not a part per
13 million. And maybe that will bear out that that
14 didn't occur through the modeling. I don't know.
15 That's why I asked the question previously. But for
16 the modeler --

17 Morris, we haven't met, but you may not have a
18 well-mix compartment ^. You're above the saturation
19 of water, you actually have aerosols so you have
20 droplets of trichloroethylene. I don't know if
21 that's true.

22 I do aerosol work in air, not in water, and
23 that's a technical question that came to my mind when
24 I get my two minutes of time to talk to you about.
25 Is that feasible? If it's saturation in water then

1 it's probably collecting somewhere as the liquid
2 itself. Is that true? I don't have data. I'm just
3 asking questions. That was my third question.

4 **MR. STALLARD:** Would you like to respond to that?

5 **MR. MASLIA:** I'd actually like to think about it a
6 little bit before responding if that's okay.

7 **DR. BOVE:** We can ask Morris at the next CAP meeting
8 ^ issues. We are assuming that you are exposed in
9 the shower and ^ water in the house.

10 **MR. BYRON:** But are you talking about the gravel, the
11 water under the ground is so saturated that now it's
12 puddling as the chemical itself on top or on the flow
13 depending on where it's heavier?

14 **DR. FISHER:** Yeah, it's heavier. It's denser than
15 water, trichloroethylene. But it's more than just
16 collecting on the bottom of an aquifer. It's not
17 being soluble in the water approaching the
18 solubility. So there's, could be droplets and not
19 just dissolved trichloroethylene. Maybe we shouldn't
20 spend a lot of time here about it because it's just a
21 question and more than likely can be answered. I've
22 just never seen trichloroethylene levels that high
23 out in an environment except at close to contaminated
24 sites, very close.

25 **MS. BRIDGES:** And we're so glad you're here to help

1 us.

2 **MR. STALLARD:** Thank you, Dr. Fisher.
3 **BEGIN DISCUSSION ON CAMP LEJEUNE SCIENTIFIC ADVISORY**
4 **PANEL RECOMMENDATIONS AND ATSDR RESPONSE**

5 This is where we say let the dialogue begin.

6 Yes, Jeff.

7 **MR. BYRON:** Number one, talking about the ongoing in
8 utero study. Out of the 106 cases identified were
9 any of those where they had two of the symptoms? Was
10 it counted as one case if you had spina bifida and
11 another case if you had cleft palate or was that
12 individual left, lumped into one case?

13 **MS. RUCKART:** I don't believe there are any instances
14 where a study child had two of the reported
15 conditions we're looking at, so ^.

16 **MR. BYRON:** Actually, my daughter has two. But spina
17 bifida was in her record. Whether that's been
18 verified or not after I had spoke to you about it
19 some years back. It sounded as though it was a
20 matter of what the severity of the spina bifida was
21 versus actually calling that one of the ^ for spina
22 bifida.

23 **MS. RUCKART:** Yeah. Well, there is a condition,
24 spina bifida occulta, and that may be what you're
referring to. And that is, it's unfortunate that
it's actually called spina bifida occulta instead of

1 something that they -- but they have different names
2 because it oftentimes gets confused with spina bifida
3 and they're for two different conditions.

4 And we are not looking at, we are not looking
5 at the occulta here, so there are no, there's a child
6 that I'm aware of and there's two that you're
7 referring to that we're studying. I mean, there may
8 be some out of a ^ another ^ that is verified. It's
9 just not one that we're studying.

10 **MR. BYRON:** And secondly, the birth records from
11 Onslow Memorial Hospital where ^ for the simple fact
12 that they didn't list any deformities that my
13 daughter had, and she clearly had several, I think,
14 it listed at least six on her first visit to the base
15 hospital.

16 **UNIDENTIFIED SPEAKER:** What's her birthday?

17 **MR. BYRON:** Nineteen eighty-five, April 27th. I'd
18 like to find out if the '85 ^ to be my daughter's
19 record ^.

20 **MS. RUCKART:** Your daughter ^. Well, let me just say
21 that's why we're not relying solely on birth
22 certificates. That's why the 1998 study did not deal
23 with ^ birth defects ^ certificate, and that's why ^
24 records that would show they have a condition.

25 **MR. BYRON:** And I noticed in our documentation that

1 was sent to me that a lot of the cases of the 106 had
2 like associated illnesses but not specifically the
3 one that we were looking for, like aplastic anemia
4 versus leukemia. So is there any statistics on how
5 many of those cases are out there that have an
6 associated illness that coincided with the illnesses
7 we're asking for?

8 **MS. RUCKART:** No, there isn't ^ and that's part of
9 our ^.

10 **MR. BYRON:** That's all I have.

11 **MS. DYER:** Frank, first of all I want to say show me
12 the money. Is there any way that we can get a grant?
13 Yeah, I got real excited when he started talking
14 about grants from the ATSDR because if we could get a
15 grant --

16 **DR. BOVE:** We have no money.

17 **MS. DYER:** We have no money.

18 **DR. BOVE:** But that doesn't mean that we can't do
19 something. I'm not the person to talk to about our
20 budget. Actually, Dr. Frumkin can tell you.

21 **MS. DYER:** That might be nice to get him in here at
22 some point to where we can talk to him about the
23 money because that's a big issue with this so that we
24 can get moving on it. One of the things that -- and
25 you said this is time to start dialogue. Here we go.

1 One of the things that I would like to look at is
2 the fact that TT, Tarawa Terrace, is an area that we can,
3 I believe, use as a cohort, and I would like, I was
4 talking to Dr. Clapp about this, if we could take and do
5 combined. You know, you have a cohort study and you have
6 a prevalence study, if we could put them together, and he
7 said that can be done. And I think that that would be
8 something that we need to talk to, talk about.

9 We need to, if we have Tarawa Terrace, and we
10 take the year, if you're not willing to give me 1958,
11 then we could take 1960 and go ahead now and not wait
12 any longer because we, on this panel, feel like we've
13 waited long enough. We would be willing to do as
14 much work as a community here to help you. Dr. was
15 asking me, well, how are you going to go about
16 getting these people that lived at TT.

17 And I would say to that that PSAs, public
18 service announcements, can go across this country on
19 major television networks. They're free, public
20 service announcements, free. If you or your family
21 lived at Camp Lejeune on base in the Tarawa Terrace
22 housing area from 1960 to 1985 or '87 -- whenever you
23 want to cut it off -- you need to call this 1-800
24 number that's going to be provided by the DOD and an
25 electronic survey comes on. You tell if you were a

1 child. You tell if you were born. You tell if you
2 were an adult that lived out there. You give your
3 age, and then you give your illnesses.

4 And the reason I say give your illnesses is
5 because I think it's real important that we not just
6 look at the cleft palates and the -- I'm not saying
7 not to, but I'm saying that we've got to, in my
8 thought process because on our website, you know,
9 we've got 800 plus, 886 at this point, people. And I
10 know it's not scientific, but just looking at the
11 data that they're giving us on the illnesses, there's
12 a wide variety of illnesses. But a lot of them, most
13 of them are the same. They're living all over the
14 country.

15 So right there besides doing the PSAs and
16 getting people to call in, you've got 886 people, and
17 the majority of them it looks like lived at TT. So
18 if we set up a website or, you know, expand our
19 websites to get people onto them if we do the PSAs,
20 if we get the Marine Corps to -- in the Globe and
21 some of their other, the military magazines and
22 things like that, to go ahead and announce it again,
23 VA magazines, VA meetings.

24 If you're sending out someone your VA benefits
25 or your retirement check comes in the mail. I mean,

1 why can't a little yellow slip, if you lived at
2 Tarawa Terrace, call, and you're showing any
3 illnesses or your children are, call this number.
4 And I just feel like that we could get this going
5 before even our next meeting. I mean, you know, I
6 would like to be able to see a 1-800 number set up
7 and PSAs going in the next month.

8 **MS. McCALL:** Before anymore medical records are
9 destroyed.

10 **MR. STALLARD:** So for the purpose of coming to a
11 conclusion at the end of the day, that's a specific
12 recommendation that you're making?

13 **MS. DYER:** Specific recommendation. I'm mean we've
14 got VA magazines all over this country. I mean,
15 there's --

16 **DR. CLAPP:** I have to say one thing though which is
17 that if you just put the PSA to respond if you've had
18 an illness then you're just collecting illness. I
19 mean, that's the point, but then you have to really
20 say compared to what. And then the answer is, I
21 think, just respond and tell us what illnesses or
22 what other things you've had, and then you can get a
23 prevalence rate for those that respond, not just ask
24 for the people that had an illness. You have to ask
25 for everybody.

1 **DR. BOVE:** Even before we do that I think it's
2 important to figure out what we want, why we want to
3 do something; what we're trying to accomplish because
4 if you're interested in a scientifically credible
5 study you'll do one thing. If you're interested in
6 figuring out what kinds of diseases people had just
7 to get a handle on the disease burden of the
8 population and what kind of services they might need,
9 that's a whole different thing.

10 What I hear you saying is let's figure out what --
11 and there's nothing wrong with it. It's just for a
12 different purpose. For a scientific study you want to,
13 you have to have exposed people and unexposed people.
14 You want to verify their diseases. If you don't verify
15 the diseases, if you just tell them to report their
16 diseases, the study doesn't have much credibility.

17 We've had some problem at my agency, we use to call
18 them -- we still call them -- inconclusive by design.
19 The reason partly was because we didn't verify the
20 symptoms and diseases that we collected. Other reasons
21 were we didn't do very well on the exposure side.

22 The third reason is we didn't interpret the data
23 very well, but so there are three reasons why they are
24 inconclusive at least. But one of them was we didn't
25 verify those diseases. In a more credible study, you

1 want to be able to verify these because that's why we're
2 going to such an effort in this current study.

3 If you want to determine the disease burden,
4 then we would do that kind of survey. But I think, I
5 mean, there's more to this discussion because in
6 trying to figure out exactly what are the needs.
7 What do we want to do here. Do we want to produce
8 more scientific evidence? Really what's driving both
9 the two studies, the study we're doing now and the
10 previous study, was driven by we want to add to the
11 scientific literature.

12 We want to add to the scientific literature
13 because there are so few studies that look at any
14 kind of drinking water contamination and chemicals,
15 and anything would be an advance. If you look at
16 what's out there on birth defects and TCE and PCE in
17 drinking water, you're going to find one study. A
18 two-site study is difficult. But ^ ^ three steps. ^
19 published, and they said the numbers in that of birth
20 defects as I said were so tiny that the researchers
21 refused to publish that study. I mentioned it in a
22 review of, Perri and I and another researcher talked
23 about it, but they never did release it. So it's one
24 study.

25 And the second study was Tucson where TCE was,

1 it was a cluster of birth defects. It prompted a lot
2 of calls for that stuff down there, and very few
3 people believe that study. I tend to, I believe it,
4 but it's a very difficult study, and I think it's
5 unfortunate ^. So -- and then there is the study we
6 worked on in New Jersey. So any additional study
7 would be a great advance on birth defects.

8 As for childhood leukemia we have Woburn,
9 right, with TCE. We have Toms River. Toms River had
10 a strange chemical in the water as well that we
11 considered one of the causative agents. A Union
12 Carbide chemical that no one knew about before. I
13 think Union Carbide knew. The rest of the world
14 didn't.

15 So there's those two studies plus the study
16 again in New Jersey which I worked on. The childhood
17 leukemia, but it wasn't the primary focus of the
18 study. The primary focus was adults actually, but we
19 saw an excess of childhood leukemia among females.
20 But that's it. So there's not that much out there
21 for PCE. There's some, there's one drinking water
22 study of adults in Cape Cod. There's several studies
23 actually in the same population. We've looked at
24 several adult cancers.

25 And then there's studies of toxic waste sites

1 they found at Lipari, for example, New Jersey, that
2 found small for gestational age. There at Lipari
3 there's all kinds of ^ organics^ coming out of that
4 site. And as ^ was saying, if you tested for a
5 chemical you'd find it. No matter what you tested
6 for it was there.

7 So because of these few studies that were
8 there, that's why we focus on small for gestational
9 age as at Lipari, to a great extent, -- not because -
10 - and then one study ^ drinking water -- and
11 childhood leukemia and because of Woburn, because of
12 Toms River and because of that New Jersey study.
13 Neural tubes, oral clefts because as one New Jersey
14 study found for TCE and PCE, and this is what's out
15 there.

16 **MS. McCALL:** Well, yeah, I think that's all the more
17 reason to do the prevalence study because this is a
18 larger population. You'll have people voluntarily
19 calling which means that possibly they will volunteer
20 verification. I mean, verification is a matter of,
21 what, collecting your medical records and sending
22 them in? I have a box of medical records. If I've
23 been sick or anybody else is exposed, has been sick,
24 they already have the medical records.

25 I don't think -- well, actually the idea that

1 Terry and I are talking about is like the
2 computerized call-in survey where you ask, you know,
3 specific questions and the computer starts out the
4 diseases and then you can choose who you want to
5 contact. If they say they have some weird disease,
6 they can be -- you know, I don't know how to do this,
7 but I know, I just feel like this can be the right
8 way to do it to get all the information we need and
9 not just use the past studies like you're talking
10 about Woburn and all these other things to limit our
11 scope on diseases.

12 Because as Terry said, there are so many
13 different kinds of things going on. I'm just curious
14 to find out how many more people have the same things
15 I do.

16 **DR. BOVE:** We didn't use the previous studies to
17 limit. We used the previous studies to give support
18 to ^.

19 **MS. McCALL:** Right. I think this is all new --

20 **DR. BOVE:** Most scientists don't think, don't think
21 that what's out there is strong evidence, and we'll
22 do a study even on these limited end points, you have
23 to make a case for it. And that's what we use the
24 previous studies for, not to limit anything but to
25 make a case for even doing it. Keep that in mind.

1 We're interested in looking at any, from the
2 scientific point of view, and the purpose, again, because
3 there's this other purpose at least, there's several ^
4 purposes. For the purpose of finding out what disease
5 burden in a population, then a survey is great. What
6 linked it at Lipari was not scientifically incredible.

7 You might be able to use it in a legal
8 proceeding. I'm not going to even talk about that
9 because I don't know anything about that whether it
10 would be useful or not. As a study a scientist would
11 say this is strong evidence for association or a
12 causal association or whatever you want to say. They
13 wouldn't do that. They wouldn't do that.

14 For that kind of credibility you need to do
15 something like we're trying to do here in this study,
16 previous study at Woburn so on and so forth. By the
17 way people disagree with me --

18 **MR. MARTIN:** I'd like to comment on something though
19 in Perri's presentation. She stated that people were
20 disqualified because they were diagnosed with cancer
21 beyond the age of 20. Is that correct?

22 **MS. RUCKART:** Yes.

23 **MR. MARTIN:** Well, that's what we're dealing with
24 now. We have the little, the children, the three to
25 five to ten to 12 year olds that were living there at

1 that time, the military dependents. And we have a
2 list of 868 people. These are user names. They're
3 not exactly names that you can contact. We can
4 contact them. There's a database. But these range
5 from several different types of cancer, parathyroid
6 disease. We have people dying from kidney disease,
7 from cervical cancer, just over and over, skin
8 deterioration, cysts, muscle pains, joints, juvenile
9 arthritis in, you know, 30, 40, 50 year old people.

10 **MS. RUCKART:** This kind of goes back to what we were
11 saying that we had to, we had a starting point and
12 for this study we're looking at the in utero
13 population and cancers diagnosed before 20 or the
14 childhood cancer. So these are all things that we
15 can talk about, and they're on the table for the
16 future.

17 **MR. MARTIN:** So this is what we're looking at in this
18 study.

19 **DR. BOVE:** Yeah, the study was on childhood cancers,
20 but one of the recommendations from the scientific
21 panel, maybe we'll get into some of that this
22 afternoon. What is to look to see if it's feasible
23 to look at a broad range of cancers, cancer mortality
24 and cancer incidence if possible. There are
25 difficulties, but a little bit more difficulties with

1 cancer incidence. But they thought it might be
2 feasible, and so the question is can they identify
3 cohorts at the base, and then follow them as ^ was
4 saying in a cohort fashion to see if we can get that
5 cancer information.

6 And one other thing that I wanted to talk about
7 today if you have the time. I'm going to give you a
8 sheet of paper about what kinds of databases at least
9 you're aware of to some extent now. In other words
10 it's not quite true that we can't look at databases
11 and start planning the future studies. That's not
12 what Perri meant earlier. We can certainly do that,
13 and in fact, we're starting to do that. And we don't
14 have complete information on these databases, but
15 what we know I'm going to pass out.

16 **MR. ENSMINGER:** With the Camp Lejeune situation being
17 the unique situation that it is which was brought out
18 before, this happened to a transient population.
19 This isn't like some community where these people
20 were exposed in one community and had exposure
21 stopped and years later those same people were still
22 there or their relatives were still there. These
23 people are gone. They're all over the country, all
24 over the world.

25 So basically, I think what Perri was saying,

1 Dave, Denita, anything that's undertaken at Camp
2 Lejeune is going to have to be done in a step-by-step
3 basis. I mean, you're going to have to do a survey
4 to do a study. I mean, the survey has to be done.
5 That's to give you an idea of whether or not the
6 thing's even going to be feasible to go on with a
7 cohort study.

8 **DR. BOVE:** Actually, that's not necessary. What we
9 need to know -- surveys may be important to do, but
10 it's possible to do a mortality study. It's
11 possible. I'm not saying it's feasible. It's
12 possible to do a mortality study, and it's possible
13 to look at some other diseases as well. There are
14 databases, this one database in particular, of -- I
15 guess I'm getting into it, so maybe I should --

16 **MR. ENSMINGER:** Well, the CHAMPS, the CHAMPS database
17 only covered people while they were on active duty.
18 How many of these people stayed in the military? How
19 many of them only did one tour in the Marine Corps
20 and left?

21 **DR. BOVE:** There are limitations to the database,
22 that's true. One thing you have to understand is you
23 don't have to study everybody. That's the first
24 thing. What you have to do is study, you have to
25 avoid biases in your study. But if I say, if I study

1 with, if we're studying in the case of cancers, we're
2 studying neural tube defects, oral clefts and TCE or
3 PCE exposure.

4 Now if you were born somewhere else in the
5 country and exposed to TCE or PCE, you know, the
6 findings in this study are relevant within realms
7 exposed, whether it was exposed in Camp Lejeune or in
8 India or Great Britain or wherever they were exposed.
9 The study is relevant. You don't have to be in the
10 study for the study to be relevant to your issue.
11 That's the first thing.

12 So the fact that people are not in the study
13 doesn't mean that they're not important. It doesn't
14 mean we're not concerned about their health or
15 anything of the sort. It means these are the people
16 we could study because we have ^, for example.
17 That's where the information was.

18 Here's where the information is at this
19 database called CHAMPS, and I'll get to that later.
20 And the question would be, and again, it's possible.
21 It's not a question of whether we want to do it. And
22 the question would be is this the best database to
23 use. Will it give us the kind of answers we want,
24 produce a scientific credible study? I'm not going
25 to answer those questions right now because I need to

1 know more about the database myself.

2 But you can study some people for some period
3 of time even though you can't study everybody over a
4 longer period of time, you still might be able to get
5 some information that then can apply to other people
6 in other circumstances. And I think that that's --
7 keep that in mind, that you don't have to include
8 everybody to be able to do something scientifically
9 credible.

10 But if you want to find out what the disease
11 burden is in a population, you've got to include as
12 many as possible. So it really does matter what the
13 purpose, what you want to see happen. What you need
14 to have happen, purposes are and so on.

15 **MS. McCALL:** Wouldn't it be important to the ATSDR to
16 know exactly what diseases these chemicals cause and
17 not slice the bologna so thin as one doctor put on
18 the expert panel? I mean --

19 **DR. BOVE:** Yes, absolutely.

20 **MS. McCALL:** -- you know, we're just hearing about
21 lymphoma and Hodgkin's and oral cleft. I don't know.
22 As a scientist, to me, all information is important,
23 and I know when you say you don't have to include
24 everybody for a scientific study to develop, I don't
25 know how that works. I don't know how you --

1 **MR. ENSMINGER:** How are we going to further our
2 knowledge of what the effects are --

3 **MS. McCALL:** Without knowing --

4 **MR. ENSMINGER:** -- if we don't look at other things
5 besides these pointed illnesses.

6 **MS. DYER:** So can we take Tarawa Terrace and go ahead
7 and start a study of the children and adults that
8 lived down there?

9 **DR. BOVE:** For a scientific study you have to be sure
10 we've identified everyone or at least a large
11 percentage of the people who were exposed.

12 **MS. DYER:** It was --

13 **DR. BOVE:** It can't just be those diseases we've
14 talked about. So in a scientific credible study you
15 have to be able identify a group -- there's family
16 housing. Or you're saying everyone down there, not
17 just --

18 **MS. DYER:** Well, I mean, the Marine Corps has social
19 security numbers. They knew every house that -- when
20 I gave them my dad's social security number, they
21 knew every house that we lived at in Tarawa Terrace.
22 So they've got the information. So if we're, you
23 know, we're here today to talk whether or not a study
24 is feasible. We have now decided it's feasible I
25 think. Now you say -- well, we have.

1 **DR. BOVE:** Remember, it has to be a process. You
2 haven't determined feasibility.

3 **MS. DYER:** Well, you said something a minute ago --

4 **DR. BOVE:** The question is feasible as to what? You
5 haven't shown me, or anybody yet, that it's feasible
6 from a scientific credible point of view. You may be
7 able to convince me that it's feasible to do a survey
8 to get a sense of disease burden doing this. I'm not
9 sure about that yet. But you haven't shown
10 feasibility. That's a strong statement, okay. I
11 just want to tell you honestly. You're making
12 recommendations, and let's pursue it.

13 **MS. McCALL:** Sick people isn't feasible?

14 **DR. BOVE:** No, no, no, the actually finding out
15 information on the sick people, that's the question,
16 not whether people are sick or not. You're not going
17 to convince me that TCE is dangerous. You certainly
18 don't have to do that. My studies show that, okay?
19 I'm convinced. That's not the issue. The issue is -
20 - Actually, there are two issues at hand. One is do
21 you want to find, and again, what is your purpose.
22 You want to find out what the disease burden is for
23 some reason such as, we need services for these
24 people?

25 **MS. McCALL:** Yes. Yes.

1 **DR. BOVE:** And for a different purpose, we want to
2 produce a scientifically credible study.

3 **MS. McCALL:** That's your, see, that's the answer to
4 your question. You want to provide a scientific
5 study.

6 **DR. BOVE:** No, I'm not answering my question.

7 **MS. McCALL:** Well, I --

8 **DR. BOVE:** I'm just asking it.

9 **MS. McCALL:** Well, but we don't need a scientific
10 study. We know we're sick. We need services. You
11 need scientific study.

12 **MS. DYER:** Okay, then tell us what you, what do we
13 have to do to show you the feasibility? What are you
14 looking for?

15 **DR. BOVE:** Well, if you did want to do a
16 scientifically credible study, you'd have to go
17 through several steps to see that. If you're
18 interested in just getting a survey of the disease
19 burden, I mean, then I mean the feasibility of that
20 depends again on do you -- how high a percentage of
21 people do you want to reach. If you send PSAs out,
22 do we have a sense of how many people would respond
23 to this?

24 **MR. MARTIN:** I think the estimate at this point is
25 like 500,000, a half a million people were exposed to

1 these --

2 **MR. ENSMINGER:** That's total.

3 **MS. DYER:** Total.

4 **MR. MARTIN:** -- chemicals during that time. And we
5 were transit. We can get really scientific. I was
6 born and lived in Midway Park which is on the Hadnot
7 Point water system, but I moved to Tarawa Terrace.
8 So, you know, if we could start with Tarawa Terrace
9 and my older brother and sister who are on this list
10 and then work back to us who were living in Midway
11 Park at that time once that modeling comes out.

12 **DR. BOVE:** Well, I think it ^ on Tarawa Terrace
13 because --

14 **MS. McCALL:** Because it's the only study that's
15 almost finished.

16 **DR. BOVE:** No, they'll all be finished very soon, so
17 you need to, I wouldn't call it a study. A study is
18 --

19 **MR. MARTIN:** Water modeling, I'm sorry.

20 **MS. McCALL:** Water modeling.

21 **DR. BOVE:** Water modeling will be done soon. And the
22 people at Hadnot Point, received Hadnot Point water
23 which includes those who switched over to Holcomb
24 Boulevard --

25 **MR. MARTIN:** Which also went back into the 1940s

1 also.

2 **DR. BOVE:** But Hadnot Point is where we're seeing the
3 high TCE.

4 **MR. MARTIN:** Right.

5 **DR. BOVE:** So it's very important -- now here I'm
6 talking about including more people. I think it's
7 important that those people exposed to those high
8 levels of TCE are included in any surveys we're
9 talking about.

10 **MR. MARTIN:** And we're also going to move back 20
11 years as far as notification.

12 **DR. BOVE:** So I would want to wait, and it's not that
13 much longer for Morris to finish his work on this.
14 So we'd actually could notify, and could affect the
15 notification issue, too. Because what we want to do,
16 want to do is put on the website the information so
17 you can go there -- we'll have to figure out how to
18 do this exactly, but this is the...

19 So you could go there and if you were at this
20 housing in this period of time and it would tell you
21 what level of contamination, what you might have been
22 exposed to. That's what we're hoping for. And have
23 it on the website and send out a media thing so that
24 people would know to go to that website to get that
25 information.

1 **MR. MARTIN:** And I think that's where a lot of it's
2 lost because my family has lived in Jacksonville,
3 North Carolina, 12 miles from the main gate since my
4 father retired back in 1974. I was unaware of this
5 until July 4th of 2005, when my brother just went
6 through some major colon surgery, colon cancer. And
7 the question was did you know the water was
8 contaminated when we were kids at TT. And I said no,
9 what are you talking about. And that's when I got
10 involved in, became very passionate about the
11 research because I have a deceased sister and mother.

12 So we can start looking at this list which is a
13 very, very small list which I believe probably
14 resulted from the media blitz that we were told went
15 on when we were in DC.

16 **MS. DYER:** No, it was a result of a personal and then
17 getting those people in those different states to go
18 around to their media.

19 **MR. ENSMINGER:** When you do an in utero study -- and
20 I remember discussions from the e-mails and other
21 documents that I've looked at. ATSDR ran into a
22 brick wall as far as being able to locate, and there
23 was meetings with DOD representatives, maybe Marine
24 Corps and the DMDC, was it DMDC database? There was
25 some haggling back and forth about privacy act

1 issues, but finally they broke this thing loose, and
2 the lion's share of people were located through that
3 website, or through that database for the in utero
4 study.

5 **DR. BOVE:** The current study.

6 **MR. ENSMINGER:** Yes.

7 **DR. BOVE:** There's all kinds of databases out there.

8 **MR. ENSMINGER:** For the survey. I'm talking about
9 the survey.

10 **DR. BOVE:** Yeah, that's part of the ^. The survey
11 used all kinds of methods, not just the data in our
12 data centers. So you use media as well, you use the
13 military network of e-mails and newsletters. We use
14 CNN. We use also any information we can gather from
15 searches as well. So that's basically, we did a
16 whole bunch of them. They're basically outlined in
17 the -- we sent to you on the survey.

18 **MR. ENSMINGER:** Well, and you know, just like I
19 mentioned in my opening remarks. Anything we
20 recommend here is not going to amount to the
21 proverbial hill of beans unless the DOD comes forward
22 with their databases and actually, truly tries to
23 locate these people. And that's number one before we
24 can do anything.

25 Now Chris came in here after that last break

1 and said there was DOD reps here that pledged their
2 cooperation. I don't know who it was, but I would
3 like to hear that from the people out there so it
4 could be a matter of this record that they pledged
5 their cooperation.

6 **MR. STALLARD:** And Jerry, just so you know, I've got,
7 I'm writing down recommendations for action so we can
8 actually see things that are going to be action
9 oriented. And I have here identify senior DOD point
10 of contact to work with. In other words, we need a
11 senior-level support to ensure that we have all the
12 things that you're asking for in the commitment. And
13 we do have someone here who is willing, that Terry's
14 going to manage that transition to speak.

15 **DR. BOVE:** One thing we stated earlier, too, that
16 they're not at the table, and that's my fault. What
17 I thought was important was for CAP to, the citizen
18 people first, and then you decide, you decide. It's
19 given that, honestly, there's a lot of anger, and
20 there's mistrust. And so I thought that if you
21 decide to include as one of your CAP members someone
22 from the Marine Corps Headquarters or whatever,
23 that's up to you. If you make that decision, that's
24 fine with me. Also, you can invite someone to come
25 to a special meeting.

1 In fact, Morris, if you want to talk more about
2 the water modeling, you can invite someone from the
3 Marine Corps, another researcher. That's up to you.

4 And so this first meeting I wanted to just the
5 community people so that you can make that decision.

6 **MS. DYER:** I don't know if I would want them on the
7 CAP, but I would like a chair and a microphone to
8 where if we would like to speak to someone
9 specifically, and that there's someone that we want
10 here at the next meeting, we can let you know. But I
11 do believe that we do need a DOD person that will at
12 least be at the meetings and be available to ask
13 questions to if we want to.

14 You said something a little while ago that I
15 want to address because it was kind of a slip of the,
16 I don't know if it was out of the side of your mouth.
17 I didn't quite get it. But it was something about
18 not everyone at the ATSDR believes that we need a
19 study or that it's, the chemicals, that the exposure
20 was that high, or you said something that --

21 **DR. BOVE:** I said this at the science panel that
22 there's controversy within my agency as in any
23 agency. But in certainly our agency, about the
24 health effects of TCE, just what it causes, and that
25 is in a microcosm what is happening in the outside

1 world, which is there's this debate. And you can see
2 that others can talk about this. EPA ^ has stated, ^
3 science panel maybe we'll see it in our lifetime get
4 finalized.

5 You know, that's the level of controversy
6 around TCE. PCE is less so. But the way to do this
7 is start talking about doing a new risk assessment on
8 PCE and then I have a feeling we'll be right back up
9 there with TCE risk assessment. So that is what I,
10 that's probably what I meant is that. We have our
11 internal battles that reflect what's going on in the
12 outside, you know, in the scientific world about
13 these issues.

14 **MS. DYER:** Are your internal battles though, are they
15 high enough up that it's going to cause any
16 conflicting, any conflicts in us getting a study?

17 **DR. BOVE:** No. No, I think the question is can we,
18 is it feasible to do this scientifically, and there's
19 a scientific study we're interested in. Is it
20 feasible to do and do a credible job? Will it mean
21 something at the end of the day?

22 **MS. DYER:** But we can't, as CAP members, we're not
23 scientists so we can't answer that. So do they
24 believe that this study needs to take place and move
25 on?

1 **DR. BOVE:** One of the goals in this is so that, you
2 know, at some point we all can understand these
3 issues. What it takes, and let's just focus for a
4 minute on just the scientifically credible study.
5 What it takes to actually do a scientifically
6 credible study. What information do we need to have.
7 So you'll all understand, so you'll come to an
8 agreement on it.

9 That's so even though there are experts in the
10 room, and non-experts in the room, I'm hoping that at
11 the end of several meetings we'll be able to, we'll
12 all understand these issues and see why it is or it
13 isn't feasible. That's the goal. That's really, you
14 know, it should be left up to experts to make these
15 decisions, and also it's my opinion at least, that
16 people who are non-experts become experts rather
17 quickly in the outside world.

18 **MS. DYER:** So you're saying it's going to take
19 several meetings to decide whether it's feasible to
20 have a study?

21 **DR. BOVE:** That's what I, yeah.

22 **DR. CLAPP:** This survey, Tarawa Terrace or larger
23 surveys. That's what we're talking about, right?

24 **MS. DYER:** Tarawa Terrace, because I thought we were,
25 my thinking was was that we were getting together

1 here to decide who the cohorts were going to be and
2 then move on. And so that's why we were coming
3 together to say that we felt like that the cohort
4 should be Tarawa Terrace, that that was a good place
5 to start because we have a year, 1960, that we can
6 start with as far as being able to notify people.

7 And that's why we're ready to move on with
8 trying to notify them and get a survey going. And
9 then once the survey comes in, you can decide once
10 you see the different illnesses what kind of studies
11 need to be done.

12 **DR. CLAPP:** Let me pose a dilemma here. Suppose you
13 put out a PSA and say everybody that ever lived in --
14 I'll try to pronounce this right -- Tarawa Terrace
15 (pronouncing).

16 **MS. DYER:** Tarawa Terrace. We all say it the same.
17 TT.

18 **DR. CLAPP:** And somebody who has an axe to grind
19 says, you know, I actually am a member of an
20 organization that can respond to that. And none of
21 us lived in that area, but we're going to say we
22 lived in there. There's nothing wrong with us. How
23 would you know?

24 **MS. DYER:** Well, that's when you go back to your
25 archives of who lived there. That's where we were

1 just given this information, and so we'll have that.
2 We'll know if you lived there or not. And as far as
3 like putting out a PSA, it's going to be somebody
4 like this gentleman on the end that knows how to
5 speak well and can write out a PSA that would reach
6 the people we need to without saying all the diseases
7 like we were talking about before. But it can be
8 done.

9 **DR. CLAPP:** And that all can be done. I agree. And
10 then the question is how many would respond to that.
11 How many people would see that PSA and say, yeah, I
12 don't know if I'm sick or my family, but I'll still,
13 I'll put in my two-cents worth on this survey.
14 That's what, we're talking about a response rate here
15 is the term. And if it's really low then you don't
16 know what you've got. You may just get the list of
17 the sick people and sort of volunteers that came
18 forward saying, yeah, I'm sick and I think it was
19 caused by whatever I drank there. And that's, it's
20 not even the disease burden.

21 **MS. McCALL:** Well, we have to start somewhere with
22 something.

23 **MR. ENSMINGER:** That's why I was asking about these
24 databases. I mean, we've got to find out from DOD
25 what they've got available from the Marine Corps,

1 from the Department of the Navy. What kind of
2 records you've got available. Can we seek these
3 people out and find them without doing a public
4 service announcement, can we find these people? Can
5 we dig through these records, find these people, find
6 out their last known address prior to leaving the
7 service and try to track them down? That's the
8 question.

9 (Whereupon, Dr. Fisher left the meeting.)

10 **MS. DYER:** Is someone from the DOD here that would
11 respond to that today?

12 **MR. STALLARD:** Hold on just a moment, we have some
13 competing voices.

14 Tom, what's your question?

15 **MR. TOWNSEND (by telephone):** My question is I have a
16 comment on the public service announcement. ^ went
17 through a media blitz about 2002, contacted virtually
18 every radio station and television station and every
19 newspaper in the United States, and they didn't even
20 do a market penetration. And I checked on about a
21 hundred different places, a hundred different
22 facilities, TV, radio and newspaper, and none of them
23 ran the story. It's too old. It's a dead fish in an
24 old newspaper. It's not going to work.

25 You've got to personally contact these people,

1 and the way to personally contact them is to have DOD
2 get off its butt and start notifying the individuals
3 that were exposed. This is just ludicrous. I mean,
4 a public service announcement's going to be put in
5 small print some place in a county newspaper, and no
6 one's going to respond. And there is a case, there
7 is a chance for fraud. There's some fraud in the ^.
8 But what the hell, that's the chance you take when
9 you put an announcement out.

10 I'm very angry that 500,000 of my fellow
11 Marines, at least that many, have been exposed to
12 this crap, and the government of the United States
13 that expects us to go off to war, and I've been in
14 the Marine Corps since 1949, prior to Korea, and
15 won't do, and just absolves itself from
16 responsibility and accountability. The least they
17 could do for us is have a morally, ethical base and
18 go out and start looking for the damn people.

19 I have three serial numbers, three numbers that
20 identify me. I have an enlisted serial number, ^
21 serial number and a social security number. My God,
22 if they can't find where the hell I'm at and what's
23 going on with my family, then there's something
24 bloody wrong with the system.

25 **MS. DYER:** They know where Tom is.

1 **MR. STALLARD:** I just would like to point something
2 out as a matter of procedure. I've reminded this
3 audience to be here to listen and not participate,
4 that we are finding ourselves finding the very people
5 that would participate would be in the audience. So
6 we're going to have to figure that out in terms of
7 ground rules for future meetings. Terry has
8 suggested that we'll have a place and that if you
9 come in as the audience, you may be called to respond
10 to the CAP. So at this point in time --

11 **DR. BOVE:** We'd like to, if we can, identify those
12 people beforehand to make sure they're here and want
13 to do it. We want to know beforehand, not the day of
14 it.

15 **MS. DYER:** I understand that a lot of them,
16 especially at the DOD, are going to have to go back,
17 and they're going to have to get permission for the
18 things they say. And so whoever comes back is going
19 to need to be someone that's going to be able to
20 speak for them and answer questions and give answers
21 to them.

22 **MR. STALLARD:** Okay, and so for the purpose of today,
23 the ^ that represent DOD ^^^, and specifically this
24 CAP is asking for a senior person to work with
25 directly. There have also been specific questions

1 that have come up that the responses were ^. You're
2 under no obligation to respond. If you choose to and
3 would like to, you may in terms of the specific
4 question that has been imposed. All you have to do
5 is say if I can respond to that.

6 All right, now Jeff.

7 **MR. BYRON:** Real quick. I lost my train of thought,
8 sorry. Go ahead with someone else first.

9 **MS. DYER:** I think he was wondering if you wanted him
10 to answer the question.

11 **MR. STALLARD:** I don't know.

12 **UNIDENTIFIED SPEAKER:** Do you want us to respond
13 today or take the questions back to respond at the
14 next meeting? This is your forum. We're happy to
15 participate, but we're not sure what the ground rules
16 --

17 **MR. STALLARD:** We're not either.

18 **MR. MARTIN:** If we asked you to respond at the next
19 meeting, that would assure we have another meeting.

20 **MS. DYER:** But the question was from Jerry is are you
21 willing to give us the records we need to get hold of
22 the people we need to get hold of?

23 **UNIDENTIFIED SPEAKER:** Do you want me to come to the
24 microphone and say who I am?

25 **DR. RENNIX:** I'm Dr. Chris Rennix. I'm an

1 epidemiologist from the Navy Environmental Health Center

2 --

3 **COURT REPORTER:** The mike's not working. I can't
4 hear you. The mike's not working.

5 **DR. RENNIX:** All right, I'm Dr. Chris Rennix. I'm an
6 epidemiologist at the Navy Environmental Health Center. I
7 was at the last meeting as an active-duty Captain and
8 I retired. And your question ^ because the Navy, the
9 military collects information for a specific purpose
10 and we just can't turn over a list to private
11 citizens.

12 **MR. ENSMINGER:** No, no, I didn't mean to me.

13 **DR. RENNIX:** You said you turn that list over to us,
14 and we'll find them.

15 **MR. ENSMINGER:** I meant to the agency.

16 **DR. RENNIX:** We, Dr. Bove and I have gone back and
17 forth trying to identify databases of value that they
18 can use to grab information. We know that there are
19 some databases, I'm sorry. We know that there are
20 some files out there that are not databases that may
21 have some value going back into the '60s. But
22 they're not databases, and the problem is they're
23 just long distances sitting in a file folder
24 somewhere that DMDC hasn't had a request for in 30
25 years, and they've forgotten that they're there, and

1 the guy that used to manage it, retired.

2 So you have to go and really aggressively seek
3 these, not databases, but just records and where to
4 get them. But they're not going to be, the service
5 back in the '60s kept their own system. I'm an
6 expert in the Army systems. That's where I do my
7 research, and I can go back to 1964 and find officer
8 and enlisted records. No family records, no
9 beneficiaries, just the fact that they were in the
10 active service and what their job was.

11 So yes, there are records that are available at
12 the VA. When a person gets out, part of your
13 discharge process is you have to give a record, a
14 place where they can contact you. From my experience
15 trying to locate people, they're not there any more.
16 They've gone.

17 Another issue is that 75 percent ^^ five years
18 old. So huge holes in the people you're really
19 looking for were only in the service for one tour,
20 probably, maybe a tour and a half against six years.
21 So the volume of address that you have to go and find
22 again becomes a huge hill.

23 I was looking at 350,000 women and was only
24 able to locate a very small portion of those for my
25 study. They don't tell the service, oh, I've moved;

1 I've moved; I've moved. They only tell them once and
2 that's it unless they're getting a check but that's
3 not that 25 year old Marine who got out. So it's
4 just difficult. The records may be there. But can
5 we use those records to further the search is the
6 question.

7 **MS. BRIDGES:** And how credible will they be with all
8 the children that we're talking about with all the
9 problems they had, learning problems or disabilities,
10 they're not the run-of-the-mill-type people that you
11 can locate quickly. They might be in Timbuktu or a
12 rehab hospital, in prison. They may be dead. They
13 may be living in a, you know, these people are, these
14 are sick people that we have.

15 **MR. ENSMINGER:** What we're talking about is finding a
16 sponsor. If we can find sponsors, we can find the
17 kids if the sponsors are alive.

18 **MR. MARTIN:** We're talking 30, 40 years ago.

19 **MS. McCALL:** Well, then my question is which one is
20 harder, using military records or using the media
21 with the PSA? Which one is going to pose less
22 barriers and obstacles? I think having people
23 respond voluntarily is an easier mechanism than
24 trying to go back 30 years, 20 years and try and find
25 somebody who lived at Camp Lejeune maybe one year.

1 It doesn't matter. People if they're sick, they will
2 respond.

3 If I'm sick, and I don't know why, and I see
4 something on TV that might explain why I'm so sick, I
5 would respond whether, I responded to the in utero
6 study. They didn't ask for me, but I responded
7 anyway because I believed something that, something
8 happened to me. I don't know what it was, but I got
9 so sick. I am so sick compared to people my age in
10 my family, I'm the sickest one around for blocks. So
11 I don't really buy that, you know, there's going to
12 be a lot of fraud, and can't help it. If people are
13 truly, genuinely sick, they will respond, and they
14 will have medical records for verification.

15 I know the hurdle you have in trying to find
16 people, using the military records. To me in my mind
17 it doesn't make any sense to do it that way because
18 all you have are old addresses. If we can't use
19 social security numbers, then why can't we just try
20 to reach people and have them voluntarily call in and
21 start there? We can sit out here all day and talk
22 about how hard it is to notify people, but we can't
23 do that anymore. We just need to try. That's all we
24 can do. We just need to try. It's very important.

25 **MS. DYER:** Yet if we don't notify them, how are we

1 going to get a study going? And when we were in
2 Washington last time, one of the things that was
3 stated was we asked them are you going to help us
4 with notification? And at that time they said no
5 because they said they felt like that they had
6 notified everybody that needed to be notified.

7 But now we're here today to say we want another
8 study. We want a study of the children and adults
9 that lived out there. So if that's the case, they've
10 got to be notified. Now one way if it looks like
11 they're going to be able to be notified is if the
12 Marine Corps will agree again to do a media blitz.

13 **MS. McCALL:** I would like to --

14 **MS. RUCKART:** I agree that the only --

15 **MR. STALLARD:** Excuse me just one moment. Do we have
16 more questions?

17 **MS. RUCKART:** I agree with you that the only way that
18 you can tell if a PSA or some kind of notification
19 effort is going to work is to do it. We can have
20 some anecdotal information to suggest whether it
21 would work or not. But I just wanted to kind of
22 remind everyone of something.

23 Everyone here is very concerned about what
24 happened at Camp Lejeune and these exposures. And
25 there are many other people who are not here today

1 who are also very concerned. But there are some
2 people who are not as concerned, and they may have
3 health defects.

4 And they may not want to participate because we
5 have, as I tried to express to you, undertaken this
6 very thorough effort to try to get records. And you
7 would think why aren't these people helping. You
8 know, why didn't they report during the survey that
9 they had whatever, and we've had to contact them so
10 many times, and sometimes it results in getting some
11 records and sometimes it doesn't. So I just wanted
12 to kind of point that out that there will be some
13 people like that. We have to acknowledge that.

14 **MS. DYER:** Sure.

15 **MR. MARTIN:** Right.

16 **MS. McCALL:** Sure, I'm positive.

17 **MR. MARTIN:** You can't force cooperation. There
18 again I think there's enough people involved in this
19 incident, enough people that were exposed that if
20 they were aware of it, your phones would be ringing
21 off the hook. If you get comments now, your phone's
22 ringing off the hook, and they're not getting called
23 back. So, and I, you know, that's not accusing you
24 of anything. That's what we're hearing is they had
25 called the ATSDR, did not get calls back.

1 **MR. STALLARD:** Dr. Rennix has chosen to come up here
2 to answer some of the questions you had specifically
3 for him. So if you have a question for Dr. Rennix,
4 thank you very much.

5 **MR. BYRON:** Okay, my question is -- I have my train
6 of thought back now. You have 12,598 families
7 identified right now that you had some kind of record
8 of as far as contact. What's the matter with a
9 sampling of those individuals, siblings, of the kids
10 who were in utero study and the parents, and then go
11 from there based on population of 12,598 what's the
12 percentage of sick people.

13 **MS. RUCKART:** Well, the thing is we had those people
14 in the survey and that survey occurred during 1999 to
15 2002. And you say, well, gee, that's only four to
16 how many years ago. It's not that long ago and we're
17 not talking about like the 1960s. And you know,
18 we're talking about this is a transient population.
19 A lot of those people have even moved since as
20 recently as 2002, so it's not as simple as just going
21 back to the address they reported at that time.
22 That's why we had to go back ^ and try to locate
23 those people.

24 So that is a starting point like you're saying
25 to contact the people or other family members. All

1 we know about is their in utero child. I do want to
2 let you know that it's not as simple as just sending
3 it out to the most recent address. There's still a
4 lot of work involved to find out where are they today
5 four plus years in the future.

6 And that's why some people who were part of the
7 survey could not be part of the study because we
8 couldn't find them. So there is some work that could
9 be done there, but it's not a perfect universe.

10 **MR. BYRON:** Right, right, I wasn't expecting to and
11 that's why I said the same.

12 **MR. MARTIN:** And attached to your public service
13 announcement, if you participated in the in utero
14 survey, call this number immediately. You know, just
15 add something to the public service announcement.

16 **DR. BOVE:** Yeah, I mean, again, what I've been trying
17 to say --

18 **MR. MARTIN:** I mean, there's got to be a starting
19 point. We can sit here and make excuses all day, why
20 we can't do it.

21 **DR. BOVE:** There has to be a starting point. The
22 Science Advisory Panel gave us the starting point and
23 that was the mortality study, a scientifically
24 credible mortality study. That's what they were
25 talking about, and if you have social security

1 numbers or if you have full name and date of birth,
2 there's a National Data Index and that can be done.
3 And I think that that definitely can be done.

4 And I think that there are -- the question is
5 not whether it can be done. The question is how far
6 back can we go? The machine ^ was computerized and
7 goes back to the early '70s. What Dr. Rennix was
8 mentioning were files that aren't computerized that
9 we have to see what is available from the Marine
10 Corps. He knows about the Army ^ the Marine Corps to
11 see if you can go back further than the early '70s.
12 The further back, I think, the better.

13 But that's the question. But certainly from
14 the early '70s on, from '72 to '85, I think it's
15 pretty feasible to do a mortality study across the
16 country by the National Death Index, so that can be
17 done I'm convinced. But we'll work, there are some
18 finer details to work on to make sure that it can be
19 done, and that's what we're trying to pursue now and
20 see what data's --

21 **MS. McCALL:** Did you just get convinced today or have
22 you been convinced about the mortality?

23 **DR. BOVE:** I was convinced back in February.

24 **MS. DYER:** Back in February, last year? You were
25 convinced then to --

1 **DR. BOVE:** We pretty much believe the Panel we'll
2 look into the feasibility of it, yeah.

3 **MS. DYER:** Could you go ahead and start it then if
4 you agreed with the Panel a year ago? Couldn't you
5 have already gone ahead and started it then and done
6 it?

7 **DR. BOVE:** We started to identify databases. That's
8 as far as we got.

9 **MS. DYER:** In a year.

10 **DR. BOVE:** Right, between other things, projects.

11 **MS. DYER:** Is there a group within the ATSDR that is
12 only doing Camp Lejeune?

13 **DR. BOVE:** There's Perri and Shannon, well, no.

14 **MS. RUCKART:** We don't only do Camp Lejeune.

15 **DR. BOVE:** They don't only do Camp Lejeune.

16 **MS. RUCKART:** We only do Camp Lejeune as far as
17 there's no other people in the agency doing Camp
18 Lejeune, but we don't only work on Camp Lejeune.

19 **MS. DYER:** And see that's our frustration, and I know
20 you understand that, but I mean I think I need to
21 give it to you again. This is taking too long. I
22 mean it's been a year since they, that we got
23 together last year. It took a year to get the CAP
24 together. A year, do you know how many people have
25 died or gotten sick during that year?

1 We as the CAP members, each one of these people
2 have a responsibility, not to ourselves and our
3 family only, but to the thousands of other people
4 that are out there that are sick and some of them
5 don't know it. We've got to do something. We've got
6 to get them notified. We've got to get a survey
7 going, and we can't wait another six months or
8 another year to start this.

9 **DR. BOVE:** The water data, the water modeling won't
10 be done, and again, until 2007. These things take
11 time as Dr. Clapp was mentioning. During the process
12 of doing any of these activities, people will be
13 dying from these exposures, getting sick from these
14 exposures. There's nothing we can do about it.

15 So that's, that's happening, but let's focus if
16 we can on what we can do to put the data that's
17 available, what makes sense to do in terms of what
18 our purpose is, what we really want to see happen to
19 the community. Speed is important, but we have to,
20 whatever you're going to do, you have to do it right,
21 too. So that's all I'm saying.

22 **MR. MARTIN:** The only thing I see --

23 **DR. BOVE:** A mortality study will not necessarily
24 take a long period of time. Once we have learned
25 exposure situations set, and we know the data, we can

1 get. If we have to computerize files that are
2 scattered around, that's going to take time. So the
3 question will be really how long will it take to go
4 beyond the early '70s back to the '60s.

5 How much time will it take to computerize all
6 those records so we can actually send them to the
7 National Death Index to see what we've got. We're
8 doing that because we want to move more quickly,
9 we'll stop at the early '70s, but that leaves the
10 people before that out of the study.

11 So these are the, there are trade-offs, and
12 that's, these are things I want us to grapple with
13 because I don't want to make that decision. But you
14 know, if you want to move further back in time, it's
15 going to take more time, but it may be worth taking
16 that time. On the other hand you may decide that it
17 takes too much time and want to know now or as soon
18 as possible and you go with those computerized.

19 That's why the two studies, the previous study
20 and this study, stop at '68. Not because we thought
21 the exposures ended or weren't there before '68. ^.
22 We knew the exposures were at least as far back as
23 '68. We thought they were earlier, but the
24 computerized birth certificates weren't available
25 till '68. That's the reason, pure and simple,

1 because to go further back in time would take even
2 more time and ^ computerized records.

3 **MR. TOWNSEND (by telephone):** Frank? Frank?

4 **DR. BOVE:** Yeah?

5 **MR. TOWNSEND (by telephone):** The vital statistics
6 people in the state of North Carolina are more than
7 willing to put that stuff they have on paper onto a
8 database if you pay them the money to do it. I am
9 particularly outraged because when you draw the line
10 in 1970, what the hell happens to the people in the
11 1960s or 1950s? That stuff is available in North
12 Carolina. I don't care if it's on paper, they have
13 every kid that was born in the naval hospital at Camp
14 Lejuene has two birth certificates. He's got one
15 from the Navy, and he's got one from the state of
16 North Carolina, and God damn it, you can find that
17 stuff and start getting off your butts and looking
18 for it.

19 **DR. BOVE:** Tom, Tom, let's -- first of all, birth
20 defects were not put, not captured on the birth
21 certificate in North Carolina until 1978.

22 **UNIDENTIFIED SPEAKER:** Sixty-eight.

23 **DR. BOVE:** 'Seventy-eight, '78. When they were
24 captured, they did a horrible job because they had
25 the ^^ database. There were very few birth defects

1 listed, and it's impossible; it's impossible. I know
2 you can't do a birth defects study using birth
3 certificates; I know that. I've seen it in New
4 Jersey how poorly it's done. This is really bad. I
5 mean, this is useless. It's just useless.

6 So that's why we're not, if we get a birth
7 certificate from after '78, and it doesn't say
8 anything about birth defects, we don't say, okay,
9 they don't have a birth defect. We just say, well,
10 we can't use birth certificates to help verify
11 because we know that the birth certificate is missing
12 most, virtually all, of the major birth defects, I'm
13 not talking about minor, but major.

14 **MR. TOWNSEND (by telephone):** No one has mentioned
15 the fact that the National Archives, the records
16 center for NARA, has most of those health records of
17 all the military people that have ever been in the
18 military. I mean, have they been required to come up
19 with that stuff?

20 **MS. ROSSITER:** I went to the --

21 **MR. TOWNSEND (by telephone):** At NARA, the national
22 records center.

23 **MR. STALLARD:** Tom, we have Shannon who's going to
24 respond to that question.

25 **MS. ROSSITER:** I went to the facility in St. Louis

1 looking for records for this study, and they do have
2 some records. There was a fire, I believe, in the
3 1980s that destroyed a number of records.

4 **MR. TOWNSEND (by telephone):** That was the Army
5 people. It didn't affect any of the Navy or Marine
6 Corps records.

7 **MS. ROSSITER:** There were also records that they
8 don't have. They just --

9 **MR. TOWNSEND (by telephone):** That's probably true
10 because they can't find the damn things. There's a
11 specific protocol for the records being sent to NARA.
12 NARA gives them a location, a file number and all
13 that crap, and they tell that to the Navy and the
14 Marine Corps ^ before they send the data in. And by
15 golly, if they can't find it, then there's something
16 wrong with the system.

17 **MS. ROSSITER:** I had a very good contact at St.
18 Louis, and you know, like any records filing system,
19 especially from older time periods, they're not
20 perfect. You know, a child's record may be filed
21 with his father, may be filed with his mother, may
22 have his own record. It's a good resource; it's just
23 not perfect. Nor is it automated necessarily.

24 **MS. McCALL:** That's why we need to do, we need to use
25 the media. We just keep going around in a circle.

1 Well, we can't get the records. Well, we can't get
2 this. We can talk to people through the television,
3 you know. I don't know why we just keep going around
4 and round and round trying to find people.

5 Have them find us. Have them come to us. That
6 to me makes the most sense. That gets rid of all of
7 this privacy, you know, issue. And so I don't know
8 why we're sitting here spending another hour on how
9 are we going to contact them, and how hard it's going
10 to be. Let's just contact them.

11 I mean, we can call this ^ Law Firm and ask
12 them how many idiots are calling you with, you know,
13 fraudulent cases, and we can -- people do this all
14 the time. You see the lawyers on TV. If you've been
15 injured by Vioxx, call this number. Well, I'm sure
16 there's a lot of dumb people calling out there
17 saying, well, you know, I'm sick from it. But, you
18 know, I mean, to find out how they deal with that.
19 Because to me the hurdle of contacting people is not
20 such a hurdle if we use the media.

21 **MS. DYER:** I mean, you're saying that, you know, you
22 can't use the birth certificates. You can't do this.
23 You can't do that. You said, well, you were talking
24 about birth certificates before certain years and
25 things like that so why then can we not just do a

1 survey and have someone come up with a program, a
2 computer program, that answers the questions that you
3 need answered.

4 And if you don't want to go with TT because the
5 water modeling is not done, and you want to open it
6 up to everyone then that's fine. We were just saying
7 TT because that would narrow it down until Hadnot was
8 done, and we could go ahead and start something now.

9 **DR. BOVE:** The problem is not narrowing it down, and
10 I haven't ruled out anything. All I'm saying, I'm
11 pointing out the limitations of the dataset so we
12 have some sense of what we can do with it, and what
13 we can't do with it. But I didn't say anything about
14 we can't do a survey. I didn't say anything about we
15 can't do a study. I didn't say that at all. In
16 fact, I don't agree with that.

17 **MR. MARTIN:** I see one major limitation though is
18 just having two people that are there or capable of
19 answering the phone. I mean, I meant no disrespect
20 when I said you weren't returning their phone calls.
21 But I understand, I mean, 50 percent of your time is
22 on the phone with us. So that's very limited.

23 We need to find a resource. We need to find
24 some scientific agency that wants these same answers
25 that are so inconclusive from all their studies in

1 their animal research, and also, the private sector
2 or something that will establish an office, a phone,
3 where people can call in 24 hours a day with a staff
4 that can answer their questions, that can screen some
5 of these people that are going to call and say, oh, I
6 think I lived in Tarawa Terrace. You know, if they
7 know anything about Tarawa Terrace, and if they were
8 a kid at Tarawa Terrace, they're going to be able to
9 answer some specific questions.

10 **DR. BOVE:** Two things: one, let me go back to what
11 you said. The same problem we have with Tarawa
12 Terrace, we have with Hadnot Point Boulevard. The
13 datasets aren't distinguished by where they lived.
14 In order to identify who lived in Tarawa Terrace, it
15 would be the same problems that everybody's having ^
16 or any place on this. It's going to be the same
17 problem. The difference will be whether you're a
18 civilian or an enlisted. That would be one big
19 difference. Whether you're an active or inactive,
20 that'd tell you another difference. There'll
21 probably be some others so it doesn't matter.

22 Narrowing of Tarawa Terrace doesn't really
23 narrow anything because what we have to do for Tarawa
24 Terrace is the same problem with the entire base. So
25 that's, you could narrow it for Tarawa Terrace for

1 other reasons, maybe you just want to focus on PCE
2 and not TCE or whatever. But it won't make a
3 difference in terms of the data availability.

4 Your issue, the problem, if we want to do a
5 survey, then we will have what you suggested, an
6 office with staffing. We design the survey so that
7 people can call in, whatever is easier. We have
8 people calling in, maybe it would be electronic and
9 it went over the web, whatever. I mean we can
10 discuss this.

11 I don't expect us to come up with any answers
12 today. I know there are people that say they want
13 to, but I don't think that was realistic. These are
14 tough issues. They're not that easy, even to devise
15 a good survey. I think you want to do a good survey.
16 There are some steps, like anything, fixing a car or
17 anything, there are some steps. And so that's what
18 we want to do. Plus, the data, doing this National
19 Death Index mortality study.

20 So that's -- say that's what we decide to do,
21 then we would talk about just how we would set it up
22 so people could call in. There'd be a staff, finding
23 the resources for that, the best way to do it. And
24 that's what we're here for.

25 **MS. DYER:** Okay, if we decide on those two things,

1 and we put kind of a little sideline to the survey, I
2 don't think that the question -- and I could be
3 wrong, and I apologize if I'm asking this again and
4 it was already answered, but I don't think it was --
5 is DOD going to give us or will they get in contact
6 with the people that lived on base again?

7 Will you do another media blitz? Will you get
8 in touch with the people so that we've got callers
9 coming in? Are you going to help us? Are you going
10 to get in contact with people? Are you going to help
11 us get in touch with the people that we need to? If
12 they can't do it, if they don't have the resources to
13 do it, then it's got to come from you all. And we
14 can't move on it seems like until we get some of
15 these people notified.

16 **DR. BOVE:** Well, we will need to do that first before
17 we ask that question. We need to tell them what we
18 want done. We need to sit down and say these are the
19 stats, and this is where you come in. This is your
20 piece. This is what you have to do in order for this
21 to work.

22 If we give it to them that way, then they can
23 vote it up or down, whatever they decide. And then
24 if they say no, then there are steps we can take. If
25 they say yes, then there are steps we can take and so

1 on and so forth. But you can't ask them that
2 question until we can tell them exactly what we
3 really want to do because they won't know how to
4 answer that.

5 **MR. MARTIN:** As you said also, it's going to take
6 steps.

7 **MS. DYER:** Do you know what we want to do? I mean --

8 **DR. BOVE:** That's what this process is about.

9 **MS. DYER:** But it seems like -- I don't know, and I
10 could be wrong, but it seems like you've already
11 decided you know in your mind what needs to be done,
12 and if that's the case then tell us. We're telling
13 you and it's not --

14 **DR. BOVE:** Just like the science panel said about the
15 mortality study, I think we should do that.

16 **MR. MARTIN:** Present them with a plan. This is what
17 we'd like to do.

18 **MR. BYRON:** On page seven, right here on page seven.
19 The ATSDR agrees that mortality and cancer incidents
20 should be receiving the highest priority.

21 **DR. BOVE:** And that's the only thing that's set in my
22 mind, and the rest is wide open. You know, I'd like
23 to do a cancer study. There's a lot of things I'd
24 like to do. But the question's whether it's possible
25 to do it, you know, whether the data's there to do

1 it, and then of course whether the resources are
2 there, and we can get the resources to do it. But
3 there's a lot of things I'd like to do, and there's a
4 lot of things you'd like to see happen, too. So I
5 wouldn't rule anything out.

6 **MR. STALLARD:** Well, folks, you can hear me. We're
7 getting close to lunch and so --

8 **MS. BRIDGES:** I just want one thing.

9 **MR. STALLARD:** You do. The sandwiches are out there,
10 but go ahead.

11 **MS. BRIDGES:** We're talking about three generations
12 ago. We've got proof. We know. Why can't the three
13 generations be studied? We're talking about three
14 generations that these chemicals are being passed
15 from one to the other. And children were altered by
16 it. From our children and going down to our
17 grandchildren, exactly the same. Our grandchildren
18 are reliving what our children did. And back and
19 forth it's the same thing. At TT, ^ can tell you the
20 same thing that I could tell you about our children.
21 The last meeting I wasn't here. I didn't come in
22 that one first day. Jeff got up and I guess --

23 **MS. RUCKART:** Sandra, you need to talk into the
24 microphone.

25 **MS. BRIDGES:** He was talking about his children and

1 what their problems were. I wasn't even here that
2 day. Some other woman got up and talked about her
3 daughter. I wasn't here that day, and I came in the
4 second day. Well, I came in and I said my speech, my
5 spiel. It was exactly the same as Jeff and Mary
6 Byron's children. My children's problems were the
7 same as his children. His grandchildren are
8 experiencing the same thing that mine are. I'm just
9 a little older, and mine are going through it a
10 little earlier.

11 **MR. STALLARD:** Okay, when we come back, I'm going to
12 --

13 **MS. BRIDGES:** That's not fair. It's not fair that
14 we're not doing something now to stop it. If my
15 child knew, if my son knew he was going to pass his
16 handicaps on, do you think he'd have children? No.

17 **MR. STALLARD:** Thank you, Sandra. I have captured a
18 generational study in terms of whatever we do.

19 Folks, what you're talking about here is bigger
20 than a survey. It's a coordinated media campaign
21 really to reach the people that you're talking with
22 support, specific support, that needs to be detailed
23 out in terms of what you want from our partners in
24 this effort to contribute. And if that's
25 notification, then that has to be put together in a

1 very detailed methodological approach. And it seems
2 that we're working toward that dialogue right now.

3 **MS. BRIDGES:** We need to do it soon.

4 **MR. STALLARD:** Well, you have this afternoon to work
5 out a plan or at least put more meat on the bones
6 here.

7 So I'd like to propose that the audience may
8 leave, and we'll resume in an hour and 15 minutes.
9 You are on your own for lunch.

10 **MS. RUCKART:** We need to come back sooner. Because
11 we ran so late, I think we need to shorten our lunch
12 a bit because some people have planes to catch, and
13 we need to make sure we get to the airport on time.
14 So it's a quarter of 1:00. Let's say come back here
15 1:30.

16 **MR. STALLARD:** Okay, 1:30. Thank you.

17 **MS. RUCKART:** But the CAP members will be eating here
18 together.

19 (Whereupon, a lunch break was taken from 12:45 p.m.
20 until 1:40 p.m.)

21 **CONTINUE DISCUSSION**

22 **MR. STALLARD:** Welcome back. I think it's fair to
23 say that the notion of our working lunch didn't
24 exactly work out as planned. We continued the
25 dialogue outside here, okay.

1 When we broke for lunch, we were in a very
2 heated discussion about what can we do or what would
3 be appropriate to do. I think Jeff had --

4 **MR. BYRON:** I know that ATSDR has handed out their
5 response to the scientific panel, and clearly, ATSDR
6 is saying that they agree that the mortality and
7 cancer incidents should be the highest priority. I
8 think if that database is already there through the
9 state, I think we should all agree to proceed with
10 that right away.

11 And then the further studies that we're talking
12 about, cohort studies, prevalent studies, and so
13 forth, of the children and parents or adults at Camp
14 Lejeune, even the panels suggest that there could be
15 a parallel study going on before the in utero study
16 is finished. I think everybody here agrees that
17 there should be further study. Now the question is
18 how we're going to go about getting that
19 accomplished.

20 Perri made a lot of recommendations. I agree.
21 It's going to take a multitude of avenues to contact
22 the personnel over at Camp Lejeune because they are
23 transient. They are all over the country and some of
24 them in other parts of the world, you know. We can't
25 have DOD putting out an inch and a half notice in the

1 "Globe" or whatever that has to be read with ten
2 power magnification either.

3 I've seen some of the notices on previous
4 releases at Camp Lejeune. I'm 49 years old, and even
5 with these reading glasses, I'd still need ten power
6 magnification. So if they're going to do it, I'd
7 like to see a true concerted effort. How about a
8 one-page ad in some of these magazines? The Marine
9 Corps has the "Marine Corps Gazette." The Marine
10 Corps has the Marine Corps League as part of retired
11 marines.

12 **MS. DYER:** Websites.

13 **MR. BYRON:** ^ magazines.

14 **MS. DYER:** Marine Corps websites.

15 **MR. BYRON:** The Marine Corps websites. I mean, it
16 needs to be a true effort, not just the mealy-mouthed
17 showing of oh, here's what we did. It has to be a
18 true effort because of the differences that we have
19 had over these years. I mean, it's been for my
20 family since 1982 we started experiencing health
21 issues, documented, for my oldest daughter. It
22 continues to this day for my youngest daughter who is
23 part of this study.

24 So some little tiny ad that can't be read by
25 anybody unless you're 18 is not going to cut it. It

1 doesn't give me any trust in the Department of
2 Defense, the Marine Corps, the Department of Navy.
3 They have to make true effort not just --

4 Let me tell you, I didn't hear about this at
5 all through the media. I got a letter from the
6 organization at ATSDR, permission to do the study.
7 That's how I found out, the official letter. I never
8 saw anything in the media about it. I am in
9 Cincinnati, Ohio, so I'm not near Lejeune. If Dave
10 who lives 12 miles from Camp Lejeune doesn't know
11 anything about it, the DOD needs to make a stronger
12 concerted effort to get this notification out.

13 **MS. DYER:** I did an interview with a Jacksonville
14 television station a week ago about this meeting.
15 And I've already had several calls come to my home of
16 people that live in Jacksonville, again, that had
17 just heard about it. I'm going to read this
18 statement from the DOD, but first, you know, to talk
19 about what you're talking about.

20 It does need to be an effort by this group and
21 by the ATSDR and the DOD working with us to get the
22 word out. And if it means doing it not just one way
23 but many ways. Then if this thing is big, we just
24 have to realize this is a big thing but the only way
25 we can do it is to get it out there, whether it's

1 PSAs, whether it's we send someone around to the talk
2 shows to get it out.

3 You know, I mean, Montel was a marine. Let's
4 have someone call him that's got some push that can,
5 to make these things happens. There are people that
6 can make it happen, but we need help with that. So,
7 you know, we can send someone on the circuits, to the
8 talk shows. There are so many different ways to do
9 this. There's e-mail; there's the Internet. It's
10 worldwide now. I mean, when you put stuff out there,
11 if you put the words in Camp Lejeune, that's how
12 we're having people contact us is if you were
13 stationed at Camp Lejeune every time they put it in
14 Water Survivors comes up, and they're like whoa, what
15 is that, Water Survivors. And then they contact us.
16 We had no idea.

17 You know, so people are looking at it, but
18 there's got to be a large effort, it's going to be
19 expensive, and we have to know. Now you did a blitz
20 for the children in utero, and we know that you got a
21 response to that or you couldn't have the studies
22 that you've got. So this is a new study that we're
23 talking about so it needs to be a new effort. It
24 needs to be a bigger effort because you're talking
25 about a larger amount of people.

1 Now the DOD said, "We appreciate ATSDR taking
2 proactive steps to establish this Community
3 Assistance Panel"-- So they're happy we're here. --
4 "to look at the feasibility of conducting future
5 studies. We support this effort and continue to
6 support ATSDR's activities. Right now we are working
7 hard to identify ways to properly provide funding for
8 this important issue.

9 "In addition, we remain committed to providing
10 ATSDR with all records that may be relevant to their
11 efforts. We recognize that it is not appropriate for
12 us to determine what is relevant to the ATSDR
13 studies. We rely on ATSDR for science and answers
14 the same as the other members of the CAP."

15 In funding I would just say, you know, if
16 you're looking for ways to fund this thing, then it
17 would be up to you to go to, yourself, DOD, for the
18 funding or get Congress to appropriate funding for
19 this. Now are you going to do that or is that
20 something you're going in turn turn around and tell
21 us to do, to go to Congress to get funding for this?

22 **MS. McCALL:** We did that.

23 **MR. STALLARD:** We want to avoid putting people in the
24 audience on the spot.

25 **MS. DYER:** This time, that's right.

1 **MR. STALLARD:** I think what we have is the issue that
2 to identify senior level DOD support and point of
3 contact and develop a strategy in how to do that. If
4 that requires a Congressional approach, then so be it
5 if that's what it takes. But that is what, we, this
6 group has to come up with is a strategy to get that
7 level of support because these may not be the people
8 in the audience appropriate to respond to that, but
9 thank you for the statement.

10 So Jeff put something on the table here about
11 do we have consensus as a group that the
12 recommendation from the expert panel. Is that
13 something that we should support as an immediate
14 first step?

15 **MR. BYRON:** I say yes personally.

16 **MS. DYER:** The mortality, absolutely.

17 **MR. BYRON:** And cancer ^.

18 **MS. DYER:** And cancer, yeah.

19 **MR. BYRON:** Because the data's there in the state
20 records, right? Am I correct?

21 **DR. CLAPP:** Most states, yeah. It's not possible in
22 some states, but if there's like two or three states
23 where most of the Camp Lejeune people are located,
24 North Carolina's got to be one, but some others, you
25 could go right away to those states.

1 **MR. BYRON:** What's the possibility of having a
2 hundred percent participation anyway, right? So
3 that's not going to be the case, but the effort could
4 be put forth and probably get plenty of data.

5 **DR. BOVE:** It would be nice if we could do all 50
6 states, but that I don't think is probably feasible
7 per cancer incidence.

8 **DR. CLAPP:** I'll tell you right now you've got zero
9 for Mississippi, zero for North Dakota and a little
10 bit from Arkansas.

11 **DR. BOVE:** So I think that what you just said ^ too.
12 Identify those states with good registries going back
13 as far as '79, and they're also alive on most Camp
14 Lejeune, people from Camp Lejeune may reside because
15 the cancer registry picks up, where you lived at time
16 of diagnosis, so it would have to be places where
17 people after they've been to Camp Lejeune where they
18 tend to reside, what states. And that means someone
19 in the study. But again, it doesn't matter if
20 they're not in the study as long as there's enough in
21 the study to find something in that study that's
22 relevant to that, whether they're in the study or
23 not.

24 **MS. DYER:** Okay, so we're doing that, okay.

25 **MR. STALLARD:** Is there a consensus on that?

1 **UNIDENTIFIED SPEAKER:** ^ have a timeline for doing
2 that?

3 **DR. BOVE:** A timeline? Well, I'd have to think about
4 a timeline.

5 **MR. BYRON:** How about the starting point, right away?

6 **DR. BOVE:** The starting point would be right away,
7 and again, identifying those databases, a database
8 that will identify the people at Lejeune. And that's
9 the first thing is to see if, and go back to the
10 early '70s with the data -- you all have that sheet,
11 yes. The data may empower ^, going back to, if you
12 look at that the notes there for that DMDC, it goes
13 back to '71 for active duty and '72 for, December
14 17th, for civilians.

15 And my understanding -- but this has to be
16 checked -- is that we have their social security
17 number and that'll be helpful and in the earlier
18 years it wasn't filled in. I'll have to see exactly
19 what that means. But certainly from the mid-'70s on
20 they did. So that's what this database can tell us.

21 Now to go beyond that, to go back to '65 as Dr.
22 Rennix was talking about, there's data in storage
23 somewhere that's not computerized. So we'd have to
24 see exactly what that is and how hard it would be or
25 how long it would take to computerize. These are

1 things I have to find out.

2 **MR. ENSMINGER:** It's computerized, isn't it? It's on
3 disk.

4 **DR. BOVE:** It's on disk. It's not in a database.
5 It's text files. Yeah, and they shouldn't take that
6 -- and correct me if I'm wrong, Chris -- and it
7 shouldn't take that much time to convert text to ^.
8 So I think the problem will be identifying where they
9 are ^.

10 **MS. DYER:** Can I ask you a question? The mortality
11 study, some of these people that have had autopsies
12 done, if you can't find medical, you know, records on
13 them, isn't the state required to keep the autopsy
14 reports for an indefinite period of time?

15 **DR. BOVE:** The National Death Index has death
16 certificate information.

17 **MS. DYER:** Death certificate, but what about autopsy
18 reports?

19 **MR. MARTIN:** You have to go back to the hospital.

20 **DR. BOVE:** You have to go back to the -- yeah, yeah.
21 But at least we can follow them. You know, it's not
22 impossible.

23 **MS. DYER:** Because the hospital that I'm talking
24 about is saying that they don't keep that
25 information. And then I went to the state, and it

1 can't be found. So I'm just, I mean, I thought there
2 was some kind of law that autopsy reports had to be
3 kept on record somewhere.

4 **DR. BOVE:** I can't answer that.

5 **MS. McCALL:** And Terry, they only do autopsies when
6 somebody dies without anybody, I mean, sight unseen.
7 That's the only time they do an autopsy.

8 **MS. DYER:** That's not the only time they do an
9 autopsy.

10 **DR. BOVE:** But the mortality studies we're talking
11 about would use the death certificate information.
12 And if you wanted to do something, a special study
13 on, that required some further information besides
14 the death certificate, we would have to look into
15 that for cancer incidence, which is preferable to
16 cancer mortality in many instances. That's where we
17 have to go to cancer registries. Then we may know.
18 We only do certain states. That would make sense.

19 **MR. ENSMINGER:** Dr. Clapp and I were just sitting up
20 here talking about this. From my experience in 24
21 and a half years in the Marine Corps and then doing a
22 tour as a drill instructor, Texas, Pennsylvania,
23 Ohio, California and New York are all big states for
24 the Marine Corps. I mean, if you took everybody from
25 those five states that were in the Marine Corps and

1 put them all in one big formation, you'd have
2 probably 50 percent of the Marine Corps.

3 **MR. STALLARD:** Name those states again.

4 **MR. ENSMINGER:** Texas, Pennsylvania, Ohio, California
5 and New York.

6 **MS. DYER:** And North Carolina.

7 **MR. MARTIN:** They grew up in the Marine Corps so they
8 all leave.

9 **MS. DYER:** That's not necessarily. You might not
10 have a Jacksonville if it wasn't for the Marine
11 Corps. So a lot of those guys that stayed around and
12 retired, I mean, my family has, so North Carolina
13 also.

14 **MR. ENSMINGER:** You're talking about retirees, but
15 I'm talking about the largest portion of the people
16 you're looking for did not stay in the Marine Corps.
17 You know, 20 percent, more than that. I mean, I'd
18 say 80 to 90 percent of the people that go in the,
19 join the service, do one tour, and they get out, and
20 they go home. So you're looking at a handful that
21 stayed in and retired.

22 **MR. MARTIN:** Yeah, but now the, a lot of dependents
23 stayed in North Carolina. Now as far as our
24 statistics and the people that we have registered on
25 our site --

1 **MR. ENSMINGER:** If the man is retired.

2 **MR. MARTIN:** -- the majority of them are still in
3 North Carolina.

4 **MR. ENSMINGER:** But the people that did one or two
5 tours in the service or enlistments, and when they
6 got out, they went back home and their kids went with
7 them. I think these five states right here would
8 give you a, and they have good cancer registries
9 according to Dr. Clapp.

10 **DR. CLAPP:** They all do. Those would all be possible
11 to do this --

12 **MR. MARTIN:** Now as far as the mortality study, is
13 that going to give any type of weight or precedence
14 toward continuing further studies? I mean are we
15 going to go from the cancer to kidney disease to
16 parathyroid disease to -- I mean where will we, what
17 information is that going to provide us?

18 **DR. BOVE:** Well, it just provides, if it's a
19 mortality study, just mortality. It will just
20 provide us with various diseases. If you want to
21 study something that is not a major cause of death,
22 you have to go to another type of study. Some of the
23 diseases mentioned will not necessarily kill you. So
24 you'd have to figure out a different way to study
25 those if you decided to study.

1 The mortality study can stand on its own. ^
2 stand on its own. It doesn't have to lead to
3 something else or not lead to something. And the
4 answer to that question is do we see any excess
5 mortality, and for cancer it's the same thing. Do we
6 see an excess of any particular cancers. And again,
7 you're not going to get everybody. The question for
8 the, you know, it's true that those have a short,
9 have one tour or one tour and a half or two tours,
10 and so the question there would be, even so, the
11 people who are in the CHAMPS database for a lengthy
12 period of time, that they're not that different from
13 the people who aren't in that CHAMPS database, from
14 people who just go in and go out quickly, we can
15 still learn important information based on that
16 population than generalized ^. So keep that in mind.

17 Again, just like New Jersey, the state of New
18 Jersey, doesn't mean that what happened in New Jersey
19 isn't relevant to everyone who's exposed ^. So
20 again, by looking at this light post it might, it
21 sheds information on everybody, even the ones that
22 weren't in that light post. The question is is there
23 enough to study or, and then the second question, are
24 they so different from the people who weren't in that
25 database, and is it related to their drinking water

1 exposures, how ^ would be unlikely. So I think we
2 can learn a lot even though ^ numbers ^. I wouldn't
3 put down that database quite yet because I think
4 it's, it might be worthwhile.

5 **MS. DYER:** All right, so we've got the mortality
6 study. What about adding the civilian women that
7 were in utero -- they weren't, that worked on base to
8 your current study? I know that, can we add it
9 along? Can it be parallel?

10 **DR. BOVE:** That could be another study.

11 **MS. DYER:** Well, then, I mean, that might be
12 something we need to look at.

13 **DR. BOVE:** We can't change this study, but the
14 question is why would we do that?

15 **MS. DYER:** Because there were a lot of women that
16 were teaching, that were drinking that water, that
17 were working in the cafeteria, that were working on
18 base in offices, and their children are sick, too.
19 And we owe it to them to let them be a part of this
20 study.

21 **DR. BOVE:** Well, for the current study we're looking
22 at these birth defects and childhood cancers. If we
23 find something in this study it will generalize to
24 their situation. So you do not have to be in the
25 study. Just what I'm say, just like New Jersey, ^.

1 When you study New Jersey people, it's relevant to
2 Camp Lejeune.

3 Our study population in this study will only
4 find things relevant to the civilians who worked
5 there, too. So that's, you don't have to include
6 them in the study for the study to be relevant for
7 them.

8 A survey on the other hand is different. A
9 survey, if you want to find out what diseases are in
10 the civilian population who worked there, that's a
11 different question. What kinds of diseases do you
12 have predominantly and the purpose may be for some
13 screening or health services or something of that
14 sort. Then you might want to focus on that. The
15 civilian portion of this Data Manpower Data Center
16 database, I'd have to see exactly what's in there.

17 If you worked on base, you should be in, you
18 know, after '72, whatever, they should be in that
19 database. They could also be looked at again through
20 the mortality study. Any part of the cohort, any
21 cohort, we have social security number on, full name,
22 or full name and date of birth or something like that
23 we can do a mortality study on.

24 **MR. ENSMINGER:** Yeah, I want to bring one other thing
25 up on these feasibility studies. And I agree with

1 some of the statements that have been made in the
2 past, concerning exposures. And some people were
3 going to be in higher risk than others. And I agree
4 with that. Look at civilian employees.

5 You know, a guy that worked in base maintenance
6 and was running around on that base from 0800 in the
7 morning till 1700 in the evening was not exposed to a
8 lot of VOCs more than likely. That's a given.
9 However, there were high risk populations. People
10 that worked at the base laundry, not where they did
11 the dry cleaning. I'm talking about the people that
12 worked in the laundry where they washed the sheets,
13 the pillowcases, the coveralls, and then pressed
14 these things. With 1,400 parts per billion of TCE,
15 those people were working in a gas chamber because of
16 the volatility of the stuff. Those people very
17 highly susceptible to mega-doses of these chemicals.

18 It's the same thing with the active duty
19 marines. Look at the cooks for God sake. These
20 people worked in mess halls where they had steam
21 tables keeping the food hot. They had steam kettles
22 in the galley, and they had a scullery machine or
23 better known in the civilian world, dishwashing
24 machine, running 24-7. Those people worked in a gas
25 chamber.

1 And when they got off work, they didn't go home
2 to take a shower. They went back to the barracks and
3 showered. There are certain groups of people we need
4 to identify that had these mega-doses and work from
5 them. Identify these people, try to locate them, get
6 the information. That will give you the basis to
7 keep moving on this thing.

8 And the housewives and the kids that lived in
9 housing, they lived in this stuff 24-7. The women
10 cooked with it. They bathed in it. They bathed
11 children in it. They cleaned house with it. They
12 washed dishes. We didn't have dishwashers back then.

13 **MS. BRIDGES:** We had portables.

14 **MR. ENSMINGER:** But there are certain populations we
15 need to identify. We need to look at. We need to
16 locate these people, get a feel for what we've got.
17 If it justifies and bears out that these people got a
18 lot of problems, then move on.

19 **MS. DYER:** With that being said we need to go ahead
20 and do a survey. I mean, we need to talk about how
21 we can go about it; where we can get the funds and do
22 it.

23 **MR. STALLARD:** Jeff, go ahead.

24 **MR. BYRON:** Well, the only thing I'd like to see us
25 do is to go through the seven recommendations from

1 the Panel, get those over with real quick so we can
2 get back to what we're supposed to be studying.
3 We've already identified, Jerry's already identified
4 some, Terry's identified the children and, you know,
5 and the stay-at-home mothers that should be
6 identified. If we get through these seven and get
7 them out of our way real quick, we'll probably have
8 half of this done. Does anybody have a problem with
9 that? You want to go through the seven real quick
10 because I think four of them are already answered.

11 **DR. BOVE:** I did do a two-page compilation of the
12 larger document so we can work from the larger
13 document, too. This might help; it may not. But I
14 guess that the sheet that we're passing out, if you
15 go to the second page, because I think we all know
16 what the Panel charge was and the fact that there
17 needed to be a CAP.

18 But the first bullet, identify the cohorts of
19 individuals with potential exposure. The scientific
20 panel mentioned four cohorts: Those who lived on
21 base so that would include family members, or adults
22 who worked on the base but resided off the base.
23 Children who lived on the base and then those exposed
24 in utero. So those are the four cohorts they
25 identified. And that's in that bullet.

1 And then I took snippets of what they said dealing
2 with those things. The first thing, the first bullet, or
3 semi-bullet says that a pilot study may be the thing to
4 start off with they were suggesting. And then in the
5 second they also said a limited subset of the overall
6 eligible population, for example, the thing Jerry just
7 mentioned, the hottest people with the most exposure.

8 And a possible subset or some other group might be a
9 possible subset, i.e., those who we don't have any data
10 for initially as opposed to -- And I think that's what
11 the Panel spoke about. We can define that any which way
12 we want.

13 And the third point under that is that there are a
14 lot of studies that are conceivable but a lot of them are
15 extremely challenging to do, but there's agreement that a
16 study of mortality options would be feasible assuming the
17 availability of adequate personal identifiers. That
18 means being able to get those databases there as
19 mentioned to study mortality and a study of incident
20 cancer cases might be feasible as well. So that's what
21 the Panel suggested and that we should initiate ^
22 completion of the current study. That's on the second
23 page of this ^.

24 So I think we all agree about the mortality study.
25 I think we're all in agreement that, correct me if I'm

1 wrong, that we can also see what we can do with an
2 incident of cancer study because in some sense on the
3 cohort side, identifying people is somewhat the same
4 issue. The issue on the outcome side is identifying
5 those states where it makes sense to use the study given
6 how good the cancer registry is and given where a lot of
7 these end up. So I think there's probably consensus
8 about that, too? Yes?

9 (no audible response)

10 **DR. BOVE:** So the -- so that -- and for a consensus that
11 we should keep moving on it and not wait until the
12 current study is done. I'm sure you all agree with that.

13 **DR. CLAPP:** You've been listening, Frank. You have been
14 listening.

15 **MS. DYER:** Keep going.

16 **DR. BOVE:** Well, that's the end of the science panel's
17 recommendations, but other -- that are --I thought the
18 CAP. ^^ it doesn't mean there aren't other
19 recommendations here we can't discuss. Of course the
20 panel, also, they mention stuff about notification, those
21 two issues, funding and health. So if you want to
22 discuss, I'm up here.

23 **MR. STALLARD:** I am, and I do want to try to summarize
24 something here. We have basically going on, if we're
25 following the path of the recommendations, the

1 notification, the cohort studies, the mortality study,
2 right?

3 (no audible response)

4 **MR. STALLARD:** And what was that last thing you said?

5 **MR. BYRON:** Incident cancer.

6 **MR. STALLARD:** No, notification and what else?

7 **DR. BOVE:** Source of funding.

8 **MR. STALLARD:** Source of funding. They're all big
9 issues. What I'd like, and I don't want to put you on
10 the spot terribly, Frank, but the question came up in
11 terms of timelines. Assuming that we have consensus now
12 to proceed with the mortality study concurrent with
13 everything that's going on; we don't have to wait or
14 anything. Can we start talking about what that might
15 entail; what needs to be done to advance that initiative?

16 **DR. BOVE:** Well, of course, money, but let's not talk
17 about money right now because I think that ^. The very
18 first job would be to identify and talk with the people
19 who use, who work with these databases and see, in CHAMPS
20 and so on, and see what they really have. What they have
21 on paper is one thing and what the people who actually
22 work with those databases know about the data is
23 important.

24 And there has been a request made to have a
25 conference call with us, the Marines and so forth, Marine

1 personnel, I guess, who run these databases to sit down
2 and see what we have. So I think that that's the first
3 thing that has to get done. Probably have to physically
4 go out and see what data are not in these text files ^
5 physically to see what we've got and how feasible and how
6 easy it is to convert it. That needs to be done, too.
7 So that's the key thing.

8 After that we have to prepare the data to send to
9 the National Death Index, and they also, you know, as
10 part of the CDC, you have to provide funds for that type
11 of service. But that's the second. I don't know how
12 much each one costs. I think maybe we can get a deal,
13 maybe not. But we, that'll be the next step. So there's
14 a, but I haven't thought all the steps through, but I
15 think those are the key steps.

16 **MS. DYER:** What's the timeline you're looking at to
17 complete a study like that?

18 **DR. BOVE:** I don't know. It's hard to --

19 **MS. DYER:** Are we just going to do this study then or are
20 we going to go ahead and try to parallel several studies?

21 **DR. BOVE:** I don't see why, again, because the,
22 identifying the cohort in these -- ^ DMVC databases like
23 CHAMPS is like and so on, will facilitate several studies
24 I think. I mean, it doesn't, you know, and so in a sense
25 they can go sort of parallel. Once we know what cohorts

1 we can identify and how far back we can go, and what data
2 is there in terms of personal identifier information that
3 can be useful later, the National Death Index, cancer
4 registries that CHAMPS has, then I can see a couple of
5 studies going in parallel, ^, a couple of studies going
6 in parallel.

7 **MS. DYER:** Okay, if that's the case, do we need to go
8 ahead and start working with DOD or on our own to get
9 funding so that we can go ahead and get this notification
10 out because you can't do a study without people. So does
11 that need to be something that we investigate? How we
12 were going to go about specifically --

13 **DR. BOVE:** No, what the studies I'm talking about now
14 won't require notifying anybody. These are data-linkage
15 studies. We have data from identified cohorts, and we
16 link that with the cancer registry data, we won't have to
17 contact anybody. That's what's nice about those studies,
18 and the outcomes are verified. So we don't have to
19 verify the outcomes, they're already verified.

20 So those studies, you know, the outcomes can be
21 looked at this way and do not require contacting anybody.
22 So it's a ^^ with personal identifiers and so on, but we
23 don't have to track people down and contact them.

24 So for those outcomes that are not available in a
25 database, and for our study, for example, there was no

1 birth defect registry in effect in '68 ^ until 1985. The
2 cancer registry really wasn't in place with decent data
3 until the late '80s either. So if they were, if there
4 was a birth defect registry going back to '60 whatever,
5 we would have used it and we wouldn't have to worry about
6 verification. In New Jersey, I did my study without
7 contacting a soul. We did the cancer that way. We did
8 birth defects that way. We did ^ that way.

9 The endpoints that we've done are no available
10 database, no surveillance data, no registries. Those
11 endpoints are the heart of this, and that's what they
12 were saying on the Panel. They were saying that for
13 diseases you mentioned, for example, there is no thyroid
14 disease surveillance. There's no lupus surveillance
15 system. Autism growing start ^. The only way to get at
16 those is -- or one way to get at it is through a survey
17 like we did to find these birth defects. It's not the
18 best way to do it, but it may be the only way. That's
19 the problem. I wish we could have used the registry
20 method; it's a whole lot better ^. So that's, when we
21 start talking about those diseases where we don't have
22 registry for them, then that's much more difficult. We
23 need to think whether we can do it or not, whether we can
24 identify the cases through the survey or some mechanism
25 like that.

1 **MS. DYER:** All right, so can we go ahead and discuss how
2 we can get a survey going? Yes, I mean, yeah.

3 **MR. MARTIN:** I had one thought, too, and there again I'm
4 trying to address this looking on a, on a very large
5 scale of 200 to 500,000 people. And one thought that
6 came to mind with technology and computerization and
7 everything else, any type of survey or notification or
8 questionnaire that says if, did you live in Camp Lejeune,
9 North Carolina through these years, and then if so, dial
10 this number.

11 Well, they dial in and then the basically the
12 computer asks the same question when they dial in. And
13 it says, if so, please enter your number now, you know,
14 you will be contacted in the future. This is a survey by
15 the ATSDR or whatever it is. So it would actually log
16 and register their telephone number at that point.

17 Between now and the next meeting or whatever, before
18 a survey is compiled, we could come up with questions
19 that people could answer I mean as far as going down here
20 listing the diseases that we saw a majority of and start
21 out with the number of cancers or whatever and work it
22 down to a smaller scale.

23 But if people are really affected by this then there
24 are a lot of things that we could really start out saying
25 Camp Lejeune, North Carolina. Then we could go to Tarawa

1 Terrace, North Carolina. Then we could go to Inchon
2 Street, North Carolina. So all these things, it wouldn't
3 be a one-time survey questionnaire or whatever it would
4 be. You'd start at the top with the bulk of the number
5 of calls, and you would phase out a majority of those as
6 those go.

7 But at least that would give them some way to
8 contact us. And we would have not even their personal
9 information, but we would have a number where we could
10 re-contact them and just see how many calls that would
11 generate.

12 **MS. DYER:** And Jerry, you mentioned certain states a lot
13 of Marines settle in.

14 **MR. MARTIN:** New York, Texas, New Jersey.

15 **MS. DYER:** So we could --

16 **MR. ENSMINGER:** States where they have a high recruiting
17 --

18 **MS. DYER:** Then why don't we take those states and do our
19 media blitz or whatever through those states first with a
20 1-800 number and start the survey through those states
21 where you're saying --

22 **MR. ENSMINGER:** Is something like that available?

23 **MS. DYER:** Well, he said it's going to be hard, and we
24 know it's going to be hard, but it might be the only way
25 we have to get it. And that's why I'm saying let's not

1 wait three CAP meetings.

2 **DR. BOVE:** We need to wait because we need to think this
3 through because what I was saying about the mortality
4 study and the cancer incident study, I'm talking about
5 scientifically credible studies. We're back to that
6 difference between that and a survey, which is not
7 credible science but would serve some other needs.

8 From a credible scientific point of view, if you're
9 talking about looking at some of these other endpoints
10 that you don't have registries for, we have to do a lot
11 more work, a lot more work to get anywhere near coming up
12 with a credible design. Now when you're talking about a
13 survey, that's different. Because now we're not talking
14 about something that's, when it has to be scientific in
15 nature, it has to be credible in that sense.

16 But we still have to figure out what we want to do
17 with this survey. Suppose we survey 12,598 or some other
18 figure, and we have now, ten percent of people who called
19 in said they had Hashimoto's disease or something like
20 that; not often. But what do we do with this
21 information? What do you think we can do?

22 **MR. ENSMINGER:** We're going to have to get some
23 statistics like that through a survey to use as a
24 springboard for an in-depth study.

25 **DR. BOVE:** Not necessarily, no, because -- well, I mean

1 it might be a springboard; it might not. I mean, even if
2 it was a springboard, you'd still have to design a study
3 -- it's very difficult to do -- of that particular
4 disease. You'd have to figure out a way to ascertain and
5 completely verify the diagnosis, just like you're doing
6 in this study. The fact that you've done a survey and
7 ten percent of the people said they had disease X, that
8 might be interesting to some extent from a service point
9 of view or some something, but as a springboard, you
10 still have to sit down and figure out how we study this
11 disease. How can we make sure we get, you know,
12 relatively complete, ascertainment, so it's not a biased
13 ascertainment. Have we captured most of the cases of
14 that disease.

15 And then we also have to take a sample of the
16 population ^^ getting a little more technical, but that's
17 how we'd have to design the study. But I would be
18 befuddled, I think, at the first step which is how can I
19 be sure of ascertaining many or most of these cases? And
20 how can I be sure I'm sure I've verified the diagnosis?
21 How can I be sure I can contact these people? That's
22 where I'd be stymied. That's not necessarily stymied and
23 then not, no --

24 **MS. DYER:** How did you do the study in utero? I mean you
25 contacted those people, you listened to what they said

1 over the phone after a list of questions, and that's how
2 you started the study. That's what we're talking about
3 doing.

4 **DR. BOVE:** Yeah, we got those cases and then we found out
5 that how many of those cases were confirmed not to have a
6 diagnosis?

7 **UNIDENTIFIED SPEAKER:** Twenty-four, 25.

8 **DR. BOVE:** So, you know, that's what I mean.

9 **MS. DYER:** And that's what we're saying. We're saying, I
10 mean, but you've got to start somewhere so why not take
11 Tarawa Terrace through a certain year and have them
12 contact, and we start the survey. We get a list of
13 diseases. And when you start seeing that 50 percent or
14 70 percent of these people have female problems then
15 you're going to know, a red light's going to go off.

16 **DR. BOVE:** The only reason I would focus on Tarawa
17 Terrace is if I was not interested in TCE. I don't know
18 why you want to focus on Tarawa Terrace because those
19 exposures have had no ^ . ^ people in the barracks were
20 exposed. Why are you now --

21 **MS. DYER:** We're only saying Tarawa Terrace, and this is
22 what the CAP talked about last night because it's the
23 closest to being completed. And you've got Midway Park -
24 -

25 **DR. BOVE:** We're not talking about that much difference

1 in time. We're talking about a couple of months. I
2 wouldn't fixate on that difference. That's not a good
3 reason to do a survey one versus another. It's going to
4 be just as difficult to look at, identify those cases in
5 Tarawa Terrace people as it is for anybody. So that's
6 something that, you know, it's going to be difficult to
7 identify and locate these people regardless of where they
8 were located.

9 **MR. MARTIN:** Right, but it's a starting point. I mean,
10 you have to start somewhere. We can wait and start in
11 Midway Park.

12 **DR. BOVE:** You can also make a case like Jerry just said,
13 start with people most exposed first.

14 **MR. MARTIN:** Right.

15 **DR. BOVE:** There are various starting points. I don't
16 think the starting point should be because of the water
17 modeling will be done for Tarawa Terrace and then a few
18 months later for Hadnot Point, that that should make a
19 difference. I can't see that.

20 **MS. DYER:** All right, what about the children? Any
21 child, because isn't that one of the things that the
22 Panel brought up before was children seemed to be more
23 susceptible? They're lower to the ground. They're
24 immune systems have not fully developed, their
25 developmental things within their body --

1 **MR. MARTIN:** That was an ATSDR statement what the Toms
2 River study is --

3 **MS. DYER:** Exactly, so why don't we start with the
4 children? If you were a child that was born or lived on
5 base, contact this number. We have to have a starting
6 point, and we have to have -- you get a computer guy to
7 write up a program, and you put it into a 1-800 number,
8 and it asks the questions. And then it's weeded out.

9 But they should be able to say this, you know, when
10 you're looking at this and you're seeing, okay, these 500
11 kids grew up at Camp Lejeune, and they've all got MS or,
12 you know, like 50 percent of them or 25 percent of them
13 have MS. I mean, that's what you're going to see because
14 that's what we're seeing in just our little puny study
15 that we're doing on the website. You know, we've got 800
16 and some people, and when you ask them to list their
17 diseases -- there's no reason for them to lie.

18 They're not putting their name on there. It's
19 secret. I mean, you're not looking at that. You're
20 looking at purely scientific. Someone saying I have
21 thyroid problems. I have a muscle disease. I have
22 asthma. I've had miscarriages, and that's what we're
23 talking about. So if you get a survey and you have this
24 and you allow them to list all this stuff then you'll
25 categorize it. And that's where we start. And it's

1 simply a survey but we have to start somewhere.

2 **DR. BOVE:** They way we do the survey you do, we do start
3 somewhere. We start at birth certificate records. We
4 only could identify them, these births. We do not have,
5 right now that's one of the jobs is to see if we can
6 identify a database for children on the base, maybe their
7 school records. That's what we need to explore.

8 But if you want to start somewhere, you're going to
9 have to start with something. What you want to do -- if
10 you want to make sure you've captured many of them if not
11 most of them, otherwise you have no idea. You've sent
12 that message out, and you don't know how many kids were
13 actually on the base so you're not going to find out if
14 their records ^.

15 I mean at least for this survey I had birth
16 certificate records, and these are at least 12,498, or
17 whatever it was, births that occurred on that base during
18 that time period. So we had something to work with. We
19 had the names of the people and so on. You don't have
20 the names or the numbers of those children who lived on
21 that base. And that's what we need to find out, if
22 there's a database that captures some of them.

23 **MS. DYER:** There isn't a database that captures that.
24 We've got to create our own.

25 **DR. BOVE:** But then you have no idea if it's complete.

1 You have no idea.

2 **MR. MARTIN:** We've said this several times. You cannot
3 force people to cooperate. If we get the word out, if
4 enough people know -- I know when I was growing up, the
5 Marine Corps community, even these guys that have been
6 retired 20, 30 years run into an old buddy they knew 40
7 years ago, those are a pretty tight-knit group of people.
8 There are still several of them, some of the old timers
9 or lifers that are still involved in the VA and Veterans
10 of Foreign Wars. The word's going to get out.

11 We'll never achieve a hundred percent. We've
12 already decided that at this point. But if we get enough
13 people with word of mouth, and with newspapers or radio
14 advertisements or whatever, calling us, that eliminates
15 us having to chase anybody. If they don't want to
16 participate, they don't have to. But we're talking a
17 half a million people here. I think we're going to get a
18 pretty good response.

19 **MS. McCALL:** And we understand that you, that this is
20 what you do for your living. You take surveys. You do
21 studies. You study. You do this, and I understand that
22 you know what the obstacles are because you could already
23 predict with this large population of exposed people
24 what's going to happen. But what we're saying is if you
25 always do what you've always done, you always get what

1 you always got. That means we need to do something
2 different. We need to start this out in a different way
3 so that we don't --

4 **MR. MARTIN:** This is an opportunity really. You think of
5 the scale, and if we get a varying degree of all these
6 different diseases from skin, just from skin rashes to
7 terminal cancers or kidney diseases or liver infections
8 or whatever this might help the scientific community in
9 everything that I've read that have, their conclusions
10 are not comprehensive because they haven't had enough
11 studies. They don't know what it causes. They don't
12 know who's affected by what chemical and what diseases it
13 caused because they don't have enough studies.

14 That's everything you read in most of this
15 documentation is enough studies have not been conducted.
16 So this is a prime opportunity, and all these agencies
17 that are spending these millions of dollars might have an
18 opportunity to find out exactly what these TCEs have done
19 to people.

20 **DR. CLAPP:** I'd like to throw something into the mix
21 here. There have been a lot of studies of people exposed
22 to TCE done, and all of the information isn't in yet,
23 that's for sure. And this would be a way to get new
24 information. I have a feeling we're barking up the wrong
25 tree here. I don't think ATSDR is going to do this what

1 we call a hypothesis generating kind of survey.

2 There are other places to go. And I think we should
3 at least consider, as I mentioned before and at lunch,
4 that the Lipari study was not actually, was initiated by
5 a grant from a foundation. And then that got other
6 people's attention, and it was actually written up in a
7 way that I think was of some use at the end of it all.
8 But it wasn't because ATSDR endorsed the idea of a survey
9 of Lipari information.

10 **MS. McCALL:** But it helps if they endorse the idea.

11 **DR. CLAPP:** Well, you know, it's like it probably would,
12 but since you can't convince the person who it is that
13 knows the most about it in the agency, then it may be
14 that there's some place else to go.

15 **MS. McCALL:** Right, but we're not the CAP sitting here in
16 the ATSDR building trying to work with the ATSDR. Then
17 we're just the stand and the few, the proud and the
18 forgotten over here working by ourselves again. We all
19 came here together --

20 **DR. CLAPP:** Oh, we're doing a lot here today.

21 **MS. DYER:** But what she's saying also is, okay, the ATSDR
22 is not or if they're not the place that we need to go to
23 get this survey done, then we're going to have to turn
24 around and go back to Washington and try to get DOD to
25 fund an independent study apart from this through a major

1 university or teaching hospital. We're going to have to
2 do that. So we're going to have to go back, and we were
3 thinking that we were coming to the ATSDR and that the
4 ATSDR does surveys, and they could help us get started
5 with funding from the DOD to do it.

6 **DR. CLAPP:** The ATSDR has done a survey in this instance
7 that as Frank explained was based on a list of births
8 from a particular population.

9 **MS. DYER:** Right.

10 **MR. MARTIN:** Right.

11 **DR. CLAPP:** We're talking about something different, and
12 it may be that that's not a survey they're going to do.
13 I just mean, I'm throwing it out, and I think I'm
14 expressing what is obvious which is that there's not
15 complete agreement here that from the ATSDR folks this is
16 the way to go. Come up with other ways of getting it
17 done.

18 **MR. STALLARD:** Jerry.

19 **MR. ENSMINGER:** Frank, why don't you sit down and give us
20 a roadmap, I mean, as you view, and clarify what your
21 stance is and what you think would best serve all these
22 concerns.

23 **DR. BOVE:** The study we're doing here, the study at Toms
24 River was cutting edge. We're not doing the same-old,
25 same-old. So that is ^. That's all. We've been talking

1 about looking at a wide range of diseases, mortality, I
2 mean, to do consensus^. A mortality study can look at a
3 wide range of diseases that cause mortality. The cancer
4 incidence studies we can do them will look at a wide
5 range of cancers. They either kill you or don't kill
6 you. So those we're committed to trying to do. And I
7 think they're important.

8 At the same time there's studies done of
9 occupational cohorts across the country where some other
10 diseases -- see, Camp Lejeune population, although
11 exposed, may not be the best population to look at all
12 these diseases to be frank with you. An occupational
13 cohort may be a better one. And I know there are
14 occupational exposures here, but I mean an occupational
15 cohort like say in a plant that produced, that works with
16 TCE.

17 Because the record's there, the population itself
18 that's self-contained. You have medical records there.
19 You can actually answer the question of whether TCE
20 causes a particular disease. With that cohort and what
21 happens with that cohort is then generalized to anybody
22 who's exposed to TCE at those levels. The kind of levels
23 we're talking about here are pretty high. They're not
24 that different from the population ^.

25 **MS. McCALL:** Does it matter whether you showered in it or

1 ingested it or just working around it? I mean, does it,
2 I mean, because the Camp Lejeune people lived in it, and
3 you're talking about people who just work in it, go home
4 and have safe water and come back to work and have that
5 exposure and go home and have safe water for the weekend.
6 But we're talking about people who drank Kool-Aid,
7 bathed, showered, swam, everything with the water.

8 **DR. BOVE:** Right, the difference is that possibly, you
9 know, the occupational exposures were higher for a
10 shorter period of time, and there's some question about
11 whether that's relevant with other doses for a longer
12 period of time. But you can still, you know, there's
13 always uncertainties anyway in science. And so we
14 couldn't answer some of those questions. And some of
15 those questions have been answered. We do know with our
16 tox profile, it's seven years old now, it goes through a
17 list of studies, both animal and human, for this
18 information. So, you know, we're not in the dark here
19 about TCE and PCE. It's been used throughout industry,
20 TCE, sure and PCE, certainly. So I think we know
21 something about the health effects based on this
22 occupational study. The only question in my mind, and
23 maybe not in other people's minds, is that for exposures
24 lower than that, lower than occupational exposures,
25 what's the effect? But in the case of, and is there

1 something different about a drinking water exposure and a
2 work place exposure. In the case of these ^ I'm not
3 convinced that there's a whole lot of difference, but
4 there's a debate about ^. So ^, I digress, but what I'm
5 saying is you don't have to study every disease in this
6 population, the Camp Lejeune population, in order to know
7 something about what TCE or PCE can cause. That's the
8 first thing, so --

9 **MR. MARTIN:** Well, and there again we're --

10 **DR. BOVE:** -- so we can focus our attention on a
11 particular disease. We don't have to study every disease
12 there if we're interested in a scientifically credible
13 study. Again, we would want to focus on other diseases
14 where we felt we could do the best study. Now, if we're
15 not, if we're interested, again, in finding out what the
16 disease burden is in this population, not interested in
17 comparing to anybody else, just trying to find out how
18 much disease is here, then all kinds of survey mechanisms
19 have been discussed in this meeting or some combination
20 of them.

21 But it's not a credible study. It's not something
22 you would publish in a scientific journal. It doesn't
23 add to the scientific learning. But it's useful for
24 other purposes. It's not a useless thing, but you have
25 to at least think of what its uses are like do we want to

1 provide services and show the Veterans' Administration or
2 the military that there's this much disease in this part
3 and this number of people responded to this, what do you
4 think? There may be even more out there that need
5 services. That might be a use of this survey data.
6 There may be some other use.

7 **MS. McCALL:** Okay, well, I can tell you this much. I'm
8 not a scientist. None of us besides the people who work
9 here are scientists. We don't care about a scientific
10 study. We want services. Do you care about a scientific
11 study?

12 **MS. DYER:** I mean, I understand why you're doing it. I
13 mean, it's a pure love of science, I understand that, but
14 you're talking to people here, and we don't care about,
15 you know, we want results, and we want action, and --

16 **DR. BOVE:** Well, when you say results, what is results?

17 **MS. DYER:** I'm frustrated because I really felt like
18 that, you know, we were to get here today to decide
19 whether or not we were going to study the children and
20 adults that lived at Camp Lejeune and how to go about
21 that. And I'm ready to start doing that, and I know you
22 want to go ahead and go with the mortality. I think
23 that's great. Go ahead and go with it, but I just feel
24 like, you know, are we going to study them or not?

25 And if we are, how are we going to start doing it?

1 And let's get some, you know, black -- you know, get it
2 on paper; what we're going to do to get this done. And
3 we don't understand when you start saying, oh, what's the
4 feasibility of this, and what's the, you know, and this
5 study and that study. You're talking to people that
6 don't know. All we're hearing about is that, it's like a
7 doctor. You can have crazy words you guys use when
8 you're talking to somebody. We don't know. We just want
9 to hear you're going to do a study. It's going to start
10 here. This is how we're going to do it.

11 **MS. McCALL:** Right.

12 **DR. BOVE:** When you said I just want results, I want you
13 to tell me what you mean.

14 **MS. DYER:** What kind of results --

15 **DR. BOVE:** Exactly right, yeah.

16 **MS. DYER:** I want answers. I want answers to why I'm
17 sick. I want answers to why my dad died at 45. I want
18 answers to why a lady that I just talked to the other
19 day, her grandchild died of leukemia. I want answers to
20 why every time I go to the doctor it's something new, and
21 I'm only 49 years old, and this has been happening all my
22 life. I want answers. That's the results, and the only
23 way you can do that is getting together a group of people
24 that lived there during a certain period of time and
25 finding out what all they've got.

1 We've got a crazy mess going on. It's not your
2 normal stuff. And that's the kind of results. I want
3 you to be able to tell me, Terry, you're not crazy, you
4 know. Those headaches you've had all your life and the
5 fact that you were hurt 24 hours a day there's a reason
6 for it. And the only way I can see you doing that is to
7 contact all the people that lived out there and find out
8 what's going on in their lives and in their health.
9 You're not going to get a hundred percent like you said,
10 but we've got to do it. We've got to start somewhere.
11 And I'm ready to do it.

12 **DR. BOVE:** Why do you think that doing this survey will
13 answer that question?

14 **MS. MCCALL:** Dr. Bove, because --

15 **MR. STALLARD:** Wait, wait, wait, please, one person at a
16 time.

17 **MS. DYER:** Why do I think a survey? Because a survey is
18 going to reach as many people. We can reach a -- let's
19 just go with small numbers. If we can reach a thousand
20 people that lived at Camp Lejeune, and we ask them
21 certain questions, you know, were you sick as a child
22 when you lived out there? What kind of illnesses did you
23 have? As you were growing up did you develop normally?
24 You know, answer some of these questions. Are you having
25 neurological problems, okay? And then once you got to

1 your developmental stage, whether male or female, can you
2 have children? Have you, you know, are you, all these
3 things. Do you have breathing problems?

4 When you get a survey going like that, and I've got
5 a hundred things across here, and I'm checking them like
6 this for everybody that calls that's going to show you
7 guys something. It's not pure science, but you're going
8 to go whoa, we do need to look at this deeper. That's
9 what I'm talking about. A survey will give you the start
10 to see that what we're saying is real. There's people
11 all over the country that have the same thing. They're
12 not everything that you're saying they should be. It's
13 more.

14 **MR. STALLARD:** Hold on just a minute. Just a moment.
15 Denita's been waiting to speak.

16 **MS. MCCALL:** Well, I just wanted to give you an example
17 of why we need results. And I'm going to use my, and it
18 just doesn't matter any more because, you know, my cancer
19 was diagnosed six years ago. I've already had the
20 surgery and the radiation, and you know, I'm living with
21 it. So results aren't really going to help me. The only
22 thing it's going to help me do is get another priority
23 rating at the VA so I don't have to wait five months for
24 a doctor's appointment. That's the kind of result I'm
25 looking for.

1 **MR. BYRON:** Can I elaborate on that? I mean, let's face
2 it, every one of these CAP members here either has
3 someone suffering now or their grieving a family loss.
4 So we want answers of what happened at Camp Lejeune, not
5 only so we can help the scientific community, which we
6 are interested in doing. Because personally, I didn't
7 ask to be a lab rat. What we want is accountability from
8 DOD. If you poison my daughter, I want healthcare for my
9 daughter. I want compensation for her past injuries, and
10 I'm going to put right out there on the line so y'all can
11 hear it because that's what we're leading up to.

12 The information that comes from here is going to go
13 to DOD. It's going to go towards Form 95 Plane^, and you
14 guys decide whether that's just to ask for or not. You
15 may come back with something that's agreeable because
16 everything in life is a compromise.

17 I'm going to ask Frank this. We're talking about
18 the study here at Camp Lejeune. He said that this light
19 post here sheds light over here. So does it have to be
20 at Camp Lejeune or can we find another affected community
21 that's similar to ours and get this rolling, that might
22 already have a database. Is there, are there studies
23 that are already out there for the children that we
24 already can identify diseases that now we can associate
25 back to the mortality and the cancer incident rate or

1 not?

2 But I do want to elaborate that we are here because
3 we want answers. We want this kind of stuff to stop.
4 There's 120 sites, I believe, on the DOD National
5 Priority List, 142. My understanding is, is we are the
6 very first group to come before the DOD with this issue.
7 Do you think there's not another 142 groups out there
8 potentially? Maybe not 142, but I'll bet there's 70
9 potential groups. You just don't know it yet.

10 **MS. DYER:** They're asking us for causation. Where are we
11 going to get it? If I'm going in front of them, I have
12 to be able to say that my illness that I've got was
13 caused because of Camp Lejeune. You're the only place we
14 know to go to.

15 **MR. BYRON:** And the other reason I'm asking for a
16 comparison to the national statistics is so that we can,
17 for once and all, know where do we stand. If Jerry's
18 daughter has leukemia, and the leukemia rate at Camp
19 Lejeune is ten times higher than the national average, I
20 think there's causation there. And if you're doing that
21 with each one of these items, spina bifida, cleft palate,
22 and they're all astronomically high compared to the
23 national average, you can bet I'm going to the Commandant
24 of the Marine Corps and to General Counsel and say I want
25 action taken for my daughter now. And I'm not really

1 willing to wait much longer. It's either we produce
2 results here or I'm going back to my life and I'm going
3 to fight them on my own, and I don't want to do that. I
4 want to work with ATS -- I really want to work with DOD,
5 but they have yet to step up to the plate. I think
6 they're willing to more and more as we get into this.
7 But that's where we're at.

8 **MS. BRIDGES:** And stop the effects on the next generation
9 of children.

10 **MR. BYRON:** We want to stop it from happening again to
11 any other communities.

12 **MR. STALLARD:** Let me see if I can't seek understanding
13 for myself. You have an issue of do you see a survey as
14 a method of notification? Those two things are basically
15 one and the same for you.

16 **MS. DYER:** Exactly.

17 **MR. STALLARD:** So the question then is if it could be
18 done, how would we do it?

19 **MS. DYER:** Where would we get funding from?

20 **MR. STALLARD:** Well, how would we do it in a way that
21 will provide, elicit the most useful responses that can
22 be verified, correct?

23 **MS. DYER:** Uh-huh.

24 **MR. STALLARD:** I'm just trying to understand so we
25 understand really what's on the table here. So the

1 question would be, if it could be done, how would we do
2 it in terms of a survey, right?

3 **MS. DYER:** Would you write the survey? I mean, you know
4 what you need to know. You know what you need to know.
5 Would you all write the survey? See if we can come back
6 next month, and you've got a survey ready for us.

7 **MS. RUCKART:** I'm sorry, but it already is 2:45. I know
8 that people do have flights right around the five o'clock
9 time, and I just wanted to allow a little time for wrap
10 up and time for talking about the next meeting. ^^ Table
11 these issues, but just talk a little about the next
12 meeting.

13 **DR. BOVE:** Just to answer quickly. A survey's been done
14 ^, so that's not the problem. The question is what the
15 purpose of the survey is. I still am not clear on that.
16 If you're interested in notification, it's a whole,
17 that's a good purpose, we can tailor the survey and all
18 the other steps if the purpose is notification. If the
19 question is what caused my disease, that's a
20 scientifically credible study.

21 **MR. MARTIN:** Frank, I'd just like to say one thing. This
22 is a list of everybody that's registered at our website,
23 860, 886 people that are all sick with varying diseases
24 that we've all discussed today. The only thing we have
25 in common with these other 886 people is that we all

1 lived at Tarawa Terrace. And that in itself, I mean,
2 it's almost a thousand people here at Camp Lejeune.
3 We're talking about a cocktail from what I understand of
4 all the chemicals that whose reactions were enhanced by
5 chlorination which they dumped into the water system also
6 trying to clean it up.

7 **MS. DYER:** Tulene, ammunition --

8 **MS. McCALL:** And fed through lead pipes.

9 **MR. MARTIN:** So it's a disaster is what it is.

10 **MR. BYRON:** And part of the problem is, is that when they
11 found out in 1980, they let the world know in '85.

12 **MR. MARTIN:** That's another subject.

13 **MS. DYER:** That's another subject, but do we want a
14 survey? Does everyone from the CAP, I mean, does
15 everyone say they want a survey?

16 **MS. McCALL:** Well, let's vote. Everybody who wants a
17 survey raise your hand.

18 **DR. BOVE:** Let me ask for the next CAP meeting that you
19 flesh that idea out a little bit. A survey of what, and
20 what do we want the survey to do? And after we get all
21 the information in, what do we think that survey can do
22 for us, for you? Not us, for you.

23 **MS. McCALL:** Well, if you show a level --

24 **DR. BOVE:** Well, no, you don't have to answer the
25 question now. I want you to think about it because given

1 what we've said today because in order to show harm and
2 causality, we're talking something a lot more than a
3 survey. And that's what you have to, and so you have to
4 really give us a sense of what you think can be
5 accomplished with the survey the way you see the survey,
6 and what do you think we can accomplish.

7 **MS. DYER:** Would you start a study before you started a
8 survey?

9 **DR. BOVE:** Yes.

10 **MS. DYER:** You would.

11 **DR. BOVE:** We haven't done a mortality look at Camp
12 Lejeune.

13 **MS. McCALL:** We'll take anything --

14 **MS. DYER:** Do a study on the children and the adults
15 living at Camp Lejeune.

16 **MR. STALLARD:** Folks, I need --

17 **MS. McCALL:** We'll take anything we can get, study,
18 survey --

WRAP UP AND PLAN NEXT MEETING
CHRISTOPHER STALLARD

19 **MR. STALLARD:** Can I have your attention, please? I want
20 to try to summarize where we are as I understand it.
21 Frank has asked for you, the CAP members, to do a little
22 bit more work in terms of thinking about what would a
23 survey do. That means the notification issues, and all
24 those things that we talked about, what would it do.

1 Likewise, I guess it would be fair to ask for them to
2 consider if it could be done, how would you do it so that
3 hopefully those two topics can mesh.

4 What we have agreed to do is that ATSDR is going to
5 proceed with this mortality study. Is that correct?

6 **DR. BOVE:** Right.

7 **MR. STALLARD:** And I presume that you will be notifying
8 the CAP members in terms of what that timeline will be
9 looking like and what the process will be, okay? I don't
10 have anyone assigned responsibility here for, but clearly
11 this is a very important issue to resolve, and that is
12 identifying senior DOD people to work with who are
13 committed to participating with this process.

14 However that has to be done, I think we have to
15 determine, Frank, I don't know what your legislative arm
16 does, but --

17 **DR. BOVE:** There's someone in my agency. I'm not the
18 person. I'll tell you right now I'm not the person, but
19 there's some, we have a ^ who works with DOD all the
20 time, and I would refer to them ^.

21 **MR. STALLARD:** Okay, so can we say then that ATSDR will
22 contact people within our agency to find out what the
23 best method and mechanism is to do this?

24 This PSA campaign linked to a web-based survey,
25 that's all that we've been talking about, that's a

1 comprehensive plan that we need to think more thoroughly
2 through for the next meeting and pick that up as a topic
3 of discussion. Is that what we all have agreed to?

4 It appears that all this stuff about laundry
5 workers, cooks, a new study on civilian females in utero,
6 that that is subsumed under the mortality study that's
7 being conducted, correct?

8 **DR. BOVE:** It's subsumed under looking at what the
9 databases can tell us. If the databases can tell us, for
10 example, that they were cooks whose occupation was in the
11 database. I don't know exactly what that means. I want
12 to talk to Dr.^ about that and others, military
13 occupational specialist, so that's the --

14 **MR. STALLARD:** What about this? The recommendations from
15 the Panel on adults who lived on base, adults who worked
16 on base, children who lived on base, children exposed in
17 utero? How does that come in then? Does that come under
18 the mortality?

19 **DR. BOVE:** Well, it fits under the mortality study, but
20 the adults on base, check the civilian database that's
21 available to see the adults who worked on base. That's a
22 second cohort. For children we're going to have to see
23 what records or information is available on base. So I
24 don't know --

25 **MS. DYER:** That's for the mortality.

1 **DR. BOVE:** Well, that's, for anything we want to do with
2 children, I would want to see what they have in terms of
3 school records, if any, and what shape it's in. So that
4 we need to go and search out.

5 **MS. DYER:** And you opened a whole new can of worms when
6 you said you could do a study before we could do a, that
7 you could do a study before a survey so just to let you
8 know.

9 **DR. BOVE:** Absolutely. What I meant by that is simply
10 this that it's not that we don't know anything about TCE.
11 There are occupational studies. There are previous
12 studies like the studies I'm working on. There's animal
13 studies and Jeff Fisher can tell us about those. So
14 there's, you can justify looking. I want to look at
15 arsenic and neural tube defects, for example. There's
16 never been a study on that. I want to do it because
17 there's some hints in the animal data that's there. I
18 don't need to do a survey. If I can find the right
19 population who was exposed and a birth defect registry,
20 I'm off.

21 **MR. BYRON:** Am I mistaken in saying that a survey
22 provides the registry?

23 **DR. BOVE:** The survey is not the best way, but the survey
24 if you don't have a registry, that's one way to do it.

25 **MR. MARTIN:** It's a start.

1 **MS. DYER:** And I guess some of the things that we learned
2 today is that DOD being out in the audience, even though
3 they weren't invited or, you know, part of the CAP, that
4 they've got to go back because there's a lot that we've
5 talked about here that we wanted Mike to have answers to
6 the next time we get together.

7 **MR. STALLARD:** Okay. Well, let's speak about that, the
8 next time we get together. First, let's figure out how
9 well we did; what went well today, and what did not go so
10 well today so that we can adjust accordingly for our next
11 meeting. So what went well?

12 **DR. CLAPP:** People spoke frankly, put it out on the
13 table.

14 **MR. MARTIN:** It was open and honest, yeah, and allowed us
15 to relieve a little bit of frustration to be honest with
16 you. Yeah, sorry to take it out on you, Frank.

17 **MR. STALLARD:** Open, frank, and what else?

18 **MS. DYER:** Great facilitator as always. Lunch was good.

19 **MS. McCALL:** And don't think that Marriott bed is going
20 to change my mind. They've got beautiful beds.

21 **MR. STALLARD:** What didn't go so well?

22 **MR. ENSMINGER:** I don't like the fact that -- I think DOD
23 ought to have a seat up here, Dr. Rennix.

24 **MS. McCALL:** We can take a vote on it.

25 **MR. STALLARD:** We can and then you all can figure out how

1 the --

2 **MR. ENSMINGER:** I mean, I don't want to have him sit up
3 here and shoot questions out there. And we're relying on
4 these people for a lot of information, and they need to
5 be up here. They need to have input, and we're beating
6 around the bush. We're chasing our tail without having
7 them up here because we're relying on them.

8 **MR. STALLARD:** That was an issue about identifying,
9 perhaps afterwards you all can talk offline about from
10 their perspective what would be the best method to get
11 someone invited to sit at this table as a member of the
12 Panel.

13 So I think I'd like to put DOD participation sort of
14 in the middle. It went well because these folks did
15 share, and they are here, and yet we have more to do in
16 terms of finding the right level of support.

17 What else didn't go so well? I'll tell you one
18 thing. The AV support. The microphones, I think you
19 mentioned one --

20 **MR. MARTIN:** I talked to some people that were watching
21 the streaming at lunch, and they said they said that the
22 only people they could recognize were who were in the
23 audience. They couldn't see the Panel at all, that the
24 camera was really just too far away.

25 **MR. STALLARD:** So America's Most Wanted ^ in the audience

1 here. The webcast camera angle on the audience.

2 What else?

3 **MR. MARTIN:** I think you mentioned earlier the comments
4 from the audience, having a podium or a microphone to
5 where they could present all their information.

6 **MS. DYER:** If we include a DOD, we won't need it, but
7 it's got to be a DOD person that can answer the questions
8 and give us answers.

9 **MR. STALLARD:** Well, let me put it this way. Having a
10 chair and a microphone for invited audience
11 participation.

12 **MR. ENSMINGER:** And I thought we were going to have a
13 briefing today. I guess I was mistaken, by Morris, about
14 the water modeling. We didn't get one.

15 **MR. STALLARD:** Do you want one for the next meeting?

16 **MR. ENSMINGER:** Yes. I mean, a detailed, not too
17 detailed, an overview of where he is and what he's gotten
18 accomplished, and anything else that he may be needing.

19 **MS. DYER:** When is the next meeting?

20 **MR. STALLARD:** That would be the next question.

21 **MS. DYER:** Is there going to be a next meeting?

22 **MR. STALLARD:** There appears to be a need. Let's just do
23 a check --

24 **MR. ENSMINGER:** Well, we've got a rep down here from
25 I&L^ . We can have a next meeting, Ms. Dreyer.

1 shouldn't plan the next meeting because right now at this
2 moment, we don't have money for the next meeting.

3 **MR. STALLARD:** So I'll put that under not so well for
4 today.

5 **MS. RUCKART:** I would like to say if we don't have money
6 for the next meeting, from DOD, it doesn't necessarily
7 mean that we can't have a meeting. We still may be able
8 to have a meeting. Up until recently we weren't sure we
9 were going to have money for this meeting, and we were
10 going through with it anyway. So I don't think we should
11 focus too much on that now. I think we should go about
12 planning it and try to make it happen and then see if the
13 funding will just fall in place. I don't want it to wait
14 until the last minute, then we can't get it scheduled;
15 find out about funding the week before.

16 **MS. McCALL:** Thanks, Perri. That's good, thank you.

17 **MR. STALLARD:** Is there anything else? A short comment
18 that anyone would like to make before we close this out?

19 **MS. McCALL:** Thank you.

20 **MR. MARTIN:** Thank you.

21 **MR. STALLARD:** Thank you, and I want to thank you all for
22 abiding by the guiding principles. It really helps us to
23 move forward together. No formal conclusion, this is it.
24 Thank you very much.

25 (Whereupon, the meeting was adjourned at 3:00

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p.m.)

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CERTIFICATE OF COURT REPORTER**STATE OF GEORGIA****COUNTY OF FULTON**

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of February 1, 2006; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 4th day of March, 2006.

STEVEN RAY GREEN, CCR**CERTIFIED MERIT COURT REPORTER****CERTIFICATE NUMBER: A-2102**