**THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**

convenes the

THIRTY-FOURTH MEETING

**CAMP LEJEUNE COMMUNITY ASSISTANCE PANEL (CAP) MEETING**

March 24, 2016

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at the ATSDR, Chamblee Building 106, Conference Room B, Atlanta, Georgia, on March 24, 2016.

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

March 24, 2016

## TRANSCRIPT LEGEND

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

(alphabetically)

BOVE, DR. FRANK, ATSDR
BREYSSE, DR. PAT, NCEH/ATSDR
CANTOR, DR. KEN, CAP TECHNICAL ADVISOR
CORAZZA, DANIELLE, CAP MEMBER
ENSMINGER, JERRY, COMMUNITY MEMBER
ERICKSON, DR. LOREN, VA
FLOHR, BRAD, VA
FORREST, MELISSA, NAVY/MARINE CORPS
FRESHWATER, LORI, CAP MEMBER
GILLIG, RICK, ATSDR
HODORE, BERNARD, CAP MEMBER
ORRIS, CHRISTOPHER, CAP MEMBER
PARTAIN, MIKE, COMMUNITY MEMBER
RUCKART, PERRI, ATSDR
STEVENS, SHEILA, ATSDR, CAP LIAISON
TEMPLETON, TIM, CAP MEMBER
UNTERBERG, CRAIG, CAP MEMBER
WILKINS, KEVIN, CAP MEMBER

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

(9:00 a.m.)

**WELCOME, INTRODUCTIONS, ANNOUNCEMENTS**

**MS. STEVENS:** We're going live now. So welcome to the Camp Lejeune CAP meeting for March 24, 2016. My name is Sheila Stevens, and I am a public health advisor with the Agency for Toxic Substances and Disease Registry, so welcome to our meeting. For those of you who don't have it in your hand, there are agendas over here at the front entrance. We are going to have -- we should be done by 3:00, so 9:00 to 3:00; we'll have a lunch break around 11:45. And so what I'm going to do is turn it over to Dr. Breysse, who is sitting right here in the middle of the U-shaped table here. So welcome, thank you. Are you ready?

**DR. BREYSSE:** Yes, I'm ready. So welcome, everybody. I was asked to remind everybody -- or inform everybody that the guy who's transcribing this is not in the room with us today but he's listening to the audio, so to make sure that the transcript is correct, even though it may get a little tedious, whenever you speak if you could just say your name, to make sure he ascribes what's being said to the right person. And Sheila, if you can

help us remember to do that, that'd be great. (inaudible comment from group) I think so, yeah. Or, you know, maybe your just initials, but last name's probably -- last names should be fine.

So we start each meeting with introductions, go around the table, make sure we say who's here. So I'll start. I'm Pat Breysse; I the director of the ATSDR today, but I'm also the director of the National Center for Environmental Health on other days of the week. Kevin, you want to start over to you?

**MR. WILKINS:** Kevin Wilkins, CAP member.

**MR. TEMPLETON:** Tim Templeton, CAP.

**MS. CORAZZA:** Danielle Corazza, CAP.

**MR. HODORE:** Bernard Hodore, CAP.

**MR. ORRIS:** Chris Orris, CAP.

**MR. GILLIG:** Rick Gillig, ATSDR.

**MS. RUCKART:** Perri Ruckart, ATSDR.

**MS. FRESHWATER:** Lori Freshwater, CAP.

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

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

**DR. CANTOR:** Ken Cantor, CAP.

**MS. FORREST:** Melissa Forrest, Navy/Marine Corps Public Health Center.

**MR. FLOHR:** Brad Flohr, VBA.

**DR. ERICKSON:** And Ralph Erickson, Veterans' Affairs.

**DR. BREYSSE:** Excellent. And as other people come up for different parts of the agenda, they'll introduce themselves at that time. But we have a number of colleagues from ATSDR sitting around the room.

But I'd like to begin -- if there's no questions about the agenda we're trying to cover today -- has everybody had a chance to look at it? I know we sent it out in advance. I just want to make sure. If there's no questions about the agenda, can we start with the action items from the previous CAP meeting. And I'll turn the floor over to Ms. Perri Ruckart.

## ACTION ITEMS FROM PREVIOUS CAP MEETING

**MS. RUCKART:** Morning, this is Perri, I'm going to just start... Oh, yes, Jerry just reminded me we should ask people to mute your phone, just to cut down on background noise. Thank you.

So I just want to start off by going over the action items from the last meeting. I'll start with items for the VA: Dr. Clancy will confirm that VA acknowledges the IARC, EPA and NTP findings on TCE

carcinogenicity, and that training for SMEs includes the cancer classification of these compounds; for example, that these agencies stated that TCE causes kidney cancer so that reasons for denial don't include that it is unclear whether TCE causes kidney cancer.

**DR. ERICKSON:** This is Erickson, and that information has been transmitted to the appropriate folks in the VA, to make sure that they have that.

**MS. RUCKART:** Okay, great. Perri again. Dr. Clancy will clarify the relationship between the ICD-10 codes and the VA's unique codes for conditions.

**DR. ERICKSON:** I'm not sure what that due-out means.

**MS. RUCKART:** Perri again. There was a lot of discussion last time about how the VA has unique codes, and the CAP was just wondering how they relate to ICD-10 codes.

**MR. FLOHR:** This is Brad. If you're talking about the diagnostic codes that we use to identify conditions in making decisions, we have nothing to do with that.

**MR. TEMPLETON:** This is Tim Templeton. When we were having the discussion about that, you guys

probably remember I was kind of leading that piece of the discussion and talking with Dr. Clancy, she's mentioned that VHA does use the ICD-9, -10, probably -10 now.

**MR. FLOHR:** They do, for like treatment purposes, yeah.

**MR. TEMPLETON:** Right, right. So she said that there was some correlation between the two, like a cross by reference between some of those.

**MR. FLOHR:** Now, we have about 800 unique --

**MR. TEMPLETON:** Right.

**MR. FLOHR:** -- diagnostic codes that identify conditions that are used in making their decisions, but they have nothing to do with that.

**DR. BREYSSE:** Has there been an attempt, just so we're clear, to, you know, to cross-walk the two codes, so if you looked up a code in the one side they could translate it to what an ICD-10 code would be? I guess that's the gist of the question.

**MR. FLOHR:** I don't know what purpose that would be what for.

**MR. TEMPLETON:** I mean, as Perri -- this is Tim again -- as Perri was pointing out, it wasn't really a question. Dr. Clancy said that there was, so I guess now we're hearing differently. I guess the

question would go back to Dr. Clancy.

**MR. FLOHR:** Yeah, we'll take that back and talk to her about it.

**MS. RUCKART:** Perri again. This is for Brad. The CAP requested that Brad Flohr provide an update on the most recent breast cancer claims, including how many were determined diagnostically to have the condition, and how many were approved and denied. I believe you sent something out.

**MR. FLOHR:** Yeah. This is Brad. I believe I sent it to you or Sheila. Yeah.

**MS. RUCKART:** Did the CAP get that? Yeah, that was --

**MR. FLOHR:** Yeah, the CAP's got that.

**MS. RUCKART:** Yeah.

**MR. FLOHR:** A couple months ago.

**MS. RUCKART:** I think I sent it a week ago, or maybe that was the early one I sent back in January.

**MR. FLOHR:** Yeah, probably.

**MS. RUCKART:** Yeah.

**MR. PARTAIN:** Brad, this is Mike Partain. Quick question on the male breast cancer stats. I believe it was 124. Are those 124 confirmed cases of male breast cancer or tumors, or what was the breakdown on that number?

**MR. FLOHR:** You know, I don't have that report with me so I can't answer that right now, Mike. But when we looked at the -- went through our data and pulled out the diagnostic code we used for breast cancer, we found out that many of those conditions actually were not breast cancer; they were something else. And I don't recall off the top of my head how many actually were male breast cancer, but it was less than that.

**MR. PARTAIN:** Could you find out for sure and provide that to us?

**MR. FLOHR:** Absolutely.

**MR. PARTAIN:** Thank you.

**MS. RUCKART:** Perri again. The CAP requested that Brad Flohr clarify what it means to not fully rely on the NRC report and that he would determine what weight is currently being put on the NRC report. The CAP also requested that the VA justify why the report is still being used to determine claims.

**MR. FLOHR:** This is Brad. When we request a medical opinion from VHA, they review every available piece of information on that particular condition that they're looking at. It would include not just the NRC report but it would include IARC

reports, NTP reports, EPA reports. They look at everything.

**MS. FRESHWATER:** Brad, this is Lori Freshwater. That's a really generic answer, so that tells me that you basically did not look into the question, which is fine, but what I want to know is why is bad science, why is that still being cited? You could say yes, we looked at Wikipedia and cited that in a denial, which is true, but I don't think you'd want to justify that to me today. So what I'd like you to do is justify that you're still using that report, and tell us why it hasn't been removed as a source, why are you still using it? Why -- I mean, why would you use Wikipedia? So I don't understand why you can't come back and say give me something specific as to why that seems to be something that you still cite.

**MR. FLOHR:** Lori, I, I'm not in charge of VHA examiners. I can't tell them what to do.

**MR. ENSMINGER:** This is Jerry Ensminger. You guys -- the VA commissioned an IOM review of Camp Lejeune. And you know, amazingly that thing just fell out of the woodwork. Where'd it go? I mean, you were supposed to have done a wash-up of that report, and come out with a statement of your own

regarding that report, and it's like the thing dropped into a black hole. Where is that report? I mean, why aren't you using it?

**DR. ERICKSON:** So point of order. There is a point in time in this agenda for VA updates at which point I can address that issue. I don't know if you want all of us to steer from action items to new items at this point. Dr. Breysse, I ask for your guidance at this point.

**DR. BREYSSE:** I think if it's relevant to the action items. I think we can probably deal with a new item at this point. As long as people don't mind if we have a little bit of a -- maintain a little flexibility with the agenda to have the discussion and go where it needs to go.

**DR. ERICKSON:** Okay, so the action item has to do with the 2009 NRC report and how it's being cited or why is it still being cited. And the question now has to do with the IOM's review of the clinical practice guidelines, which is an entirely separate issue. The update that I will give you is that it's at the final stage of staffing. As is the case frequently in government agencies, it's with our lawyers right now, and they are very careful with every adjective that's used, even though it's

primarily a clinical piece of policy. We've discussed this a little bit. I know Danielle, you had a number of questions about this at the last CAP meeting. My sense is that folks will be very satisfied as it comes out, that it's simply not finished in staffing at this point.

It's not propped and buried, and it's not been forgotten. I will tell you that the folks who actually work those issues, as it relates to executing the 2012 law, are the same people who helped to fix a number of things to make them much clearer in the rewrite of the clinical guidelines.

**DR. BREYSSE:** Okay, so this is Breysse. So I think that addresses Jerry's question about the IOM report or about the clinical practice guideline. So we'll hear more about that in the future.

**MR. ENSMINGER:** Well, and the reason I brought that up was because that IOM report should go hand-in-hand with what this -- doing away with this NRC piece of crap that was issued back in 2009.

**DR. BREYSSE:** So the question, I think, is still on the table about --

**MR. ENSMINGER**: And the clinicians should be told use the IOM, not the NRC.

**MS. FRESHWATER:** And I would like to put in a

formal request, I guess, because I don't want this to get moved again to another action item, and then hear this same exact answer again. So I would like to request that that NRC report not be used, not be cited, and tell me whatever I need to do, whatever follow-up I need to make or the CAP needs to make to make that happen. Lori Freshwater.

**MR. PARTAIN:** This is Mike Partain. Dr. Erickson, just out of curiosity, all the processes and reviews that you're describing on the IOM report, were the same processes and reviews done for the NRC report that you guys so readily use in Camp Lejeune's decisions? I understand it was done by the NRC but -- I mean, do we have -- are we comparing apples to apples here?

**DR. ERICKSON:** Whether -- it's apples and oranges in the following way, and I know this -- what I'm about to say is a little bit complex in that the adjudication of claims, as it relates to veterans' claims and such, is an entirely separate process from the working of claims that relate to the 2012 law. Okay, there are two separate pathways within VA.

The first being one that Brad is able to speak to, and relates to primarily just veterans and

relates to compensation, what could be a check that arrives every month in addition to healthcare, et cetera. The second is the 2012 law, which is very narrowly prescribed in the law as the 15 conditions, and to who -- you know, what the dates are, et cetera and who qualifies, but also includes, not just veterans but family members.

The challenge here is that, in complying with the law, the 2012 law, the VA is constrained to follow very specific rules and such, and that is what the IOM review of the clinical guidelines went to, was how VA would then interpret what are those 15 conditions, and what would be covered by the 2012 law. I apologize if that sounds like double-speak, but as is so oftentimes the case with federal agencies, and in this case Veterans' Affairs, we're bound by very specific aspects of that 2012 law, and so there's a separate process to make sure that we stay within the boundaries of what's called for.

**MR. PARTAIN:** Well, that goes back to the question, though. The NRC report was pretty much readily used with the VA soon after its publication, and it just appears that, because the IOM report has some language in there that doesn't jibe with what the VA's doing, it's being put through a much more

arduous process. I didn't see any reviews by the VA on the NRC report. There wasn't any delay. There wasn't any, let's look at it closer, let's have our lawyers check the adjectives, the commas, the periods and what have you. Out of curiosity does the VA have their extensive bibliography that the examiners are using available, so we can see what they're looking at? And is the IOM report on that bibliography that these examiners are using?

**MR. FLOHR:** This is Brad. Mike, I don't know that. I don't know if there's a bibliography. The people that provide medical opinions work for a different part of VA than both Loren and I do. But we could find out.

**DR. ERICKSON:** So there are, again, two different pathways here. I'm going to start with the first part, Mike, if I can remember your complex question. I wasn't with VA at the time that the NRC report -- when it came out. I wasn't part of VA when it was processed and when it was brought into the flow of the work of VA, so I can't really speak to whether or not something was more comprehensive or more deeply done or delayed. I just don't know.

I will tell you that, as it relates to the 2012 law and the specifics of that law, we do have

clinical guidelines that provide very specific guidance and reproducibility toward the medical examiners of those records for the claims that come under the 2012 law. I will tell you that for them it's not -- for the 2012 law piece it's not a matter of looking at a deep bibliography because, for those medical evaluators, it's does the person filing the claim qualify based upon, you know, the dates, the eligibility issues? Do they actually have medical evidence of having one of those 15 conditions? Are these additional claims that relate -- that are being filed, do they relate to that condition? This is something that we'll show some slides on, Dr. Breysse, here during our time. And so that's a very prescribed process related to 2012.

As it relates to claims for compensation to veterans that are separate from the 2012 law, I believe there is a bibliography. I thought this perhaps had been shared. I apologize that it hasn't. We'll make this a due-out for us to send this to you. I will tell you that, as a general rule, you know, we don't have a degree of censorship that involves, you know, approved sources of, you know, what can be on a bibliography and what cannot, though I will tell you that we are continually

working with that separate office that handles the medical review for those claims for those veterans, again, a separate pathway from what Brad and I are involved with. But we'll try and get that for you. So Sheila, if you would put that on our list.

**MS. RUCKART:** This is Perri. The next item was about the bibliography. The CAP requested that the VA make public the bibliography of studies used by the SMEs for determining claims. So that's what we're still talking about?

**MR. ENSMINGER:** Yeah. I mean, and, you know, the previous director of ATSDR, Dr. Chris Portier, issued a letter in October of 2010 regarding the faults with the NRC report, and I know the VA got a copy of that. And has that been provided to your so-called subject matter experts? Have they received a copy of that letter?

**MR. FLOHR:** Jerry, this is Brad. I don't know.

**DR. BREYSSE:** So can I -- this is Pat Breysse. So our position on that letter was -- on that report was drafted prior to my tenure here, and we stand behind that assessment. But I think in addition to that, it seems now that the report is old, all right, it's dated, and there's literature that has superseded that. And while I don't think we want

to, Lori, I think, tell the reviewer it can't look at a piece of information like the report, I think, you know, it should be clear to them that it is aged, that it is outdated, and there is probably more recent things that should be given greater weight than that report.

**MS. FRESHWATER:** This is Lori Freshwater. I understand. I agree, and I understand what you're saying, but I guess what I'm thinking about on a common-sense level, how do we put that into the bureaucratic system of the VA when we can -- we can't even get the bibliography from last time, when we asked for it, and none of the questions so far that were action items have even been looked into. So how do we get some nuance into what the examiners are looking at?

**DR. BREYSSE:** Yeah, I understand. And I can't speak to what the examiners looked at. But I do know that if I was one, I would not appreciate it if somebody said don't -- you know, discount this report. Don't look at this report. But hopefully they're getting feedback in such a way that kind of identifies new guidance as to how you weight evidence, giving stronger weight to more recent findings and the less weight to things that might be

more dated and reviews that might now be, you know, ten years old, essentially.

**MS. CORAZZA:** This is Danielle Corazza. This issue came up because we found -- we were given letters of denial that included language copied and pasted from Wikipedia. So I think the bar was a little lower; we'd like it to be a little higher. That's where the bibliography came in. Cutting and pasting from Wikipedia is not acceptable.

**DR. ERICKSON:** Yeah, certainly. So clearly we have failed to get you that bibliography, and I apologize for that. We'll work on that. If there have been recent -- 'cause I've come to two other CAP meetings, and I heard about the Wikipedia thing. If that is still going on I would want to know that, if Wikipedia is still being cited in the midst of those write-ups. If it's old news then it's still bad but it's not as bad as if it's still happening.

But the other piece, and this is a request I make to Dr. Breysse, the forward facing version of the 67-page document that you guys so ably put together, that would really help us. That would be something that I would promise, man-to-man, that we would promulgate to our folks, okay? Because I mean, honestly it's a great piece of work that has

references. It has a lot of, as you said, up-to-date information. It brings into the discussion international agency classifications, it's footnoted. This would be very helpful to us, and it would give -- it would provide something substansive [sic], and something that is a recent compendium of all that's known, or at least a lot of what's known. I realize there might be some areas it doesn't cover. So I would ask for that.

**DR. BREYSSE:** If I can explain what you mean by that. Right now that's an internal assessment that we provided to the VA, that we all recognize has now become the public to some degree. But I think you're free to use that already, but you probably wouldn't be -- because it's not an official document you probably couldn't cite, you know, that report as an authoritative reference by itself, but certainly you're free to take advantage of the, even now, you know, the breadth of the literature and the distillation of what it means.

**DR. ERICKSON:** Right. And this is good we're talking about this. This makes me really happy that it came out early. Whereas the clinical guidelines document that is being perfected right now, that the IOM reviewed for us, has a very specific purpose for

the 2012 law, and it goes to a slightly different purpose. To be able to present to the disability medical assessment people, who are handling those veterans' claims, something like this, something that you say, yeah, this is the final version. It's on your website. You know, it's got the Pat Breysse stamp of approval, whatever it requires, would really help us, because then we -- you know, I would have no problem saying, okay, guys, you might have been using something that was a little out of date, maybe it was the NRC 2009 report. We got something really good for you, that, you know, the first thing you would want to pull off your shelf at this point from here on out is this ATSDR product, and I would do that.

**MR. FLOHR:** Yeah, this is Brad. I do want to say that I did have a conversation with the chief consultant in the office of disability medical assessment, who controls the examiners, clearing the subject matter experts for Camp Lejeune, and I did point out that mere citations of only the NRC 2009 report would be inappropriate and should not be done. I said, well, I hope they're not making decisions where that's the only report that they're citing. But we did have that conversation.

**MS. RUCKART:** Okay, this is Perri again. This item was actually completed. It was the CAP requested from the VA a list of miscellaneous diseases and the numbers associated with each one. That was provided on December 16th.

The CAP requested the number of claims where the VA made a decision without needing an SME review.

**MR. FLOHR:** I'm told by our data folks that we really are unable to determine that.

**MS. FRESHWATER:** Freshwater. Why?

**MR. FLOHR:** It's just not available in our data.

**MS. FRESHWATER:** Could you take it back and ask them to find one?

**MR. FLOHR:** I will take that back.

**MS. RUCKART:** Perri, again. The CAP wanted to know the percent of people who have received letters letting them know that their claim is being held until new rules are developed.

**MR. FLOHR:** Sorry, I was writing. I missed that.

**MS. RUCKART:** The CAP requested the information needed to -- no, the CAP wanted to know the percent of people who have received letters letting them

know that their claim is being held until new rules are developed.

**MR. FLOHR:** Is that an action item from the last time? I don't remember that.

**MS. RUCKART:** Yes, these are all action items from the last meeting.

**MR. FLOHR:** I do not remember that, Perri. And I can't tell you but I can find out and let you know.

**MS. FRESHWATER:** Freshwater. Brad and Eric, did you guys look at the action items? Did you get a copy of the action items? Have you -- can you tell me one action item that -- because it really does seem -- with all due respect it really does seem that none of this was addressed.

**DR. ERICKSON:** I think I've heard a couple action items that we at least addressed. I don't know if it was an all-or-none phenomenon here, Lori. Sheila, did you send us --

**MS. STEVENS:** I'll go back and look at that last one and make sure that that was on there.

**DR. ERICKSON:** Yeah.

**MS. STEVENS:** But it's on the list that Perri has, so I'll go make sure --

**DR. ERICKSON:** Yeah. I mean, we -- you know,

the thing is we want to work in good faith to do all we can in this regard, and if this is on us, we apologize.

**DR. BREYSSE:** And we'll make sure that it wasn't something that slipped through the cracks from our end as well.

**MS. RUCKART:** So Perri again. Moving on, the CAP requested the information needed to FOIA the ethics review of the SMEs.

**DR. ERICKSON:** We don't recognize that one either; I'm sorry.

**MR. ENSMINGER:** Let me ask this question. This is Jerry Ensminger. Let me ask this question. This subject matter expert program was created by VHA, and it stills falls under VHA?

**DR. ERICKSON:** It does.

**MR. ENSMINGER:** Okay. I'll wait 'til this afternoon to go into the rest of the...

**MS. RUCKART:** Perri again. This is also for VA. The CAP requested a copy of the release of information form needed to speak on behalf of a veteran for a claim before a meeting that was scheduled to take place yesterday, so there would be enough time to have them sign. However, that meeting didn’t take place. I don't know if there's

an update on that item anyway.

**DR. BREYSSE:** For my benefit -- this is Pat -- would somebody remind me what the background of that request is?

**MR. PARTAIN:** Yeah, the -- going back to what Dr. Erickson said about SMEs and the reviews and things like that, we have a lot of veterans that come to us with their denials, and we were trying to get a way -- you know, when we help the veterans on their end, in all fairness to the VA, they can't divulge privacy information, so we were asking for a form that we could sign, have the veteran sign -- fill out that we could -- when we help them we can talk about their cases.

**DR. BREYSSE:** So it gives you permission to have access to their private medical --

**MR. PARTAIN:** Well, not private medical, just to be able to discuss with the VA their case.

**DR. BREYSSE:** Okay. So is there such a form?

**MR. FLOHR:** You'd have to have a release from the veteran.

**DR. BREYSSE:** Okay, so I guess what we're asking for is a copy of the form that the veteran --

**MR. FLOHR:** I don't know if there's an actual form. I mean, it can be --

**(Multiple Speakers)**

**UNIDENTIFIED SPEAKER:** (off mic) ...to be able to talk -- So Dr. Bishop, who is in the VA, is able to talk to Emory, and Emory is able to talk to them. With all this rigmarole that's being said --

**DR. BREYSSE:** Sir, what was your name? Sir, what was your name?

**UNIDENTIFIED SPEAKER:** (Unintelligible).

**DR. BREYSSE:** Thank you very much.

**MS. STEVENS:** And sir, we'll have a part at the end where the audience can ask questions.

**DR. BREYSSE:** But I thank you for your attendance and your input, but you will be given a formal time for all community members to participate.

**DR. ERICKSON:** Yeah, so I have a recommendation, and this is just one of realizing that Brad and I are not perhaps the best people to speak to this issue. But that we invite from VA at the next CAP meeting someone who represents DMA and who can speak authoritatively to issues such as this type of form, and some of the issues that Mr. Ensminger is bringing up, et cetera, 'cause I think these are important issues. It's just at this point some of the specifics Brad and I will not be able to

provide. And so -- and I apologize for that, but I think if we make this a specific request for the next meeting, we would have that person attend.

**DR. BREYSSE:** I think we can consider that a request. And can we ask -- you're probably in the best position to figure out who that person should be?

**DR. ERICKSON:** Oh, no, absolutely. But what would help, though, is if ATSDR/CAP makes that a specific request, that you'd like someone who runs the DMA to attend, to be able to speak to those issues. Okay, in the meantime, for instance, I'll definitely look in that bibliography we failed on. But I think it would help the discussion to have someone who's right in that office speak to you.

**DR. BREYSSE:** Great, great.

**MS. FRESHWATER:** Freshwater. I think what I keep asking from the VA each meeting is that you become more proactive, because we talk a lot about how we want to improve our relationship and how we want to have a better working partnership to help veterans, which we're all here to do. So I think, when we have an action item, that we want you to say, well, perhaps this person would be helpful and might be able to actually answer this question, that

we asked four months ago, and so maybe we should think about bringing them or asking them. And so again, as we go through these items, we wait all these months in between CAP meetings without having -- without being able to move forward in what we're trying to do because we're waiting for responses.

So I would just once again ask that you guys be more proactive in your advocacy to help us with this kind of thing, because we don't know what a DMA is; you do, right? So yes, I would like to formally request that the DMA be at the next meeting, and I would like to also request that maybe we would be able to have them on the next conference call or in some sort of email situation so that we can start talking about this stuff. What is a DMA exactly?

**MR. FLOHR:** The Office of Disability and Medical Assessment. They're the ones that conduct the examinations, do the examinations.

**DR. ERICKSON:** Right, and I think in one of the previous CAP meetings, it may have been a year ago, we did have a few representatives from disability medal assessment participate, but it sounds like we should re-invite them at this point.

**MR. PARTAIN:** Great. And on these items, if

there's any way we can get them before the next CAP meeting, since we -- you know, there's no sense of waiting four more months on this.

**DR. ERICKSON:** Oh, yeah. No, certainly. And good point, Mike. And what I would ask is, you know, Sheila just -- you know, that we -- 'cause I know there's a transition here coming up, which means another potential for miscommunication, that we redouble our efforts, to make sure that we're transmitting and receiving all of this. Thank you.

**MS. RUCKART:** Okay, this is Perri again. I want to remind everybody it would be really helpful if you could state your name before you --

**DR. ERICKSON:** Yeah. That was Erickson. I'm sorry, I forgot; I was talking so much, Perri.

**MS. RUCKART:** That's okay. I think, though, when I get the transcript I most likely will be able to attribute it to the right person, but this would just help.

Okay, last item for the VA: VA will provide an update on the process of getting an ombudsman to help with the claims process.

**MR. FLOHR:** This is Brad. I really don't know the answer to that. I don't know what an ombudsman would do.

**MS. STEVENS:** Let me -- I'm going to take a check and make sure that we're on the same list. 'Cause it's so unusual that we've had this many that are not the same.

**MS. RUCKART:** Well I will say, regardless of that, I mean, I know that these issues were discussed at the last meeting, at least I hope they sound familiar to everyone.

**DR. BREYSSE:** Another comment about the ombudsman. This is Pat. Brad, what was your comment?

**MR. FLOHR:** I don't know how we would go about doing that or who would do that. I really just don't know.

**MS. FRESHWATER:** Do you remember the discussion from last meeting?

**MS. RUCKART:** Okay. The next item -- this is Perri again -- I have is for the DON. The CAP requested that Craig Unterberg, a member of the CAP, be provided with the names of attorneys who are involved in making decisions about releasing documents to the public.

**MS. FORREST:** Melissa Forrest. Pursuant to FOIA exemption B-6 and DoD policy, the Marine Corps will not be releasing the names of attorneys who

have been providing advice for the release of documents to the public.

**MR. UNTERBERG:** How do I communicate with them?

**MS. FORREST:** Any questions or information that you want you'll need to provide through me, and I can bring it back, you know, through the CAP, unless you do some sort of, you know, official FOIA request.

**MR. UNTERBERG:** I guess -- yeah, I guess my question is how do we work with them to get the ability for confidential information. I think the same question I asked last time, and you said you needed to talk to the attorneys. So I said, can I then talk to the attorneys. And obviously I can't talk to the attorney. So it's the same question. I'm just not really sure --

**MS. FORREST:** Okay. Well, I'm sorry, the question that, you know, I responded to -- and I must have missed the -- another one was just if we could give you the names so you could contact them personally, and I can't do that.

**MR. UNTERBERG:** No, I understand. I think I only asked to contact them personally 'cause I asked you if there was a way for us to get confidential information, and you said that you're not an

attorney; you'd have to speak to your attorney. I said that's fine; can I speak to them. And then you said, I'll see if I can get the information. So I guess what I'm saying is the base question was how do I work with them to get us NDAs and other documents necessary for us to get confidential information? I think you deferred to the attorneys last time, and now the attorneys are deferring back to you. So it's a little circular.

**MS. FORREST:** I think that I'm going to need to talk with you so that I get a better understanding of what your question -- what your request is, so that I can formulate it better.

**MR. UNTERBERG:** Right. Well, the question is we would like to be able to sign NDAs, and then be able to get confidential information, which I'm sure they do with other consultants and other groups to allow confidential information to flow.

**MR. ENSMINGER:** Nondisclosure.

**MS. FORREST:** Nondisclosure agreements is what you're saying.

**MR. UNTERBERG:** Yes, nondisclosure.

**MS. FORREST:** You would like to be able --

**MR. UNTERBERG:** Or confidentiality --

**MS. FORREST:** -- to sign a nondisclosure

agreement to get access to documents that haven't been cleared for public release. Okay.

**MS. RUCKART:** This is Perri again. Before we move on, I just want to check in with our transcriber. Ray, can you confirm that you're able to hear the audio, and that you're pretty much getting who's saying what.

**THE COURT REPORTER:** Everything's going very well, Perri.

**MS. RUCKART:** Thanks, Ray.

**MR. UNTERBERG:** Melissa, was that a federal rule, that you cannot give out personal? I mean, that, that sounds --

**MS. FORREST:** It was DoD policy, and they also cited FOIA Exemption B-6. I can give you a copy of what I just read out. I've got an extra copy.

**MR. UNTERBERG:** Oh.

**MS. FORREST:** I'll give that to you.

**MR. PARTAIN:** I think we should recognize it's lawyer-speak saying that we don't want to talk to you.

**MR. UNTERBERG:** I'm sure they can speak to me if they wanted to, but I guess they don't. Okay, that's this one.

**MS. RUCKART:** Perri again. Also for the DON,

the CAP requested that the Department of the Navy send a USMC representative to the next CAP meeting.

**MS. FORREST:** Melissa Forrest again. The Marine Corps remains committed to the founding purposes of the Camp Lejeune Community Assistance Panel and to receiving useful input from the CAP. To that end the Navy and Marine Corps Public Health Center CAP representative will continue to relay information back to the Marine Corps and Department of the Navy team so they can determine how best to support those principles.

**MS. FRESHWATER:** I would like to make a request that the UMC -- USMC send a representative to the next CAP meeting, please. A uniform representative.

**MR. PARTAIN:** And I'll take their response as no.

**MS. FORREST:** The response that I just provided is, I am the official representative for the Department of the Navy and U.S. Marine Corps.

**MR. PARTAIN:** And no disrespect to you but our request was for a uniformed representative of the United States Marine Corps to be present at these meetings as they were in the past, when the CAP began.

**MS. FORREST:** I understand.

**MR. PARTAIN:** And we'll repeat that request again.

**DR. BREYSSE:** I don't think that means instead of you. I mean, you can still serve as the official person. I just want to make sure you're clear we're not saying we don't want you.

**MS. FORREST:** We hate Melissa.

**MS. FRESHWATER:** And actually -- it's Freshwater -- I would like the Marine Corps to give me a statement addressed to the Marines who have been exposed at Camp Lejeune as to why they won't send a uniform representative to this meeting. I don't want it addressed to the CAP; I want it addressed to the Marines.

**MS. FORREST:** I'm sorry, I'm just trying to take a few notes.

**MS. FRESHWATER:** No, I know.

**MS. RUCKART:** Perri again. This next item is a joint action item for ATSDR and the DON. The CAP requested what current SVI and VI testing, so that's about the soil vapor intrusion that's being done at Camp Lejeune and where it's being done. The CAP is particularly concerned about the school at Tarawa Terrace.

**MR. GILLIG:** Rick Gillig, ATSDR. Melissa, I

understand you have a statement prepared by the --

**MS. FORREST:** Yeah, it's pretty long, 'cause we have a fairly robust vapor intrusion investigation going on, you know, throughout Camp Lejeune.

**MS. FRESHWATER:** Can we get a copy of it also after you read it?

**MS. FORREST:** Yes, you can.

**MS. FRESHWATER:** Thank you.

**MS. FORREST:** Sorry, I apologize in advance. Marine Corps base Camp Lejeune conducted several base-wide vapor intrusion investigations between 2007 and 2015. They saw known existing contaminations.

The data collected as part of these investigations have been provided to ATSDR for their soil vapor intrusion public health assessment.

Currently additional vapor intrusion evaluations are conducted in areas where new construction of sensitive facilities is proposed; examples: schools, daycare centers, residential facilities, administrative facilities, et cetera. Environmental sampling is conducted at these proposed construction sites when sampling data is not readily available to evaluate whether or not VI may become an issue with the newly constructed

facilities.

VI evaluations, vapor intrusion evaluations, are also regularly performed at our active remediation sites when data indicates a potential for vapor intrusion, when proposed remedial actions have the potential to impact the vapor intrusion pathway, example, air sparging, biosparging, et cetera, or if soil groundwater contamination is migrating within close proximity to a sensitive facility.

With regard to the existing elementary school at Tarawa Terrace, a vapor intrusion evaluation was conducted in 2010 to 2011, due to a nearby volatile organic compound groundwater plume. Shallow groundwater, soil gas and indoor/outdoor air samples were collected, and multiple lines of evidence indicated that vapor intrusion was not occurring at the school. A similar investigation was conducted at the nearby child daycare center, and vapor intrusion was also found not to be occurring.

Currently soil gas samples are periodically collected near the Tarawa Terrace school in order to evaluate the potential for vapor intrusion as part of ongoing remediation efforts for the groundwater plume. As previously stated the data collected as

part of these investigations have been provided to ATSDR for their soil vapor intrusion public health assessment.

**MS. FRESHWATER:** Thank you very much. I have a question. I'm not sure who to address it to, but can we just get a date on the last test done?

**MS. FORREST:** At Tarawa Terrace?

**MS. FRESHWATER:** At the school.

**MS. FORREST:** At the school?

**MS. FRESHWATER:** Yeah.

**MS. FORREST:** I'll take that. A date on the last?

**MS. FRESHWATER:** The last --

**MS. FORREST:** Any type of --

**MS. FRESHWATER:** I'm assuming they've tested since 2011, so if we could just get an update on when the last testing occurred at the school? Thank you, Melissa.

**MS. FORREST:** You're welcome.

**MR. ORRIS:** Melissa, this is Chris Orris. Those vapor intrusion tests, are they industrial levels or residential?

**MS. FORREST:** I'd have to go back and confirm. You mean as far as where we're using EPA screening levels or as compared to like an OSHA or do you --

industrial versus EPA, or do you mean as in the exposure assumptions of, then the number of hours, number of days per year that you'd have residential versus industrial?

**MR. ORRIS:** Correct. I mean the number of hours for exposure, whether the school was tested for industrial or residential.

**MS. FORREST:** I will have to go back and look at that. I could make a guess but I don't want to make a guess.

**MR. ORRIS:** Thank you.

**MS. FRESHWATER:** Does anyone at ATSDR have any information on that, that could help?

**MR. GILLIG:** Mark Evans is our lead scientist -- Rick Gillig, ATSDR. Mark Evans, our lead scientist, is not here today, so I don't have that level of information.

**DR. BREYSSE:** We will tell you what the most recent report that we have in our file relative to that school. We'll get that information to you.

**MS. FRESHWATER:** Thank you very much.

**MS. RUCKART:** Perri again. Just a few more things to go here. This is also a joint item between ATSDR and DoN. The CAP requested that ATSDR discuss with the Navy the time frame for when their

reports and documents can be released to the CAP, and to provide a day and time when the documents will be available. When the ATSDR drinking water and soil vapor intrusion assessments are released the cited documents will need to be available to the public.

The CAP also requested to review all documents provided to ATSDR for their consideration in updating the PHA regardless of whether we used them or cited them in the final report. The CAP wanted to know if they need to provide an official FOIA request for these documents.

**MS. FORREST:** Melissa Forrest. The Department of the Navy review process under the Freedom of Information Act is nearing completion; however, we can't provide an exact day or time when the review will be complete. Once the review is complete, the Department of the Navy will provide the documents to ATSDR for release to the Community Assistance Panel or public. Further, there is no need for the CAP to file an official FOIA request as this will not accelerate the review process.

ATSDR identified a large volume of documents that they determined are potentially relevant to their Camp Lejeune soil vapor investigation PHA

effort, and have asked the Department of the Navy to review those documents for release to the CAP and public. The volume of documents currently being reviewed for release is much larger than just the documents that will be cited within ATSDR's SVI PHA.

**MR. TEMPLETON:** This is Tim Templeton. Is there any way that they can at least do some limited releases on these? Because I mean, if we're waiting for the baby to be born, you know, we'd have to get a chance to see like an ultrasound of what the baby looked like. I want to -- I'd like to see an ultrasound first, and make sure we got a baby in there.

**MS. FORREST:** Rick, do you have any comment? I mean, I can take that back as a request. I understand at this time the plan is to do it as one block of -- one, one mass release of documents.

**MR. GILLIG:** Rick Gillig, ATSDR. That's my understanding as well. And Chris, I hate to put you on the spot, can you tell us how many documents we've shared with the CAP at this point, ballpark?

**MR. FLETCHER:** Chris Fletcher, ATSDR. I don't know the number off the top of my head. Everything that's available you guys can check out now is on the FTP site. And I think everybody's got

instructions to that. Maybe some of the new members haven't seen those. But those include all the documents from North Carolina Department of Environment and Natural Resources. I'm blanking on it. That's right, the UST files that were originally released through the drinking water stuff. And I think there's another small group on there. But the majority of the documents we're waiting for DoN to finish their review. And then when they do we'll put all those up on the FTP site and you guys can --

**DR. BREYSSE:** Chris, would you say your last name for the transcription?

**MR. FLETCHER:** Fletcher.

**MS. FRESHWATER:** So can we put in an official request for -- that we get documents as they become available as opposed to waiting until all are available? Is that the right wording, Tim? That was Freshwater.

**MS. FORREST:** I'm sorry, I was thinking about what I was going to -- what were you saying? Repeat that again?

**MS. FRESHWATER:** Can we put in -- we would like to put in an official request that we get documents as they become cleared as opposed to waiting until

all documents are cleared and dumped on us. Dumped on us is not official language; I understand. Please translate to official government language.

**MS. FORREST:** I understand. Thank you.

**MS. RUCKART:** Perri again. The last action item was for ATSDR. The CAP requested that we invite Dr. Blossom, she's an immunotoxicologist, to the next CAP meeting. She was not available to come to this meeting. And Tim and Sheila will be working with her to get her here in the future.

**DR. BREYSSE:** So that takes us to the end of the action item part of the agenda. We're running a little bit behind, but these meetings always have their own flow to them, and I want to make sure we maintain that.

So the next item on the agenda is an update on the health assessments. And I'll turn it over to Rick Gillig.

**UPDATES ON HEALTH ASSESSMENTS**

**MR. GILLIG:** This is Rick Gillig, ATSDR. I want to cover the soil vapor intrusion project first, and that's a very brief update. We are still looking through the documents provided by the Department of the Navy. We're pulling data out of

those documents and populating a SQL database, so that's a long process. There are quite a few documents to go through. Any questions on that project?

**MR. ENSMINGER:** What's an anticipated completion date?

**MR. GILLIG:** I think it's going to take us at least six more months to pull the data out. And that may be too conservative of an estimate. And then we need to -- once we get the SQL database populated we need to analyze it, both from a temporal and a spatial standpoint, and then write our health assessment. I wish we could do it quicker but going through documents and pulling out data takes a lot of time. Any other questions on the soil vapor intrusion project?

If not we'll move to the next item, and that's to discuss the public health assessment on the drinking water analysis. Before we get started with that I want to introduce the team that put this document together. Please stand up when I mention your name. Bert Cooper is the team lead for the staff working on the project. We have Danielle Langman who is new to the team. Danielle reviewed the lead data and helped draft portions of the

document. Rob Robinson, I've introduced in the past. He has accepted another position at ATSDR. He is not with us today. And then we have Dr. Mark Johnson. Mark is the regional director out of the Chicago office and the lead toxicologist on the project. And Mark will be going through a summary of the findings in our public health assessment. Mark?

**DR. JOHNSON:** Yeah, thank you. I indicated the objectives we had with this assessment. (Unintelligible) as a team effort. We really wanted to make sure that this assessment –- Can everybody hear me okay?

**MR. PARTAIN**: No.

**DR. JOHNSON:** Okay. I'll try to be closer. We had three objectives for this assessment. We first wanted to use the most current science, both in terms of assessing exposure, use Morris Maslia's modeling project results as a basis for our exposure. We utilized the most current science about the toxicological effects of exposure to the contaminants in the drinking water at Camp Lejeune. And we also sought feedback from the CAP regarding some of our assumptions about exposure to the various groups, to make sure that hopefully our

assessment was in fact in alignment with the exposures that occurred at Camp Lejeune. And the last objective we had was to make sure that our assessment results were presented in a way that was informative to the public and to the veterans who served there, to make sure that this is understandable. It wasn't just a document that we released but it was actually something that was understandable and presented in a way that would be informative to those individuals.

So we'll go through this. This has been -- it has gone through extensive internal review. It's gone through peer review last fall. The CAP was provided an opportunity to review that at that time. And then now we've incorporated those peer review comments into this version, which is now going to be released for public comment review. And we welcome that input and feedback on the clarity of the information we're presenting in that document.

Obviously I don't need to introduce the background information to this audience about Camp Lejeune. Some of the topics we're going to cover in this overview is the background, the populations that we evaluated, so that you can be clear about what groups we targeted for our assessment of

exposure and ultimately for indicating the potential impacts on their health.

We focused mainly on the volatile organic compounds, VOCs, in the exposure assessment. Those are contaminants in the drinking water that could then be resulting in exposure, both through ingestion of drinking water but all through the inhalation of the water as it's used for various purposes, mainly for showering and bathing.

We also included what we refer to as a special VOC exposure. That would be something in addition to the typical kind of exposure you would experience in those natural settings. For example, the CAP had the input and requested the assessment of special conditions like laundry facilities, food preparation areas where water is used extensively in those activities. So there's a section of the document where that was evaluated.

We also included exposure to lead from ingestion in drinking water. That was part of the assessment in terms of looking at potential exposure to health impacts, mainly of the young children but also to adults as well.

And then finally wrapping that into an overall assessment of health impact findings with actions

and recommendations for follow-up. So that's kind of an overview of what I'll be talking about.

Background information. You don't need to know this. You already know this, that our public health assessment focused obviously on drinking water. Again, past exposures where we believe the contamination was -- goes back to the early 1950s and then continued on 'til the 1980s, when those wells, contaminated wells, were shut off.

As I mentioned the inclusion of more recent data on lead in drinking water, which is mainly the result of the contribution of lead service lines that are present on the base and can provide an ongoing potential release if those conditions are not maintained to maintain corrosion control. And so you're monitoring of water quality to make sure that lead is addressed.

I mentioned about the peer review process and the CAP's comments on the draft, which was last fall. It took us -- we had a lot of comments. It took us a while to incorporate those. We feel we have addressed those, and now we're going to be releasing this document for public comments.

So with most of the populations that we evaluated in this we needed to focus on specific

groups that allowed us then to address the main individual or groups of people who would be exposed or have been exposed. So the first one was young children who lived on base with their families. The second one was adults, could be spouses or other family members, adults, who lived on the base. That was also inclusive of women who were pregnant at that time. We also included workers who were employed at the base, but who would -- who lived off base but were still exposed to water on base and related to their employment. And then finally Marine personnel who trained and lived on base was a primary focus, again, of our assessment, which included a more intensive evaluation of the exposure to water during training, as we included information that was available to us to assess the more intensive exposure to Marines in training because they're more likely to have water use in terms of during their training they would be ingesting more water but also they would be showering more frequently during the day. We included that information in our assessment.

So these are the exposure pathways. The main concern we have with exposure to water is through ingestion, through dermal contact, also through

inhalation of vapors through showering and bathing.

And the main focus was on the contaminants that are listed here: PCE, tetrachloroethylene, trichloroethylene, dichloroethylene and vinyl chloride, which are all breakdown products of the solvents that were utilized -- used on base, were impacted on the base, and were contaminants in the groundwater that was then used as a source of drinking water for Camp Lejeune water systems.

We used the modeled water concentrations that I mentioned Morris provided to us. To assess the overall concentration we did what we refer to as a three-year running average. So we assumed that the average time or upper end of exposure duration for Marines who were in training was three years. That includes those -- the family members. We then assumed that for workers, though, that it might be a longer duration, that they may not necessarily be there for that limited time, but we assumed that they could be there working and exposed for up to 15 years as an average.

As I mentioned we also included site-specific values that for Marines in training, and the CAP provided some input to make sure that those were in alignment with what was really appropriate for those

exposures for Marines.

And then we used that information, then, to estimate the exposure, both the average but also what we refer to as the upper end, or the 95$^{th}$ percentile. So we're looking at a range of exposures that would be inclusive of the -- even the most intensive individuals who were exposed.

I mentioned about the special VOC exposures, so the assessment also included assumptions about the exposure to these other opportunities, indoor swimming and training pools. I've taken information about the frequency of those activities. We estimated the air concentrations that could be -- could occur in those environments, then, to assess overall exposure. We also included laundry facilities, civilian workers who worked in those facilities, food preparation, dishwashing operations gave us an estimate of those exposures in those settings. That would be in addition to those that I mentioned earlier about the more residential-based exposures.

Lead exposure assumptions through the drinking water, we used what EPA refers to as the integrated exposure uptake biokinetic model. That's a mouthful. It is a tool that's used for estimating

the impact of exposure through all sources. It would include water, include air, include diet, soil as a measurement of the potential impact on blood lead in children. And the assessment then uses, then, what we -- to predict that and determine what level of exposure could lead to an elevated blood lead in a child. And that's based on the most recent guidelines that the CDC has for blood lead measurements of five micrograms per decimeter as a reference level for that comparison.

And so we utilized the site-specific drinking water levels in that assessment, assumed a background level of lead that could come from soil as a hundred parts per million, which is believed to be the average level on base, to make that prediction and that comparison.

In terms of our evaluations of the exposure part of it, then we also looked at the toxicity. What does that mean in terms of health impacts? So we summarized this in two categories. One is referring to the non-cancer endpoints. How does that exposure relate to other health effects? That's based on specific effects on the organ systems, and I'll talk about that. But also the concern about this just wasn't one chemical. There

were at least four different chemicals that were present there. And the ability to assess the combined effect of that exposure to multiple chemicals was part of our assessment.

And then the second part of that is looking at the effect on cancer risk. There's a separate determination about cancer risk which is different than what we refer to as the non-cancer hazard. We also utilized age-dependent adjustment factors. We know that, based on studies, that exposure to young children has a greater impact for chemicals that act by what's called a mutagenic mechanism of action. Chemicals that act by causing mutations can have a more significant effect on young children. And so for example with the trichloroethylene assessment for kidney cancer, we applied an adjustment factor to account for that early life exposure risk, which is greater than if the exposure occurred as an adult.

We also applied another adjustment for vinyl chloride, which is similar to what I was just mentioning, that based on animal studies, that exposure to an animal at birth has a greater impact in terms of its cancer risk than if that exposure occurred as an adult. So our assessment included an

adjustment for that maternal exposure that would account for the impact in the early life. And we applied that up to the age group of six years of age.

So what are the findings? So there are five conclusions in the document that I'll summarize briefly. And we've organized these according to locations and specific topics. So the first inclusion is addressing Hadnot Point exposure. That would address individuals who lived at Hadnot Point, residents, but also Marines who lived there and were also exposed during activities, and in areas where Hadnot Point was providing water supply to other areas of the base in addition to the residences.

And through this quickly. The past exposure to VOCs in the drinking water supplied by the Hadnot Point water treatment plant were high enough to increase both cancer and non-cancer risk to Marines, Marine recruits, Navy personnel, residents and civilians who drank the water during the exposure time periods. Now to mention we break that down into assessments for both non-cancer, which the main effects of these exposures that the ones that set about in terms of their impact were the effects on the immune system, particularly in children as well

as exposure to pregnant women and the effect on the developing fetus of causing potentially fetal heart malformations in the offspring. And also the cancer risk, we found evidence increasing risk for kidney, liver, non-Hodgkin's lymphoma and lung and brain. And that was based on both looking at the animal toxicity data but also the epidemiological data that has been developed both in terms of other studies but also Camp Lejeune-specific studies that looked at these endpoints as well.

The second conclusion is focused on Tarawa Terrace. So just to read this again, past exposure to VOCs in drinking water supplied by the Tarawa Terrace water treatment plant might have harmed the health of young children and Marines in training. The estimated levels to which young children were exposed would have resulted in an increased cancer risk and increased potential of adverse non-cancer effects.

**MR. ENSMINGER:** I got a question on that. This is Jerry Ensminger. Doctor, in your writing there you said that the estimated levels to which young children were exposed, you left out fetuses. Why? Fetal exposure.

**DR. JOHNSON:** Right. So the way we have

organized the assessment is that the exposure would occur to a pregnant woman, and so that the impact, then, is reflected in that exposure. So the document does go into these -- for example, with fetal cardiac malformations, then, is obviously a fetal effect during exposure to a pregnant woman. So we're not ignoring it but we're acknowledging that that is a mechanism by which the health effect is exhibited, is through exposure to a pregnant woman.

**MR. ENSMINGER:** No, no, wait, wait. Wait. Yeah, but you're not addressing cancerous effects to a fetus that was exposed in utero.

**DR. JOHNSON:** Well, we're certainly including the cancer risk for the child who is exposed at birth. And we're including, as I was mentioning, where the additional adjustment for that additional risk because of that exposure occurring at that point.

**MR. PARTAIN:** But when you read it, it doesn't look right.

**MR. ENSMINGER:** No. There's no explanation of that.

**DR. BREYSSE:** In terms of this slide in particular? Is that what you --

**MR. ENSMINGER:** No, in the -- okay, the assessment itself.

**MS. FRESHWATER:** Jerry, what page is that?

**MR. ENSMINGER:** It's in the preface. It's Roman numeral 14. And then -- well, go ahead, because I'm jumping ahead of you. But okay.

**MR. PARTAIN:** This is Mike Partain. Just when you read this, I understand you're saying children, but is there not a -- these chemicals affect a fetus differently than a child, okay. These chemicals would affect a forming fetus differently than a child who is outside the womb. And the way this reads, and what I'm hearing here, it does not appear to address that. And I would think that there would be, from a health perspective, there would be more of a concern on exposure to a fetus because of that risk, and I don't see it being addressed.

**DR. JOHNSON:** Well, the document does describe the outcome of the (indiscernible) studies that have looked at birth outcomes, in terms of low birth weight and other outcomes related to the outcome of pregnancy.

**MR. PARTAIN:** But for the benefits of, you know, you may -- I'm sure to you may be perfectly clear, but to other readers down the road and policy

decision-makers down the road who are looking at this, you know, lay people who are looking at this, it doesn't jump out. So it may need to be spelled out for them: *Idiots' Guide to ATSDR's* (unintelligible). It just doesn't jump out.

**DR. BREYSSE:** All right, Mike. So you guys are totally welcome to comment again going through, and it's now a public release. So we want to entertain all your suggestions. So make sure -- my first comment is make sure you get it in the system where it's formally -- we have to respond at that point.

But also recognize that a public health assessment is, by definition, a scoping kind of exercise. And we have to assess what we think the potential health risks are based on things that have been quantified in the literature. That doesn't mean that other things are not possible. That doesn't mean that other things are not there. But we just -- if there's a potential cancer risk but there isn't an exposure-response relationship in the cancer risk that would allow us kind of make a quantitative assessment of what that is, we're limited in what we can say. So just keep in mind that not everything can be addressed in a public health assessment because the science is not always

-- not always there in a way for us to be quantitative. But that doesn't mean we can't qualitatively identify those things that we couldn't quantify as a potential risk factor. But just keep that in mind, and so that we can't possibly quantify everything that's possible because the literature isn't strong enough for us to do that. Was that clear?

So if there's no data that allows us to calculate what the risk for cancer is for being exposed in utero, right? So there could be epidemiological evidence to suggest that, you know, exposure in utero might, you know, result in increased cancer risk. But if we don't have any exposure-response data or any quantitative data that allows us to say, okay, if a woman drinks this much while she's pregnant, therefore her risk goes up this much. So if we don't have that -- if we don't have that kind of data, we can't quantify an in utero risk.

**MR. ENSMINGER:** But you did a study.

**DR. JOHNSON:** But our study --

**DR. BREYSSE:** So we're in a bit of a bind here, if I can be honest. So normally the way things would work is a public health assessment would come

first, and then we'd use that to inform a more detailed epidemiological investment going forward. So in this case where we got the cart a little bit ahead of the horse in that regard.

But our epi study is a more firm evidence about what the health risks are for the people we studied and what we're estimating here. So the epi study was an actual assessment of the health risk in people; this is just an exercise where we're estimating the health risk based on what we think might happen in a population of people who drank or showered or used this water. That's the difference between the two.

**MR. ENSMINGER:** Yeah, and also aren't you supposed to address these health conditions for the most vulnerable populations?

**DR. BREYSSE:** Yes, yes.

**MR. ENSMINGER:** Well, isn't a fetus vulnerable?

**DR. BREYSSE:** Absolutely. And where there's data that allows us to --

**DR. JOHNSON:** Correct. Yeah, I think this is exactly right that this assessment is really a predictive tool to take in a special amount of exposure and, based on the toxicological data, estimate what could be the outcome. But there are

many gaps, as Dr. Breysse mentioned, where the epidemiological study's looking at the actual impact and measurement of that, and that's the distinction here. So if it's something that we need to include, please comment that. We can certainly explain that in more detail.

**DR. BREYSSE:** Well, we want to make sure that people don't assume that if we weren't able to quantify something here or that these necessarily, you know, supersede what we might measure in epidemiology studies. That's not the case. Ken?

**DR. CANTOR:** So my question is just an add-on to this. If you have animal toxicologic data that shows fetal effects, or effects of exposure on the fetus, and as it affects after (indiscernible), would they be adequate to enter this into the public health assessment?

**DR. JOHNSON:** Right. We have done that. As I was mentioning the vinyl chloride is an example where early life exposure has a significant difference in terms of risk. And there is some data regarding occurrence during pregnancy, and that's part of the literature review that's included in the assessment.

**DR. BREYSSE:** But if we've missed some data,

please let us know. If there's something that we didn't miss -- but you'll see we do estimate the possibility of fetal cardiac malformation 'cause there's actual data that we can use to estimate that. That doesn't mean that other in utero exposure, other health effects are not caused by in utero exposure. So that has to be clear.

**MR. ENSMINGER:** So why don't you just add fetuses, unborn fetuses to this?

**DR. JOHNSON:** Right. We should certainly make that more clear. But again, the point is that the exposure, or pathway, is through the pregnant woman being exposed. The impact is on the fetus.

**MR. ENSMINGER:** I'm sorry. This is Jerry. It's like Mike brought up, you've got decision-makers and you got other laymen who don't understand the process of exposure through the mother, which crosses the placenta to the fetus, okay? But you don't have to explain all that. All you got to do is add fetuses to that paragraph, unborn fetuses.

**MR. ORRIS:** This is Chris Orris. And this touches personally to me. I'm sure most of you are aware I was actually exposed in utero at Tarawa Terrace, and in 1974 I was born at the base, at the hospital on base. And during that time frame they

did not conduct fetal tests like they do now at birth.

I'm a living example of a fetus that had cardiac malformation. And my heart malformation was not diagnosed until my mid-30s, when it almost killed me. And my data has never been included in any toxicological studies that have been done by ATSDR or any other agency because of the limitations of the epidemiological study.

I think this is a good and valid time to relook at the birth study and to maybe open up the parameters based on the limited data that was there, to see if we can't do more fetal exposure studies going forward.

**MR. HODORE:** Also -- my name is Bernard Hodore. I want to address the -- what about the women Marines with miscarriage? Multiple, multiple miscarriages.

**MS. RUCKART:** Okay, well this is Perri Ruckart. First I'll address Chris and then I'll address your comment. So you know, we've had a lot of discussions with you about this, and you know, just as you were mentioning how your heart condition was not identified at birth, you know, that's just the way it is, and these records are not readily

available, and it's just not something that we're able to look at. We're not saying it doesn't exist or that there isn't a connection; it's just not something we're able to address, and we've explained to you, and I thought the group -- why we just were only able to look at the birth defects and adverse pregnancy outcome conditions that we did. It's just based on limitation. It's not that we wouldn't want to, but I just don't see how it's feasible. I mean, we have looked at all different kinds of sources of possible data, and they're just not there.

**MR. ORRIS:** So Perri, it's not just focusing on cardiac malformation. We know that exposure (unintelligible) for the babies exposed. And what I'm proposing at least on a health study to all of the babies who were exposed in utero and do an entire health study based on their current health issues, not what you can go back to in the 70s and the 60s.

**MS. RUCKART:** So about that, with the health survey we attempted to address those concerns as well. We included those births that we knew about from our other studies, and we sent them health surveys where they could report, you know, a variety of conditions that they experienced over their whole

life. And we only got, I can't recall off the top of my head, but a few thousand back, and that'll be presented in our health survey report.

**MR. ORRIS:** So as a member of the CAP, I mean, I never received a health study, never. My family never received a health study, and this ties back to Melissa Forrest with the Department of the Navy has never notified children exposed at the base of their exposure. They refuse to do so even though that entire population is an adult population now.

And this is something that really speaks close to my heart because in utero-exposed babies probably do not know the health risk that they face based on their exposure to these chemicals. Now, you know, if you would like to do another study and send me a study, I've got about 30 health conditions that I can include on that study that might add a little more weight to your science.

**MS. RUCKART:** Well, we also have discussed this in the past, just how we identified people to include in the study, and we know that there are more people out there than we could identify, but we had to identify people in a systematic fashion. You know, we had, at the time when we were developing the health survey, really tried to get a good handle

on what records were available, and we wanted to broaden just from the births that we knew about in our other two studies, so we went and looked at school records, and those records are in really poor, old condition, on microfiche. It just wasn't something we could use. They did not have a record of all the yearbooks. You know, we had worked with the Marine Corps and the Navy, the DoD. We got their (indiscernible) entire data center. I mean, I understand your frustration, and I am sorry, but I -- I'm not sure what all --

**DR. BREYSSE:** And if I can just add, so we will -- we constantly re-evaluate what we can do, what we should do, what we are doing. We will rethink that -- rethink what we might be able to do, Chris, I can promise you, recognizing that there are limitations for what we can do. But it's in no way meant to diminish your suffering or to imply that these aren't tragic situations in people's lives as well. So but we will look at it again.

**MR. PARTAIN:** Dr. Breysse, you know, just going back with the in utero study, and I brought this back up a couple years ago, you know, we had to identify the children born at the base through their birth certificates, and I believe they had at one

point Social Security Numbers and everything, to do the original study. I understand that data has been discarded, destroyed or what have you, if I'm correct. But as far as the Social Security Numbers being able to identify the children, because to Chris's point, you know, this is -- we are an adult population. I'm one of the children as well. And I have talked to countless children born at Lejeune over the years, as I've been involved in this. Some of them are dead now. I mean, most are in our 40s. We're seeing cancers, ovarian cancers, (indiscernible) cancer, breast cancer, male breast cancer, and of course the effects like Chris that manifest itself. And, you know, going back to this point with the public health assessment, if we're looking at studies to try to provide answers, you have a group identified. You have a rather unique group in fetuses that were exposed in utero to a known -- three known carcinogens. Now that we're in our -- you know, we've had time elapsed. Why aren't we going back and studying the children? So you can answer this question back up here.

And you know, that going back with our public health assessment, please understand, you know, the reason why we're -- I don't want to seem we're

nit-picking on the words, but going back to my point about people are going to read this afterwards -- and just like we have seen -- and we're not bringing this up just to bring it up, but we have seen policy-makers; we have seen the VA nit-pick and take things out of context and interpret them differently than what was intended. So if it's not spelled out or the fetus added into this paragraph, and it's published, and then three years down the road we're trying to get something done, they're going to come back and say, well, ATSDR didn't say that. And I've heard those words been used against us as we've tried to bring this out.

**DR. BOVE:** Let me go over what -- this is Frank Bove -- let me go over what data we have, okay. We did a study years ago, with Perri as the first author, of those who were born either at Camp Lejeune, or were in utero at Camp Lejeune but born elsewhere, from 1968 to '85, okay. And that's the basis for the study that looked at neural tube defects, a brain defect, and oral clefts, cleft lip and cleft pallet, as well as childhood leukemia, okay.

So with that data -- and again, we had to ask the Marine Corps for help to identify those who left

the base, because there's no information. A lot of that information came from word-of-mouth or media outreach. So we have that group of people, from '68 to '85, born at the base or born off the base but had their pregnancy on the base.

We then sent surveys to them. We did the study and found associations with neural tube defects. Some of that's also in the literature from previous drinking water studies, either Woburn or New Jersey, that I participated in, for example. And we then, what -- oh, okay. We stopped -- we started in '68 because the data was computerized, partially computerized, at the North Carolina (indiscernible) records for birth certificates, that was started in '68.

Also back then we did not have the drinking water modeling effort that Morris and his team did. So we didn’t know exactly when the contamination started, so we thought '68 wasn't a bad time to start, and actually it isn't because the contamination was pretty good then. It was less as you went further back in time. So we have that data, okay.

We have -- well, we don't have Social Security Numbers on these children. That's one thing we

don't have, okay. We sent surveys to them. We had a very poor participation rate for the survey, and we're going to go into that once we go into -- when we're ready to present those results. Poor in the sense that a survey that's mailed out to people, and that includes the census too, in these days have poor participation rates. Even the census, where you have to fill it out by law, they still have a poor participation rate when they mail it out. They have to go door to door to actually increase the -- to an acceptable level. So this is a problem with surveys that are mailed out, whether it uses the web to answer the survey or whether you mail it back to us, it's still a problem.

Okay, so it's everyone that we could identify and have an address for who were born at the base between '68 and '85, or born off base, that we were aware of, were sent that survey, if we -- if the locating firm had their current address and they had a real address that they could be mailed to. Okay, so these surveys went out; we got very few back in a sense, relative to amount sent.

**MR. ORRIS:** Frank, just to clarify, were those surveys sent to the children who were exposed or were they sent to the --

**DR. BOVE:** Yeah, they were sent to the parents and the children. And if we had the address, if the locating firm -- I think it was Equifax -- could find the address, they were mailed. We mailed hundreds of thousands of surveys out. Okay, so this has been done, and this is the best you can do with a survey.

Better studies are done when you have already collected data from a cancer registry or a birth defect registry or so on. And that's why we're doing a cancer incidence study, which we'll talk about later. But we're limited by the data we have.

But other studies have been done in other populations, and we can use that information. As I said there was a drinking water study done in New Jersey that we used to justify our study, and Woburn as well, a study done there that justified why we wanted to look at childhood leukemia. So we tried to pull in information from other studies. If you see it in another population exposed to the same contaminant, you can make the inference that it will also happen at Camp Lejeune. And so that's what we try to do when we review the epidemiologic data. And so -- and again, the health assessment has a different purpose than our studies. It also has a

different purpose than our effort to brief the VA, for example, on what we saw in terms of the epidemiologic evidence, because the health assessment, correct me if I'm wrong, Mark, bases the risk estimates on published information on what they call cancer potency and other reference level parameters that are based primarily on animal data, because that's the best data, where you can control how much the animal is exposed, and then be able to calculate these. Some of them are based on human data but most, I would say, are based on animal data. So keep all that in mind.

So then the exercises that Dr. Breysse was mentioning, where we're trying to predict, and Mark mentioned too, a risk, we have to use these kinds of published parameter data to do that. But that doesn't mean that if you look at the epi evidence we'd have a longer list maybe of cancers on that line there.

**DR. JOHNSON:** Right, so the quantification is, as Frank mentioned, is based on animal studies and to some extent some human studies. But we acknowledged in the discussion and in the document, though, that there are other studies that validate this or indicate other risks as well. So the other

point I wanted to make here is I'm just going on two sentences from the conclusion discussion. The end point you mentioned about fetal cardiac malformation is in fact the exposure that occurs in a pregnant woman and the effect on the fetus. We can certainly reword this in a way that's more clear.

**MR. ORRIS:** Just to tie back one more time. Frank, I just want to ask you, is there valid scientific -- would you find from a scientific standpoint any useful information from doing a current study on children who were exposed at Camp Lejeune? Would there be a body of scientific evidence that could be useful from a study of children exposed at Camp Lejeune, even as far as the DNA study?

**DR. BOVE:** Well, the survey is that attempt, and we'll discuss that when we're ready -- when it goes through clearance and so on. But that is the effort we did for that purpose.

**MR. ORRIS:** But would there be valid scientific usefulness for a study of an exposed population (indiscernible)?

**MR. ENSMINGER:** The problem would be finding them. That was the problem they had with the initial study and the survey. First they did the

survey. And they had so much difficulty because there are no records on those kids. I mean, there's so many of them, I mean, you'd have to track them all down, and I don't know -- it would be a monumental task.

**MS. FRESHWATER:** Can I just --

**MR. ORRIS:** Well, hold on just one second, Lori. Really quick, thanks to the efforts of everybody here, the level of knowledge of exposure at the base has greatly increased. There is a large percentage of people who were born at the base who are experiencing problems that were not contacted initially. But maybe an effort ten years after the last survey was done would generate better participation results.

**MR. ENSMINGER:** Well, and I can tell you now, from my knowledge, that the way that the health effects that were selected for the initial study were whittled down by the Department of the Navy. Your health effect was left out of it.

**MS. RUCKART:** And this is Perri; I have a response for this. So for our studies we have to use a population that is identified systematically in an unbiased fashion, you know, not where we have people call in; we have records. So we have that

for the health survey. Also, though, for the health survey we did send those to people who registered with the Marine Corps. We did get information from those people, and we will be publishing a separate report about what they reported. It'll be separate because they weren't identified in the same way, and it's not seen to be as scientifically credible. But we do have those people, and we will be publishing that -- some type of report on that as well.

**MR. ORRIS:** So would a birth certificate from the base suffice to be able to be included in that study? If you were born at the military hospital on base, wouldn't you be able to be included in that study? And, and a further point here, just to let you know, my father is a retired 30-year sergeant-major in the Marine Corps who was also a retired civilian employee at the base. And you guys are telling me, for somebody whose father worked at the base during the time that these were going on, that somehow I was not able to be included in the study, and I never even knew about it until a couple years ago, when President Obama signed the law with Jerry Ensminger. It's a complete and utter failure of notification.

**MS. FRESHWATER:** Chris, Chris, let me --

**MR. ORRIS:** So what, what I'm saying is --

**MS. FRESHWATER:** -- Chris, Chris. Let me --

**MR. ORRIS:** -- is, is --

**MS. FRESHWATER:** -- just say something. I think -- I'm not going to disagree with you, but I think at this point we have to -- I lost two siblings to neural tube defects. They're not included in any study. There has been -- right, I know, but what I'm saying is that at some point we have to put our personal -- because it's a science -- the science is doing all it can, and we can't -- because -- I mean, what we're looking at is an impossibility --

**MR. ORRIS:** Right.

**MS. FRESHWATER:** -- to try and go back and find where people have moved, and all of that. And I agree that --

**MR. ORRIS:** I disagree --

**MS. FRESHWATER:** -- we can move in that direction --

**MR. ORRIS:** -- the effort should be made.

**MS. FRESHWATER:** They are making effort, I mean.

**DR. BREYSSE:** Chris, we will reconsider what is conceivable, what we can do -- if we think we can do

a better job, reconsidering it, we will look into that. Frank and I know about the limitations that we have talked about.

**MR. HODORE:** I just have one question. I didn't mean to interrupt you, Dr. Breysse, by no means. I just want to know that these women Marines are having multiple miscarriages, multiple miscarriage. And the Marines has, in certain cases, covered these miscarriages up, to these babies.

**MS. RUCKART:** Bernard, I didn't forget about you. We just haven't had a chance to get back to you, but --

**MR. HODORE:** I'm sorry. I'm sorry.

**MS. RUCKART:** That's okay. Miscarriages are included in the health survey as something we were looking at. And when we report on the health survey results when they're available, we'll give the results of what we found, so we didn't -- you know, we did include it. I don't want you to think that we forgot about your question. And also we did look at that, as among the Marines and the civilian employees. So we had both those groups.

**MS. FRESHWATER:** And Chris, I just want to say I know, Chris, your frustration. You found the baby graveyard. But I'm saying it does have something to

do with it because we keep -- it's limitless the amount of times that we keep getting new information on people who were in utero on base who didn't live when they were born. So I'm just trying to validate, not only yours but all of the people who you're speaking for, and myself who lost family because of it.

**MR. ORRIS:** As a child who was exposed before birth, the medical problems that I experience are different than a lot of other people, and other children like Mike who were exposed in utero, before birth. We are a willing population for further scientific study. Like Mike said, this is a pool of medical information that can be used, not just for this situation but for many others, and I think every effort needs to be made to try to address this.

**DR. BREYSSE:** I don’t want to let Mark off the hook, thinking we’ll forget about him. We hear you, Chris, and if we can do better, do more, we will try.

**DR. JOHNSON:** And the third conclusion, again, focusing on the --

**MR. ENSMINGER:** Let's just back up to conclusion two because you didn't cover the rest of

that, because you had a however at the end of this. It says, however Marines who were exposed to water from Hadnot Point that lived in Tarawa Terrace may have had cancer risks similar to Marines who lived at Hadnot Point.

I don't know what you guys think about the dependents that lived in this other housing area which was Tarawa Terrace, but they weren't sequestered there, okay? All the main services on that base were located at Hadnot Point. The mothers, up until 1983, when they took their children to the hospital for check-ups or they were sick, for doctor appointments, went to the old hospital, which was on the Hadnot Point system. They would go to the commissary and the main exchange. If they had legal appointments they had to go over to the base legal office. All this stuff's located at Hadnot Point, the bowling alley. I mean -- stables. I mean, everything was -- yeah, the theaters, I mean, everything was -- I mean, so could you say the Marines, the sponsors that lived at Tarawa Terrace, and then went to Hadnot Point to work, and then came home, had an increased risk. You're leaving out their family members.

**DR. JOHNSON:** Right. We can -- that's a good

point. And again, the focus of this was on where people would've received most of their exposure to water, which would be residential. We tried to include it in the uncertainty discussion that there were risks that could be in addition to that of the residents.

**MR. ENSMINGER:** I still think that poo-pooing 215 parts per billion of PCE in your tap water is saying that that falls within the EPA's acceptable risk levels is a bunch of crap, because the EPA created a standard of five parts per billion, an MCL. We know that the highest levels in the tap at Tarawa Terrace were 215 parts per billion. But, you know, no harm, no foul? No.

**MS. FRESHWATER:** And let's not forget the children were bussed to Tarawa Terrace from Main Side, which I was. I went -- I lived in Paradise Point and was bussed to Tarawa Terrace for school for three years. So just to mention, again, family members should always be included as being everywhere on base.

**DR. BREYSSE:** And these are great comments, and we want to hear them all, but I want to caution you again -- this is Pat -- make sure you put these comments in writing so we get them in the system as

well. But we -- you know, the report has some limitations, and if we can address those limitations, we'll try. If not, we'll make sure we acknowledge them appropriately so they're not -- so that they're in the report and people understand that there are certain things we weren't able to do.

**MR. ORRIS:** And this -- just one more thing. This is Chris Orris again. Something that I do not see in here, and some of your sister agencies talk about, is the exposure level to vapor intrusion of TCE and the risk to pregnant women. And I'm looking right here, and I mean, the EPA's guidance is that there is no acceptable level of TCE exposure to women who could be of child-bearing age because of the risk of cardiac defect in utero from the exposure.

And then all of this, I'm not seeing, you know, this is the very simple fact that any pregnant woman who walked on that base received enough of an exposure level, according to the EPA, to have a cardiac defect. And I really think that that should be addressed in there somewhere.

**DR. JOHNSON:** Right. So the vapor intrusion assessment is a separate assessment. This is for the -- a different data source. We're looking at

the drinking water used and exposure from that. And that's obviously the effects on in utero exposure as a primary outcome that we evaluated in terms of TCE exposure in the document.

**MS. FRESHWATER:** Dr. Breysse, would it be helpful for you to do a very brief -- to speak to how this is kind of a retroactive redo? Because I bet there's probably a lot of people that don't understand the history of the PHA. Do you know what I'm saying? That might explain to the --

**DR. BREYSSE:** Yeah, but I'm not sure I'm the one who can explain the history since a lot of it predates me.

**MS. FRESHWATER:** How about Rick or Dr. Bove?

**MR. GILLIG:** Rick Gillig, ATSDR. So ATSDR issued a final public health assessment back in 1997. That was prior to Morris doing his modeling effort. As a result of what Morris and his team did for modeling the drinking water distribution and exposures, this new public health assessment, that we're discussing today, incorporates the results of the water modeling effort. So we have much more information about where on Camp Lejeune contaminated water was distributed and where it was consumed, and that is why we're updating that older document.

**DR. BREYSSE:** And I'll add to that, that we did not, when we got the new data on the water modeling, we did not want that report to stand as being anywhere near the end of the story or what we think really happened.

And so at that point, even though we'd already started the epi studies, we were trying to be more quantitative about this (indiscernible) exactly. And so we had to do this public health assessment because it was flawed, and we had to address those flaws with the most recent information, to set the record straight. So I think that's part of what we mean when we say the cart's a little bit ahead of the horse here. But I think it's important for us to acknowledge that that report wasn't right because we didn't have the correct information, and we're trying to make it right today.

**MR. PARTAIN:** And to add to what Rick was saying -- yeah, and thank you for pointing out that the original document was flawed. From 1997 to 2009 it stood, and the Agency stood behind that document until the community established that there was benzene in the water.

Now, back in September of 2014, 2015, Jerry and I did a presentation to ATSDR at a CAP meeting of a

lot of issues with the original public health assessment. So it's not just the water model that's preempting -- having you guys go back and take a look. The document was seriously flawed to begin with, and it was withdrawn by this agency because of those flaws. And every Superfund has to have a public health assessment, so therefore it had to be revised.

One thing I wanted to get back on track on, with the Tarawa Terrace. EPA's Superfund target risk range, what is that number? Because I know when looking at the snarls from the EPA back in the day, in the 1980s, they were addressing short-term exposures. And the exposures that occurred at Tarawa Terrace were, you know, not occupational; they were lifestyle exposures. And some families went on for years and up to a decade. And the snarls at the time for the EPA, you know, said specifically that these were not meant to be addressing long-term exposures, so I'm a little concerned with that verbiage to say that it's within the accepted EPA risk range. Can you give me a number?

**DR. JOHNSON:** Yeah, the citation of the EPA's cancer risk range is (indiscernible) contacts. It

doesn't affect decisions or conclusions. So for example, the EPA uses a 10 to the minus 6, or one excess cancer risk in one million exposed individuals, as for the screening level. And it affects their regulatory decision process. So (indiscernible) one in a million, there's no further option.

And then the other endpoint that was cited is the one in 10,000, one excess cancer risk in 10,000 exposed individuals, or ten to the minus four. So between those ranges decisions can be made whether or not there's need for remediation or removal from exposure. So that's the context that we provided in the document.

**MR. ENSMINGER:** How are they coming up with these numbers?

**DR. JOHNSON:** It's based on an estimated theoretical cancer risk, which is assuming a certain potency of these carcinogens, then utilizing the exposure estimates to determine what is that cancer risk.

**MR. ENSMINGER:** So you're using rats?

**DR. JOHNSON:** The quantitative assessment of cancer risk for these chemicals is predominantly in animals; that's correct.

**MR. ENSMINGER:** So basically it's not based on any human data.

**DR. JOHNSON:** Well, as Frank mentioned, we do include in the discussion even though the quantitative cancer risk is based on these studies that allow us to make those response conclusions, because these are designed to know what the relationship is, there's more uncertainty about the exposure in humans to -- that would cause specific effects. But we certainly cite the evidence for that in our discussion section of the document that included other endpoints that were not part of the animal studies.

**DR. BREYSSE:** So these are reasons why this is considered kind of a scoping exercise in terms of just what we think it's possible what we should focus on in more detail. So it doesn't preclude anything else, I want to say again, from occurring, and it doesn't suggest that these risks now define the populations in a way other than indicated. There are general health effects. We believe those health effects are associated with exposure at the base, and that's the take home now.

**DR. JOHNSON:** And another point about the drinking water standard. We're not saying that

that -- the fact that these levels were not a concern or should not have been addressed. The issue is whether or not these levels would've caused health effects. So it's a different question of whether or not it exceeded the drinking water standard, which should have triggered a regulatory response to take action. We're addressing more the health impacts of that exceedance of the standard.

**MR. ENSMINGER:** Yeah, well, hell, I mean, if you're going to turn your nose up at 215 parts per billion, why don't you just make the MCL 300?

**DR. JOHNSON:** The drinking water standard is not intended to be a threshold for health effects. It was intended to be a buffer so that you're not taking action at levels that cause health effects. You want that actually to be well below that.

**MR. ENSMINGER:** No, I disagree. That's crap.

**MR. PARTAIN:** It just seems like the verbiage on here is downplaying exposures for adults at Tarawa Terrace. That's what -- I mean, that's what I'm reacting to, 'cause me, reading this, it says, okay, you're exposed. There's nothing here. The risks are here, which is what -- that's what I'm reading, and I'm concerned.

**DR. BREYSSE:** So that's a fair comment. We

will consider that comment. Can I make a procedural kind of request? So we're past where we want to take a break. And you have how many more slides to go through?

**DR. JOHNSON:** A few but we can go through them quickly.

**DR. BREYSSE:** So there's two things here. I want to make sure that -- the goal of this presentation is just to give you guys an overview. And of course like I said before, you know, we want comments, and you'll have an opportunity to make those comments. But maybe, just to expedite, if we can walk through the rest of the slides, if there are really important things, we can deal with them, but we can -- this is not the end of your opportunity to have input into this report. Just keep that in mind.

**DR. JOHNSON:** Okay. So then the third location is Holcomb Boulevard. Again, our conclusion generally is based on the evidence from a sampling of -- and modeling of Holcomb Boulevard water supply. That was not expected to be expected to harm human health. However, the caveat, though, is that there were periods of time, in 1978 and also in early 1985, where Holcomb received water from Hadnot

Point water supply. And during those periods of time there could've been exposures that could've led to health effects for pregnant women and we think on the fetus, and we acknowledged that as a potential risk.

The other exposures that we included in the assessment, then, as I mentioned about laundry facility, dining operations, indoor pools during that time could also have been associated with human health impacts, and those non-cancer endpoints are described there.

**MR. ENSMINGER:** You need to include base firefighters to that. They lived there at the firehouses aboard the base two weeks at a time.

**DR. JOHNSON:** Okay. And then, you know, civilian workers on the base are part of the overall assessment. If they lived on base they would obviously have had a greater exposure than living off base.

I won't go through these results here. As I mentioned one of the objectives we had with this assessment was to present information as clearly as possible, and our attempt here was to summarize probably hundreds of pages of tables and spreadsheets in a way that might be more visually

effective. As an example here, this is showing that we have this for each chemical. And if my cursor shows...

**DR. BREYSSE:** Is there a pointer up there or?

**DR. JOHNSON:** (pause for equipment) So this is the example for trichloroethylene. What we've done here is looking at both ingestion of TCE in drinking, and then inhalation through showering and bathing. As with the spike here that is for Hadnot Point and Tarawa Terrace, identified the groups that had the highest exposure. So in this case we have children, we've got workers and we've got Marines in training.

What we're showing here then is, in yellow, is the cancer risk that we've quantified in the assessment. And we're showing here in the dot is the average exposure. And the end of that, the stick, is the upper end, 95$^{th}$ percentile. So this gives you a sense for the range of exposure and the cancer risk associated with that. And we've done that for both Hadnot and Tarawa Terrace.

And the other comparison to that is what's shown in triangles here, and this is the cancer risk estimates that I mentioned, the ten to the minus 6$^{th}$ and ten to the minus 4$^{th}$ is in context. And so we

can see, then, what the cancer risk is for those groups at those locations.

**UNIDENTIFIED SPEAKER:** (off-mic question)

**DR. JOHNSON:** Right, they're probably either our assessments we'll call (indiscernible) or EPA's reference doses, right? And then --

**MR. TEMPLETON:** Excuse me, is that cancer risk any time in their life? Is that cancer risk any time in their life?

**DR. JOHNSON:** Right, so this is a lifetime cancer risk. So I mentioned that we were looking at were the children, families and for Marines in training, a three-year period, but we're looking at lifetime risk from that exposure, right. That's a good point.

And then the purple color, then, is the non-cancer endpoint that I mentioned, liver, kidney and other effects, as well as the fetal effects on development. And those are shown as what we refer to as the non-cancer doses, and those are, again, shown for each of those groups. And then these are the reference comparisons and the -- for the triangles, then, to these various endpoints.

So the idea is trying to put this into context, so you can see where the exposure -- these are the

maximum levels of exposure. It's in context of how this relates to effects that we've identified either from epidemiological studies or from animal studies, of the comparison of those doses.

**MS. CORAZZA:** This is Danielle Corazza. I have a question. It says zero to three for the child residents, but the earlier cite said children under six. Was there a reason for the age?

**DR. JOHNSON:** I think under six had to do with vinyl chloride specifically, the adjustment. So that the zero to three would've included that adjustment at this point.

**MR. TEMPLETON:** This is Tim Templeton. I'm looking at the non-cancer effects and the cancer effects.

**DR. JOHNSON:** Yeah.

**MR. TEMPLETON:** And it looks like the non-cancer effects is at a higher dose.

**DR. JOHNSON:** Yeah, so this is just a dose estimate.

**MR. TEMPLETON:** Shouldn't it be the opposite?

**DR. JOHNSON:** Right, so the way you estimate cancer risk is that you take the duration of exposure, which would've been three years, and divide it over a lifetime. So you're averaging that

dose over that lifetime. Whereas with the non-cancer you don't do that. You do it for the duration of exposure. So it gives the impression of a difference in -- it's just the way the calculations are in terms of the exposure dose, that we compare it to the reference levels.

**MR. TEMPLETON:** You know, given that, and thank you for the explanation, but it seems like the non-cancer effects would actually be at a lower threshold, might occur at a lower threshold.

**DR. JOHNSON:** That is true. And especially the fetal effects are definitely at a lower dose.

**MR. TEMPLETON:** That's the way I read the LLPLL and the other metrics. Okay, thank you.

**DR. JOHNSON:** So that, again, we welcome feedback about this as a visual tool that will help communicate information that we hope is better than just a bunch of tables and numbers, that it might be a more effective way to visualize these conclusions that we've drawn from the document.

And so I'll just show you this is tetrachloro-ethylene, the same idea, the same format, looking at the two locations, the same sorts of references, then, for those, so I'll just kind of show that example.

And then vinyl chloride that I mentioned where we applied the additional risk factor for the early life exposure, where you see, you know, to the distinction here in terms of non-cancer and cancer risk. So again, these are tools that we're using to try to communicate information, but we welcome your feedback on those.

Regarding the lead exposure, the conclusions are that past exposure to lead in tap water at the 14 locations where it was being monitored could've harmed people's health. And that's related to not only drinking water but also exposure to other lead sources that could be in the home, lead-based paint as being one of the primary concerns of that exposure to young children, and exposure to pregnant women and the developing fetus.

And then for the current and future exposures the potential does remain, because it was mentioned there are good lines that are providing drinking water currently that need to be monitored and sustained so that you limit exposure from those sources. And so the statements here that the lead could be from the copper -- I'm sorry, from the fixtures as well as from the lead pipes that are used to the -- in the water system it could leach

lead into the tap water, especially when it's used for hot water, to increase the rate of leaching into the water.

And we also support the additional efforts of Camp Lejeune that began in 2013 to increase monitoring frequency, to make sure that if there are problems they're identified early, minimize exposure, to collect an immediate follow-up sample whenever there's lead that's elevated is detected, and to follow EPA's guidance regarding schools and daycare (indiscernible) strategies, to make sure that those -- early interventions are identified early on before exposure becomes a problem.

In terms of follow-up, the next steps we have is to continue to provide health education information when individuals are concerned about their health risks, through the CAP, through the VA, through our website as a resource for -- to get information, and also to provide copies of the document that we're releasing now to public health officials as well as the public for their comment and review. It'll also be posted on our website as well.

**MR. TEMPLETON:** I got a question concerning the lead attachments that are on there. I know there's

been a little bit of public debate with recent events in Michigan and so forth about the way that some of the tests are done and the way that they are interpreted in the current regulatory framework on it, and that maybe that's not adequate. You may have heard that. I'm not expecting a response from you on that, but my question is that were the results from those used for this or were there some tests and results that went beyond the regulatory tests that are required? Especially something on the order like, if you know if you only have five sites that show elevated --

**DR. JOHNSON:** Right.

**MR. TEMPLETON:** -- then it's not reportable, not actionable. It's not above an action level.

**DR. JOHNSON:** Right. A good point. I spent over a month in Flint. I just came back last night along with Dr. Breysse. And so the issue has to do with the EPA has a lead and copper rule that regulates lead exposure in lead systems, water systems. And so there's several issues. I know one of the problems with Flint was that they were utilizing a septic protocol which would allow for flushing the water before you take your sample, which could underestimate that early exposure that

could occur when you first turn your tap on in the morning. And so that was certainly a violation of what should've happened in terms of assessing. So they probably were masking some problems because of that septic protocol.

The feature of the lead and copper rule is that intervention's already required when 10 percent of the samples exceed the actionable level of 15 parts per billion. And that's a regulatory criteria. And there is debate about whether that's an appropriate endpoint.

**UNIDENTIFIED SPEAKER:** (inaudible)

**DR. BREYSSE:** We can't hear you if you're not using the microphone.

**MR. TEMPLETON:** Yeah, this is Tim. So that's what was used, not anything beyond the regulatory criteria.

**DR. JOHNSON:** I'll let Danielle Langman, whose (indiscernible) prepared the one section of the document, to respond to that question.

**MS. LANGMAN:** Okay, hi, I'm Danielle Langman, and I did the lead evaluation. The data was that the -- that had been collected, that, to my knowledge, it was through the public works website in reporting it. And it did follow the rules where

it let the water be stagnant for eight hours, and then you take the sample, so it did not include flushing in the lines.

The way that we evaluated health in the document was using that EPA model. And we did not use the lead and copper rule, where if you have -- you have to have 10 percent over one. We looked at it that if you have one -- it's a single sample, over 15, and what that could do for elevating blood lead.

The base did change in 2013, and the data that we had pulled when we started writing this went through 2013. But now, if they get a single sample when they go out to -- when they do their monitoring, if they get a single sample that reads 15 or above, they immediately will go back and do a second sample. And I think that's a really good thing 'cause some of the reported levels were, you know, 1,400, which is way above 15. And there wasn't an immediate follow-up sample to see what was going on. And so I think that the base did change the way they're doing their monitoring and how they're reacting to they're monitoring, so hopefully, you know, there won't be elevated levels of lead in water, and if they are, they immediately

will take a follow-up sample, and if they need to, you know, replace a faucet or find out what that -- where it's coming from.

**MR. TEMPLETON:** So now they are going beyond just what the regulatory requirement is.

**MS. LANGMAN:** Yes. The regulatory requirement is that lead and copper rule. There also there's EPA put out guidance for daycares and schools, which goes well beyond that -- that they don't have to follow but they are following that as well. And they have their own sampling strategy that they go out immediately -- if there's a sample at 15 or above, they will immediately go out and take a follow-up sample to see, you know, was it an aberration, you know, did they not test right, you know.

**MR. TEMPLETON:** Thank you very much. I have just one quick little point and I'll let this go, but it is an important point. Is that in going back and looking at these (indiscernible) that are issued all the way back to (indiscernible) from the base. This is Tim Templeton again, by the way. There were some -- there was a situation that they actually did have some violations, but yet in a three-year period, if you don't have any violations, then you

can use the results of the last report that was used. And they did that, but they did that in a scenario where there were violations. So why they were using data from a previous report that shows there were no violations, when they had violations that had occurred. It actually should have kicked in on the rule. It should have kicked in a little more aggressive testing regimen, but it apparently did not.

**MS. LANGMAN:** Yeah, and that's one of the reasons that we originally had pulled the data and were looking at those consumer confidence reports, but they are summaries. And so I think I only had a paragraph in the document saying that, yeah, we took a look at them, and they're summaries. And instead of making a health call and doing an evaluation on the summaries, which are averaging data and doing those types of things, we instead went back and pulled the actual sample results, and reviewed the sample results ourselves instead of using those summary reports.

**MR. TEMPLETON:** That's very thorough. Thank you very much. That answers my question.

**MR. ORRIS:** I have a follow-up question as well. I noticed in the report that I -- this is

Chris Orris by the way -- I noticed in a report that you had mentioned that there were three children who had blood lead level in 2014 and 2015, and what I did not see here is the follow-up on where that exposure occurred. Were you given that information? Did the base itself follow up and find out where those blood levels were -- where that exposure was that caused that blood level increase?

**MS. LANGMAN:** Danielle. We actually, before I became the lead person working on the site, Rob had asked many, many times for blood lead -- the, you know, sampling data, so that we could report it. And when we had the original, the version that the CAP and the external peer reviewers, after that report went out the Navy provided us with a summary report. So I don't know, you know. Like all I have is the data that was reported there. And we can go back and ask to see, you know, specifically -- I included that data in between, you know, when I got it in November and today. But, you know, if you provide a comment or I can note it at this point, but it's always good to have it in writing because then I have to formally respond to it in the final version of the document. But we can go back and try and find out for those children if there had been a

water sample collected at their residence. I'm not sure that they're going to have done that. But I do believe as part of the -- I'll have to look at that specifically and go back to that report, but I'm pretty sure they do, if the blood lead level is elevated, that they do go back and do an impact type of assessment where they try and find out is there something in the child's environment, whether it's the soil or the water or whatnot, to stop, you know, that exposure. And then there's always follow-up testing that's done. Unfortunately I did not have that. I just had -- there were certain people with -- you know, three children with elevated levels. But I don't know where they lived or anything other than that.

**DR. BREYSSE:** So Chris, it's standard practice -- this is Pat Breysse -- standard practice in the lead field, if you have elevated blood level, to do a -- put that child in some enhanced surveillance that includes going to their home looking for where the exposure is. So that's probably ongoing, but I think you just heard that we didn't have access to those data.

**MR. ORRIS:** So can I ask for an action item that Melissa Forrest bring that information to the

next meeting, if possible, what the Marine Corps does do when they do have blood lead levels that are elevated as a result of testing?

**MS. FORREST:** This is Melissa Forrest. So you want to know what process we follow for follow-up, to gather more information on how this child might have been exposed?

**DR. BREYSSE:** Yeah, follow up when you have high blood lead levels.

**MS. FORREST:** When you have high blood...

**DR. JOHNSON:** Yeah, you might refer to it as case management is the term that might be applied to those cases.

**MR. ORRIS:** Correct, and also to be able to identify where that blood lead level exposure occurred, and what the Marine Corps is going to do to mitigate that.

**DR. JOHNSON:** Okay, my last slide is the current ongoing activities we're doing. You'll hear more from Perri and Frank about the health survey and also the cancer incidence study this afternoon. I'll just also mention the vapor intrusion evaluation is ongoing as well, so those will be future information that you'll be provided.

So again, as I mentioned our document is now

out for public comment. We welcome your comments and ways we can improve this, both in terms of the text and content, but also in the visual graphics that -- feedback from you about the effectiveness of those as well.

**DR. BREYSSE:** Okay, I have 11:30 -- 11:15 on my -- let's be back here at 11:30.

**MS. FRESHWATER:** I'm sorry, can I just ask on the public comment, how long is that open for?

**MR. GILLIG:** The document has not gone out for public comment yet. Y'all got an advanced copy. The document goes out next week. It's dated on the cover March 30th. It'll be out for 60 days -- actually a little over 60 days. We're asking for comments by close of business June 3rd.

**MS. FRESHWATER:** Thank you.

**MR. PARTAIN:** One last thing, Dr. Breysse. With the public health assessment, two caveats. I do understand that this is a scientific document, but there is an historical aspect on the document, and I know that there's not a lot of room to go into the history, but in the background description of what transpired, of how the contamination was discovered on the base, it is very opaque and misleading. And it could be corrected with a few

facts that are missing on there. The way it reads, it does -- the way it reads as stands, it seems like the Marine Corps started testing out of their good will in 1983, and discovered the contamination. That's not what happened. And I just want to make that for -- it didn't come out here obviously because it's not really the heart of the document. But it is important, as an historian, that the background information, that people who are going to be reading this, be correct.

**DR. BREYSSE:** I agree. We actually want to be correct. And if it means that we have to admit that we, you know, were publishing a report to correct something that we wrote in the past that was flawed, we need to say that. And if you can make sure you put that in writing so we get that.

**MR. PARTAIN:** Oh, I will.

**DR. BREYSSE:** Morris?

**MR. MASLIA:** This is Morris Maslia, I guess, speaking out of turn, but just to qualify that, I didn't want to give the impression that ATSDR was not going back further than that, because we've got very, very specific history of contamination, and one of the water modeling reports that specifically go through the documents that were uncovered, I

mean, the Agency's aware of that. And that's out there in the public as well.

**MR. PARTAIN:** Yeah, I understand that, Morris. And like I said, it's the background information, the beginning, which what people are going to read, and I've testified in Congress about it, and Jerry has too, and it's just the way the background introductory is written, it's the benevolent testing of the Marine Corps that found the contamination.

**DR. BREYSSE:** Tim, your sign's up. Do you have a question?

**MR. ENSMINGER:** Hey, Morris, you going to serenade us with your bongos later?

**DR. BREYSSE:** His ukulele. It's time for a break.

**MS. STEVENS:** Be back at 11:30. Bye.

(Break, 11:20 till 11:40 a.m.)

**DR. BREYSSE:** All right, let's get going. All right. Welcome back, everybody. We just finished up with the drinking water public health assessment reanalysis, and now we'd like to get updates on the cancer incidence study and the health survey, so we'll turn it over to Perri and Frank.

**UPDATES ON HEALTH STUDIES**

**MS. RUCKART:** So this is Perri. Some good news to report. The health survey report is in final draft, and it was started in our clearance process earlier this month.

**MR. TEMPLETON:** Is there an ETA on when it might come out?

**MS. RUCKART:** Well, I'll let someone else maybe speak to that point because once it leaves my hands I don't really, you know, can say what other people are going to take to review it, but our thought process at this point is to publish it as an Agency report, a full document that has all the cohorts studied in one place, and that would be the Marines and Navy personnel, the civilian workers and the children and spouses from the former survey all included in one; whereas you saw for the mortality study it was a journal article. It was in two pieces, one for the Marines and Navy, one for the civilian workers, and so then there was a delay between getting the full picture up there. But our thought is to have one Agency report for the whole health survey, and then produce a journal article later on just the Marines and Navy personnel. So that is subject to change but that is our thought process at this time. I don't know if Pat wants to

say any more about that.

**DR. BREYSSE:** I have nothing to add at this time.

**MS. RUCKART:** The cancer incidence study, we're also moving along there. I will mention again that the cancer incidence study protocol was approved last year. And we've recently brought on some staff to help with beginning the process of engaging the cancer registries and getting their approval to receive the data, so we have some staff back there who are working on that. They just started in the last week or so, but there is movement there.

We've been meeting with colleagues about the virtual pooled registry, the VPR. It's an effort by NAACR, the National American Association of Cancer Registries, and NCI, the National Cancer Institute, to help facilitate large studies like this that want to involve a lot of registries. So we're continuing to engage with them, and wherever possible gain some efficiencies by linking them into the process.

**DR. BOVE:** So and I have -- I made ten copies of the protocol. It's not exciting reading but if you want a copy come see me. I'd like to give one to the VA but I only made ten copies, so I'd like to -- if we could spread it around somehow or I can

make more copies later, so that we can -- everyone who wants one can get one. Yeah, I can send it to you electronically. Maybe that's better. Okay.

**MR. TEMPLETON:** This is Tim. Can we disseminate that publically?

**DR. BOVE:** You can take it to CNN this afternoon if you want. I'm sure they're not interested but you can do that. Yes, it's official. It's cleared. We're operating from it. That doesn't mean there may not be some amendments down the road, if needed, but this is what we're going to be using.

As Perri was saying, there's this effort to try to -- for the mortality studies there’s a national death index, where all the states report the death information to one central place that's run by CDC. And we can go there, and the studies are facilitated very well that way. For cancer incidence, you have to go to each state individually because there is no such national system.

However, this effort that's being -- it's a pilot effort. We're encouraging it. We actually gave them the Camp Lejeune data that we will probably use in the cancer incidence study. We'll probably have a little bit more data when we're

ready to actually do -- go to the registries. But initial data for them to send out to, I think, about 46 of the state cancer registries. They'll give us back how many hits they had in their registry, nothing more than that, and the year of that hit. So we'll have counts. Yeah, a match, I'm sorry, yeah. And so if they match in their registry a person in Camp Lejeune to their registry they'll -- that's one person, and they'll say what year. So if we have several counts, we'll get the number of counts -- the number of hit -- matches by year, by diagnostic year, for that state.

So that'll help us in terms of prioritizing what states we're going to go after first or, you know, say a state has very few, we'll still go after it, 'cause we want all of the states, if we can, but they'll have less priority than a state that has a lot of matches, okay?

So we're using this -- and we are also hoping this helps the process along for a national registry. So that's really the reason we worked hard to get the data into shape for them. We had to change -- do quite a bit of data manipulation. So that's the situation.

Going back to a previous discussion, we have

Social Security Numbers on the Marines and the civilian workers. That's all we have Social Security Numbers on. And for this kind of a match Social Security Number's going to be key because there are errors in the actual names in the database that we got from the military. There are errors in date of birth, unfortunately, too. For some people they have two different date of births, usually a year different -- a couple years' difference, and so the problem is the actual year, not the day and month. But some I tried to fix but some I couldn't fix. For example, if someone either was a private at age 18 or a private at age 28, I figured they were probably a private at age 18. So those were easy. But a lot of them weren't that easy. So you have issues like that.

So but so if you don't have Social Security Number, which we don't have for the children. If we had Social Security Number for the children, I would include them in the cancer incidence study, for sure. But we don't, and so that's why it has to be the Marines and civilian workers for this effort. So anyway, so that's the -- any, any questions?

**MR. ORRIS:** Yeah, this is Chris Orris. Did you make a request to the Department of the Navy for the

Social Security Numbers of the dependents?

**DR. BOVE:** I don't see how they would have that information.

**MS. CORAZZA:** That’s ATSDR (indiscernible).

**DR. BOVE:** What we're going to do is, in order to do this study, we have to know if the person's alive or dead. So when we get a -- down the road, after we get approvals from the cancer registries, we're going to hire a contractor, and that contractor's going to use a locating firm to identify who's alive and who's dead, and in the process get a current address that might be helpful to the registries. And maybe if there's any information on date of birth it might help us. I'm not sure what they'll be able to get, but any information that will supplement the information we got from the defense manpower data center, the personnel data, we'll use.

**MS. RUCKART:** This effort was already undertaken for the health survey. We sent all the names and whatever identifying information we had for this group at that time, and without Social Security Number it can be hard to find people these days, especially with the women getting married, changing names. They got -- they didn't get a

hundred percent.

**MS. CORAZZA:** But if you think it's 95 percent, would that -- I mean, you'd be able to include them or?

**DR. BOVE:** Again, you'd have to get Social Security Number for the children, and that's the problem. We don't have it.

**DR. CANTOR:** Okay, Frank, I have a question. Many states right now have very extreme restrictions in terms of accessing their data and matching -- and getting back to you specific data that would be helpful in an incidence study. So is there any discussion now of trying, within the group that you're working with or the extended group, to go back to states to have them change their legislation, statewide legislation, in fact, to make this more feasible?

**DR. BOVE:** I haven't heard that discussion. You know, I'm going to bring that up when we discuss it with them that this is another issue. They're aware of it. They're definitely aware of it. There's also issues between the state and the VA in terms of reporting issues, and they're well aware of those too. And so we're going to be talking to them about it. The VA issue we can resolve because we're

going to work with the VA and the Department of Defense's cancer registries too. But -- so that's not an issue. But the issues with the states that can't -- or by law some states cannot give us cancer data linked to the person's -- we're going to give them the Social Security Number, the name, the date of birth and so on, but some states cannot give us the data back with the cancer data linked to that Social Security Number and name, by law. And so we're going to have to figure out another way we can get the same information from them some other way. We're going to have to figure that out. And there'll be some states where that will not be possible. So it's likely that we won't get all 50 states involved in this cancer incidence study.

Keep in mind that the study that used the most cancer registries, as far as I'm aware of, was a study of Gulf War cancer study. And they used 28 states, and they didn't link it with personal identifying information, so we're doing something that hasn't been done before in this country, and so we'll see how it goes.

**DR. ERICKSON:** Frank, if I just make a quick comment -- yeah this is Loren Erickson, I'm sorry -- just for everybody, this is an extraordinarily

complex and difficult study, and yet are tremendously important for many reasons. And just for everyone who's in attendance, ATSDR, VA, we've also linked arms and we have a common, shared purpose in wanting to have a national cancer registry created. President was asking for input for legislation. It was -- they call it the moon shot, you know how can we move forward cancer research. And something that we both, I think, independently came up with, and suggest that we can also -- we've been in some meetings where we've actually spoken to lawmakers. We've made this clear that this is something we have to have.

**MR. ORRIS:** I have a question. Since you said that you're going to be working together with the VA and ATSDR in regard to this information, so the family members who have registered for the family member program through the VA, are you going to be able to forward that information to Frank so that he can include them in his study?

**DR. ERICKSON:** Is that in your protocol, Frank?

**DR. BOVE:** No.

**DR. ERICKSON:** So you know how this goes, with research and such. It would need to be a part of other study design that we would've discussed, et

cetera, so I think it's impossible.

**MR. ORRIS:** I mean, most of the people who have registered for that are living with some kind of problem, so that would certainly be a good pool for you to pull from as well.

**DR. BOVE:** Again, we'd have to consider whether it's a scientifically valid sample. And that's a key issue. Right now, I think we have -- if we can get this study done, which is extremely difficult, as I said, it hasn't been done to this extent before, we'll be good.

We're also -- we're aware of some of VA researchers who are interested in Parkinson's disease and maybe some of the other neurologic diseases, where the VA has a national coverage, and that might be added to this protocol at a later date, if that becomes feasible. So we're still limping around there. But I would like to look at that too as an additional thing, if it's possible, because there is a national coverage for that.

So again, this is looking at the workers and the Marines. We're also -- in the mortality study, we're going to expand the workers a little bit. As for the Marines, we may try to expand a little bit there too using some other methods that we didn't

use in the mortality study. Again, it's in the protocol. I don't want to get into details if we're not -- people aren't interested.

**DR. BREYSSE:** If there's no further questions, I'd like to move to the next agenda item, which is the Camp Lejeune CAP charter overview that we conducted yesterday. Sheila, could you lead that?

## CAMP LEJEUNE CAP CHARTER OVERVIEW

**MS. STEVENS:** Yeah. I'm going to be -- do kind of a quick summary so we can get back on track and be back on schedule for lunch, and then follow that with the 1:00 VA portion of the meeting.

So yesterday we met with the CAP members, and we discussed the charter. We renewed the charter that we had. And what will happen, just so people in the audience know, is I will make updates to that charter. I will send to the CAP members as well as members of ATSDR the changes to the charter as well as a clean copy, so people can see where those are in the charter, and then those -- that charter gets posted to our website, so then everybody can see what the charter looks like when it's in its final. So I expect it to be posted no later than May of this year, after everybody looks at it.

The second thing that we discussed was where our future offsite locations would be for public meetings. And the first one -- so in FY '17 fiscal year, we're going by fiscal year, we will have our meeting in Jacksonville, North Carolina, so that is where Camp Lejeune is. So that will be the next meeting. In fiscal year '18 we will have our second meeting -- the next offsite will be in Washington, D.C.

So we're looking at probably January of 2017 for the Jacksonville meeting, and we are looking at probably the following January -- trying to do this, though, because as you are aware, we're in a year, we can't really do it in the December/October -- October/December time frame 'cause sometimes we're at risk for funding, and not having a budget to work with, so we are trying to do this so we know when we'll have a budget and we can work and move forward with people in travel and having an offsite location.

**MS. FRESHWATER:** Sheila, can I just say something real quick?

**MS. STEVENS:** Sure.

**MS. FRESHWATER:** I just would like to ask everyone in the audience here and everyone listening

to please reach out and let people know we're going to be having those two offsite meetings. And so since there's clearly a lot of time to plan, so that we can really have a good presence. Both places are important symbolically. Washington, D.C. will be an excellent opportunity for all of us to reach out to Congress and to show a presence. So just keep that in mind, and everyone try and follow that and join us in those two offsite locations.

**UNIDENTIFIED SPEAKER:** What's those dates?

**MS. STEVENS:** We don't know exactly when those. We're looking at January of 2017 for the Jacksonville meeting. We just don't have a date secured with that. And then we will look at January 2018 for the Washington, D.C. meeting.

The next CAP meeting that is in Atlanta will be August 11th, and that is based off of space available here on our campus. We keep growing, and we have limited space. So we will have that meeting August 11, so for folks here in the audience, it'll be August 11th.

The other thing we discussed, real quickly, is that we are going to expand the time that we put our meetings on our website. So usually we post our meetings 30 days prior to our meeting, for people to

register for. We're going to go ahead and, probably by tomorrow or Monday, I'll have the August 11th web thing posted. Okay. It won't take long because we have a template already put together. It just has to change dates on it; so it won't take long to get that posted.

But the other piece of that, for people who are in the audience, just so you are aware, we do have our secure -- our physical security, 'cause this is a federal campus. We have to go through a security thing. People do a background check on all names for people who are registered, so that's why we have kind of a ten-day period before the actual meeting that we close the registration, so our physical security can go ahead and check names, to make sure everybody is good to come on campus.

So that is pretty much summarizes yesterday's meeting. So again, August 11th will be our next CAP meeting here in Atlanta, Georgia. That's all I have.

**DR. BREYSSE:** So I have almost noon on my phone. And I'm -- am reminded, having been at the airport last night, and anybody who’s traveling this afternoon knows that the extra time has to be allowed for security, in particular in Atlanta,

which is, you know, a big hub airport. So we want to make sure that we finish on time or a little bit early if possible. So let's have our lunch go from 12:00 to 1:00. Normally we have an hour and 15 minutes scheduled for lunch, but let's try and start back here at 1:00.

**MR. PARTAIN:** One quick thing, Sheila, and this is just for a request. For the Jacksonville CAP meeting, if we could request from the Marine Corps that the Marine Corps sponsor and hold a meeting somewhere, either the visitors' center or on the base or what have you.

**MS. STEVENS:** Mike, I will -- here's what my suggestion would be, and we'll talk offline, but I would prefer that to be an off federal campus because of the security things, and all the things you have to go through for that.

**MR. PARTAIN:** That's true.

**MS. STEVENS:** And I have no control over it.

**MR. PARTAIN:** I'm sure they have some type of facility off base that they could offer.

**MS. STEVENS:** Your folks wanted Embassy Suites.

**MR. PARTAIN:** Yes.

**MS. STEVENS:** Okay. And we can discuss that offline.

**DR. BREYSSE:** All right, see everybody at 1:00.

(Lunch recess, 11:55 a.m. till 1:04 p.m.)

**DR. BREYSSE:** All right, why don't we get started. I have to apologize if I duck out for a minute, but I may have to duck out, but I'll try and get back in as soon as I can. So right now we're on the VA updates, which is always my favorite part of the agenda.

**VA UPDATES**

**MR. FLOHR:** Okay, this is Brad Flohr with VBA. I want to talk -- we're going to talk about the healthcare we're providing to veterans and their families. We'll do that after we talk about the benefits. Besides, I think you're most interested in that. I may be wrong but I don't think so.

I'm sure you're aware that in December, after we had briefed Secretary McDonald about Camp Lejeune and told him of the noted association between vinyl chloride and liver cancer, and benzene and leukemias, and kidney cancer with PCE and TCE. He's familiar with those chemicals. He used to be involved in the dry cleaning business of some sort, so he had an interest.

And after we had briefed him, and he had talked

with others, he'd like to meet with Senators Burr and Tillis and Isakson, along with him and some other people from VA as well. And he stated his intent to create a presumption of service connection for compensation purposes for three cancers: liver cancer, leukemia and non-Hodgkin's -- no, not -- with kidney cancer, liver cancer and leukemia.

And he asked Dr. Breysse, who was there, if ATSDR would work with us to go over the science as it existed and provide us with a review of the science and what they found. Then he and Frank and his staff -- we met with them a couple of times, came down here once, and then had conference calls with them. Did an excellent job. Put together a very large review.

And the Secretary determined -- then he announced in February -- or on December 17th that he wanted to create eight presumptions of service connection. Those eight are kidney cancer, liver cancer, non-Hodgkin lymphoma, leukemia, multiple myeloma, scleroderma, Parkinson's disease and aplastic anemia together with myelodysplastic syndromes.

So we started right away getting busy writing regulations. We informed the senators we would have

to go through notice and comment rule-making. And after our discussions with OMB on that, that was confirmed that we could not do a very quick rule-making, but we drafted the regulatory language fairly quickly. We were able to cost it fairly quickly, and we put it into concurrence. We got it out of VBA. It came back from general counsel, they wanted some additional language in the rule-making.

While we were doing that, the Secretary, just last week, week before last -- I think he's going to announce it formally today, some of you may have already heard, we're going to add bladder cancer to those [applause]. That will make nine conditions. Of course we had to pull back the rule-making and re-cost it, and we did that in one day. Got the initial language and got it costed working with our finance people in one day, so it went back into concurrence. So now it goes into -- goes back to our general counsel. If they approve as it is written now, it will go up to the Secretary's office. They review it. Then they send it to OMB.

OMB gets up to -- they generally take up to 90 days to review regulations. We're going to push on them to do this much quicker. This is the Secretary's highest priority rule-making. And we've

already -- like I said, we've already talked to OMB about it. They're expecting it. They're waiting for it to get to them. We think they'll do it much quicker than what they normally take. When they approve it, it comes back, it gets published in the Federal Register for notice and comment for 60 days.

We expect we will receive a lot of comments, some favorable, some unfavorable. And when that happens then we have to go through all the comments, and we have to address each one in the final rule-making. We draft a final rule-making, and once that's done it goes back into concurrence. It goes back to OMB for a second time. Then it will get published as a final rule.

I can't tell you how long that will be but it won't be within the next 90 to 180 days, I can tell you that for sure.

**MR. ENSMINGER:** I have a question, Brad.

**MR. FLOHR:** Yeah.

**MR. ENSMINGER:** This is Jerry Ensminger. What about all the denied bladder cancer claims?

**MR. FLOHR:** Okay. We have -- we can identify them. Once the rule-making is finished, we will get those -- that information. We will grant those claims.

**MR. ENSMINGER:** So these folks that were denied will not have to file an appeal.

**MR. FLOHR:** That's right. We're going to get that -- we'll pull them out of our data, and we'll grant those claims. [applause] Now, currently we're continuing to process all claims, including these nine, in Louisville, in our regional office. If they can grant the claim, 'cause we do grant some claims, they're going to go ahead and grant it. If one of the nine conditions they can't grant, based on our current process, they're not going to deny it. We're going to stay it. We'll inform the veteran we're staying the decision until the final rule-making is published, and then we will grant those claims as well.

**UNIDENTIFIED SPEAKER:** So Brad, even though the rule's not enacted, and I know you said you had discussions earlier with the SME group, I mean, can you have a discussion with them saying, look, these are going to most likely be approved. And I think at the core I saw was that you guys approve if you can, only reject if you have to. So but even without the rule, can't there be an internal presumption that these should be most likely approved, and lower the burden?

**MR. FLOHR:** Yeah, it's -- that's tricky. We'll have to think about that. You know, the people who provide the medical opinions will be aware of this, but well, we can tell them, hey, don't deny them. I don't know if we can do that, based on evidence.

**UNIDENTIFIED SPEAKER:** Yeah, actually I'm not saying -- you know, don't deny them, but maybe the protocol's different.

**MR. FLOHR:** Give it -- consider them a little more carefully or?

**UNIDENTIFIED SPEAKER:** Well, instead of having a 90 percent rejection rate maybe you have a 70 percent rejection rate, or something better than what you have right now.

**MR. FLOHR:** We'll take that back. We'll talk about it. So that's the news on the benefits side. And I think it's good news, it's probably you all think it's overdue, and it most likely is, but we're going to do this as well as we can. Yeah, Tim?

**MR. TEMPLETON:** Of course we just had the presentation on the PHA that's coming out, and it looks like that there's some additional information that may regard some -- well, it appears to regard some health conditions beyond the ones that are in a presumption so I'm kind of curious, is there any

road map or some type of sort of a plan to incorporate any of those or to examine those in further depth?

**MR. FLOHR:** This is Brad. Yeah, any time we get a new study, something like that, we review it. And if it looks like we should add something, we will.

**MR. ORRIS:** Brad, is that also going to include for the family member program or is that only for the veterans right now?

**MR. FLOHR:** Well, I think all of these are on the list of 15, so it doesn't change anything far as dependents or family.

**DR. ERICKSON:** Yeah, so Chris, you and I talked about this earlier, but for the group, and I'm going to tie together Tim's comment and question along with Chris. This is not a one-time event. Science goes forward. New information becomes available. Frank Bove knows that I'm his biggest fan, waiting for the incidence study to come out, even as complex and difficult as it is. We're going to keep looking for new information, new studies, new guidance, et cetera. We're going to keep collaborating with ATSDR, looking to have oversight from Congress. There's lots of players in this.

So as it relates to where we're at right now, this is a big step. It's a historic step in that the Secretary has, for the first time, declared presumptions for a garrison-based exposure. Okay, this is not a deployment, go-to-war kind of exposure situation; it's garrison-based. It's a big deal, a very big step, one that's very, very necessary. But this list, these nine, this is not the end of the story. But as more information becomes available we'll take steps.

Now, Chris, you and I talked about it, I'm going to expand this a little bit. As we're made aware of new information and ways that we need to make adjustments, there are things that VA can do, maybe through the Secretary making additional presumptions on that list, but there are things that Congress will have to do because there are things the Secretary just simply can't do by law. Okay, in other words, the Secretary cannot tweak the different aspects of the 2012 law. Congress will have to amend that law, okay, as it relates to the family members. So Chris, you're question's very well placed. Thanks for talking to me ahead of time.

As we see disconnects between what the veterans

are now being recognized -- will be recognized for and what the family members are, then we'll be working with ATSDR, together we'll be working with Congress, whose duty it will be then to amend the law. 'Cause what we don't want is a list for the family members that looks different from the list for the veterans. We're all in agreement, right? Okay. Does that answer your question?

Okay, and as it relates in particular to the childhood issues and the birth defects and all that, that is very much in the purview of the rewriting of the law, okay.

**MR. ENSMINGER:** That's in the works already. And congenital heart defects are being added, so.

**DR. ERICKSON:** Yeah, thanks, Jerry.

**MR. FLOHR:** Okay, this is Brad again. Just want to also mention that when the final rule does become -- is published, there will be as many as 2,500 veterans who will be added to the compensation rolls, who will begin receiving benefits.

**MS. FRESHWATER:** Any update on liver cancer?

**MR. FLOHR:** Liver cancer's on the list.

**MS. FRESHWATER:** Yeah, oh, it is? Okay.

**MR. FLOHR:** On the list of presumptions.

**MR. HODORE:** Yes, this is Bernard Hodore.

**MR. FLOHR:** Frank, what was your question?

**MR. HODORE:** Okay. Go ahead.

**DR. BOVE:** Okay, what I asked Brad was whether liver cancer is on the list under the Janey Ensminger Act for healthcare benefits, and it's not, but it's on the presumptive list. So there is a difference in those two lists that we'll try to resolve, I guess.

**DR. ERICKSON:** Right. This is Erickson again. Let me also just emphasize because you asked the question. What's on the presumptive list that's not in the 2012 law is liver cancer, Parkinson's disease, and those, those are the two, I guess. It's liver cancer and Parkinson's disease.

**DR. BOVE:** Yeah, but the VA report -- that report by IOM talked about Parkinson's.

**DR. ERICKSON:** Yeah.

**DR. BOVE:** They expand the neural behavioral --

**DR. ERICKSON:** Right, right. So it's -- trust me, there are now these multiple lists that need to be harmonized so as to not leave anybody out. You're exactly right.

**MR. HODORE:** Yes, this is Bernard Hodore. Now, when you say Parkinson's disease, do you also include that as a neural behavioral effect?

**DR. ERICKSON:** This is Erickson. Bernard, you probably get credit for the toughest question of the day. And the -- Brad knows why I'm saying this -- the law in 2012 was written in a way that was a little awkward to interpret. The IOM, in a subsequent review of our clinical guidelines, recommended that we interpret the words in the law, neural behavioral effect, to include Parkinson's disease. VA, within the purview of what we can do, we stepped out and we recommended to the Secretary. Now he's made the proposal that Parkinson's disease, as a known disease entity, a defined disease, be covered in the presumptions. But the finer point is the rewriting of the clinical guidelines right now as to how VA interprets this. And so like because it's not been finally signed, I told you it's with the lawyers, I can't answer the very last part of your question. But you've identified something that is very important.

**MR. TEMPLETON:** This is Tim Templeton. I have a few questions, and so I'll try to make it as quickly as possible, to observe everyone else's time to here too. When you said that IOM was in the hands of the lawyers, you're talking about OGC, right, office of general counsel? Okay. I just

wanted to make sure I'm clear about that.

I had sent an email for everyone else's benefit here. There was some notice of someone who unfortunately happened to be a VA employee, it appeared had made some statements on social media concerning Camp Lejeune. He was talking about how this course reflects (indiscernible) but not others. It seemed to be contradictory. The information that they were putting out was contradictory, and they got into a bit of a, let's say personal attack on some of the people on social media.

I know I forwarded it to Dr. Erickson too, and so I wanted to at least let you guys know that there are some instances of some VA employees that are on social media, and in some cases spreading misinformation. One case they were talking about how much worse -- and I don't want to get into, you know, whether one part of the base (indiscernible) another. There's metrics on that that you could probably go into. But the information that they were spreading out was wrong. And then they also started attacking some of the other members too, like a couple of people here on the CAP, when they took notice of this and went to try to correct them.

So I'm not necessarily interested in, you know,

something horrible happening to this person but I just don't want it to see it become a trend. I want to make sure that VA does have at least the mindset that they're trying to help rather than spread misinformation.

One piece of misinformation that we've seen, not just on social media but from a lot of people who come into the VA hospitals and so forth is they will talk about the dry cleaners, about the issue with the contamination with the dry cleaners. And then they'll -- they will pretend that no other contamination existed on that base, and it didn't exist in other places. And we've seen this throughout the -- I say throughout, meaning I've noticed at least a couple handsfuls [sic] of incidents where they were saying, oh, yeah, it was the dry cleaners. That was the dry cleaners. No, actually that wasn't the largest piece of the contamination; that was something that was there.

And the reason why they were doing it, and they even kind of came clean with the reason why they were doing that, was because the cleaners is not a government entity, and so it made it easy to be able to blame it on something else, you know, someone else or something else.

And I'd like to make absolutely sure, if I can here, to stress that we want to clear that kind of misinformation up. That misinformation has been out there for a long time. It came from the early days, and Ms. Forrest no offense, it actually came kind of from your court, there to try to, I'm not sure what -- whether there was intentional misinformation; I can't say that. But I would say that, you know, they went quite a ways to try to put blame where -- and not accept blame where blame was concerned. So that was what I wanted to cover on that. If you want me to stop for a second and make some comments on that.

**MR. FLOHR:** Yeah, Tim. This is Brad. Thanks for those comments. I just want to re-emphasize that only our claims process in Louisville make decisions on claims or benefits, and so they're not involved in this. They don't -- you know, it's not something that comes into their thinking.

**MS. FRESHWATER:** And I'd like to follow up, and I'm not quite as sometimes as polite and nice as my colleague. This person was a VA employee, and he was lying, straight out lying. And I don't care if he was involved in Louisville or not. He was on a Camp Lejeune social media group, and I would like to

know if he has faced any repercussions for misleading, lying, whatever words you want to use about it, and also him personally attacking other people involved. And, and he represented himself as a VA employee.

**DR. ERICKSON:** Having been also the object of that type of thing on social media, I can appreciate how that's problematic, and, you know, inappropriate. We work really hard to try and educate the 300,000-plus employees across VA, and are doing that, you know, there are actions right now to that end. But as with those of you that served in the military, along with me, there's a very significant role for on-the-spot corrections. You know, this is something that MCOs do, officers do, you know. You put the word out, you educate, and then you do on-the-spot corrections. And this seems to be clearly one of those cases. I don't have an answer for you as to what action's been taken, and I may not be privy to that.

**MS. FRESHWATER:** I don't want to hear like all of that bureaucratic-speak. I want know if him -- if he was set straight.

**DR. ERICKSON:** I, I don't know.

**MS. FRESHWATER:** I don't care about the lineage

and the chain of command. I want to know if you guys took it upon yourselves to go to this person and say, you're representing yourself as a VA representative, and you're saying that all of the contamination was on the civilian side, and that if you lived in certain parts of the base you weren't exposed to contamination. That is really damaging information to people who may need to be looking out for health effects from this water. And I want to know that if you see something like that -- you said you knew who he was -- you, you admitted he worked for the VA in the email.

**DR. ERICKSON:** Who, who admitted this?

**MS. FRESHWATER:** You want me to name the name of this person?

**DR. ERICKSON:** No, I don't want you to name the name. I'm saying are you pointing at Brad and myself, saying that we, we admitted this?

**MS. FRESHWATER:** I'm saying -- there was an email exchange that I was involved with, with Brad, and Brad admitted that he knew who this person was at the VA. Do you want me to show the email; I'd be happy to put it up on the PowerPoint. So why wouldn't someone go to him and say don't do that anymore?

**MR. FLOHR:** I'll have to go back and --

**MS. FRESHWATER:** I mean, honestly --

**MR. FLOHR:** -- look at my email, Lori.

**MS. FRESHWATER:** -- this is ridiculous.

**MR. FLOHR:** 'Cause I don't -- I don't recollect that.

**MS. FRESHWATER:** I don't want to hear you don't remember again today.

**MR. FLOHR:** I don't remember.

**MS. FRESHWATER:** Like seriously.

**MR. FLOHR:** Do not remember.

**MS. FRESHWATER:** Well, then you honestly, you need to start taking better notes or you need to take -- go to a memory class, Brad. No disrespect intended, but to have someone out representing themselves, and you were made aware of it, and then for you to not even send an email to this person or their supervisor, and say he is saying things that are very damaging to the efforts of the Camp Lejeune community to save lives, is, is -- I find it very difficult to stomach.

**MR. FLOHR:** I apologize for that but I don't remember the individual, his name or the circumstances.

**MS. FRESHWATER:** Ray Nolan.

**MR. FLOHR:** But I will look for them when I get back.

**MR. TEMPLETON:** Great, thank you. I appreciate that. Thank you, Lori; I appreciate that.

The second piece mainly has to do with the Camp Lejeune family member program, and I realize that Brady's not here, but I want to kind of discuss it, and I know that Dr. Erickson and I had discussed it a little bit.

**MR. FLOHR:** We do have someone here in Brady's place.

**MR. WHITE:** Okay, this is Brady. I'm actually on the phone, if you guys can hear me.

**MR. TEMPLETON:** Brady, hey, how you doing?

**MS. FRESHWATER:** Hi, Brady.

**MR. WHITE:** Hello.

**MR. TEMPLETON:** Hey, I've got a question for you. One of the things that I've come across here is an item called a TPR, and in the TPR apparently there's a need for those for the folks that are in the Camp Lejeune family member program, and that need for a TPR, and I'm not sure even whether a TPR is described as being needed.

**MR. ENSMINGER:** What's a TPR?

**MR. WHITE:** The TPR is the treating physician

report.

**MR. TEMPLETON:** This kind of goes towards -- is that a part of the orientation, the TPR being necessary? Is that part of the CLFM orientation program? Or is that to get into the program?

**MR. WHITE:** That's a kind of a method that we have to help us determine if the family member has one of the 15 covered conditions or not. So we ask the family members to have their treating physician to fill out this report, and basically, I don't have one up there in front of me, but it asks them to identify if they have, you know, the specific conditions. And for instance if it's cancer, if it's in an active phase or remission. And then we also ask them to provide kind of backup medical documentation with that.

**MR. TEMPLETON:** Got it. Okay, so that leads me to the next piece. First off, I wanted to make sure that the need for a TPR is stressed within the orientation for folks that are entering the CLFM program. 'Cause I talked to some folks that have worked with some of them, and apparently they weren't aware and didn't, didn't hear anything about the need for a TPR within the orientation and to get when they were entering the program.

This leads me to the other piece of it, that actually dovetails here, is that the active versus remission status. And I know I'd sent an email out asking a little bit more information on how you become in remission status, at least as far as the VA is concerned, and how you're defined in active status. And Dr. Erickson was, you know, kind enough to take a little bit of a sidebar with me and discuss it a little bit. But for the benefit of everybody else, and especially all the people who are applying for this program, including veterans that aren't in this program, I think, if we could have a little bit better understanding of how someone gets put into remission status from active status.

I've heard a couple of stories here that say that some of the people were moved from active into remission status without their knowledge, and they were still in fact in active status, and had to fight extremely hard to get back into active status. So I don't know if you can speak to that at all or could go back and get information and bring it back to us at the next CAP meeting.

**MR. WHITE:** Yeah, so I'm sorry, but my -- somehow my phone lost reception in the middle of

what you were saying, but I caught the tail end of it. So briefly if I could just explain what we need and why we need it. So when a family member applies to the program we go through a whole process of, you know, determining three things to really make them eligible for the program. We determine what we call administrative eligibility, and that's basically, you know, was the family member a dependent of the veteran? Was the veteran stationed at Camp Lejeune? And then was the family member also there for the covered time frame?

So once somebody becomes administratively approved, then we send them out a card, an ID card, and along with that it's got some information, some fact sheets, about what we need, how we need it, how to submit claims, kind of due dates for that. And we recently had some suggestions on how we can better inform them of the kind of the 60-day time frame to submit their past bills to us. So thanks for your input on that.

But when it comes to, you know, determining if they have one of the 15 conditions, obviously we need some kind of medical documentation. So what is that? Early on we were hoping we could use this form, this TPR, as a tool to help us, you know,

quickly process their clinical eligibility, right? And again, on there it has -- it lists out, you know, pretty clearly what we want the physician to do, and then again, we need -- we request additional medical documentation along with that form.

And I think we can always revisit this, and again, this is still a fairly new program so we're always looking for ways to improve what we do. But I'm pretty sure that the fact sheet or a letter that goes out to the family member is fairly clear about what we need. Now, I'm -- certainly again, I'll revisit that, and, you know, I welcome your input as well, you know, if we need to revamp it or not. We can certainly look into that.

**MR. TEMPLETON:** Okay, thanks, Brady.

**MR. WHITE:** So again, without hearing your whole question, did that answer it?

**MR. TEMPLETON:** For the most part. The one thing that I would like to ask, if I might, is if you could go back and check to see active versus remission status for some of the folks that are in this program, just to make sure that some of the folks aren't, by some crazy process or whatever, getting kicked out of active status and into remission status.

**MR. WHITE:** Right, and thank you for bringing that up. That's actually a great question. Early on, what we decided with Dr. Erickson, I'm not sure if you were even part of our group then, but Dr. Walters and her team looked at this whole issue. And for cancers what we decided was during what we're calling an active phase of treatment for that cancer, meaning, you know, they're undergoing chemotherapy or radiation or something like that. What we're going to do for the family member is basically cover what we call whole body coverage, meaning unless it's on the list of either treatments or medications that we absolutely do not cover or are prohibited from doing so, we're going to basically cover anything -- any medical treatment that that family member received for whatever. And there is some clinical rationale for doing that that Dr. Erickson might be able to go into a little bit more detail on.

But so when it comes to active phase, the important thing from a business prospective is for that certain period of time we're going to cover every medical treatment that comes up, again, unless it’s forbidden. But then after that, after that active treatment, you know, we all know, you know,

most cancers -- again, I'm not a clinician or I can’t speak to this directly, but, you know, after a certain period of time the treatment, the aggressive treatment is finished, and there's maybe a maintenance phase, kind of period of time.

So during that maintenance phase, we don't want -- we can't cover whole-body coverage. So therefore we put some dates on there, and we got feedback from the clinicians on when to do that, you know, how long can active phase of cancer happen. One thing we have done is -- and again, this is requested on the treating physician report, for the most part, and it's given to us by the physician. But after that active phase of cancer and that date, if we continue to receive medical bills that indicate, that clearly indicate, that somebody's still ongoing -- you know, receiving ongoing treatment, active treatment for cancer or there's chemo, radiation or what have you, we'll extend that time automatically, you know, for another six months, okay? So it's after that period of time, that six-month period ends, that we go back to kind of maintenance coverage. So that's kind of a long-winded answer to your question, but did that help?

**MR. TEMPLETON:** Yes. So after six months it automatically drops them off if they haven't gotten any TPRs that say that there's any treatment underway?

**MR. WHITE:** Yeah. If they don't submit anymore medical bills or anything, to us it indicates that they're not still undergoing active treatment, and at that time they're -- you know, it's no longer considered whole-body coverage, unless, again, we receive a medical bill, and then we'll start that back up. So and we'll extend it out another six months. Again, we're trying not to put the burden on the family member just to provide us with another form or more documentation. We've taken it on ourselves to extend that time, and again, extend whole-body coverage for an additional six months.

And I think the feeling from Dr. Walters at the time was that's generally going to cover most, most doctor treatment periods of time. So again, we can revisit that, and Dr. Erickson, you're welcome to weigh in on the clinical aspects of that, if you want.

**MR. TEMPLETON:** I would like to ask if -- that it would be revisited 'cause it seems to me that the burden actually is on the patient in that case

rather than vice versa.

Is there someone, just a quick question, then I'll -- unless there's any other follow-ups, I'll let it go, here. But as far as when you -- let's see. When you have the medical records come in and do the automatic extension that you were talking about, so does someone actually take a look at those and then make that determination or is it a bill comes through, and the system says, oh, a bill comes through, this guy is active, and so we will just -- does the system automatically does it? I'm assuming that there's probably some manual intervention there.

**MR. WHITE:** Yeah. Right now we have, we have somebody actually looking at that. I mean, ideally, if we were smart enough, we could create our system to automatically make that happen but that's not the case yet.

**MR. UNTERBERG:** Brady, this is Craig Unterberg. When you said maintenance coverage, so people are getting ongoing scans to make sure they're still in remission, will that be covered, the cost of CAT scans and MRI?

**MR. WHITE:** Yeah, absolutely. Yep.

**DR. ERICKSON:** Okay, Brady, this is Erickson.

So the window's very wide open when we talk about whole-body during the active phase. The window doesn't shut at the end of six months, if we think someone's in remission; it just narrows down to things that are more generally directly related to the cancers. And so such as things as ongoing screening studies, you know, is clearly covered.

It sounds like, you know, through this very fruitful and profitable discussion, that we need to look at these business practices, to see what is the best way to interact with the family member who's had the cancer, so as to have the best information.

**MR. ENSMINGER:** And this is Jerry Ensminger. What about collateral effects from the treatment that, you know, go along with, you know, the radical treatments that a lot of these cancers require, and people acquire other effects from that treatment or from the cancer itself? Are those covered?

**DR. ERICKSON:** This is Erickson again. The short answer is yes. Those who are -- there's a small group -- there's a very small group of medical adjudicators who are very favorably disposed to very graciously look at those second- and third-order effects, because it is understood that once -- you know, once you've had radiation, once you've had

chemotherapy, once you've had major surgery of this regard, there -- you know, your life's different. Okay, body systems may function differently. There are second- and third-order things that could be going on.

**MR. TEMPLETON:** And Brady, one last question but this is the big one. I know this year we're going to have a report prepared for us on the claims updates so I know you're over the phone here but I'm kind of curious -- well, hey, it just happens to be on the PowerPoint; they pointed out to me. Sorry, thank you.

**MR. WHITE:** Okay, not a problem.

**MR. HODORE:** Hello, I have one question, just one question. My name is Bernard Hodore. What about those veterans who are -- like I got one veteran who has prostate cancer. He's 66 now. And they said he was in remission, and he's had this prostate cancer for over ten years, and he's 66 years of age. Is there any limit for age process on this prostate cancer? Are we examining the prostate cancer?

**DR. ERICKSON:** Brady, I don't know of any limit of age. Do you?

**MR. WHITE:** Yeah, is this a veteran issue or a

family member issue?

**MR. HODORE:** This is a veteran issue.

**MR. WHITE:** Yeah, I'm not aware of any kind of limitation for age.

**MR. HODORE:** Well, they said they're going to reduce his hundred percent to 20 percent, and he's been suffering from prostate cancer for over ten years now.

**MR. WHITE:** Yeah, that's probably more -- that's probably more of a VBA question than about disability.

**MR. FLOHR:** Yeah, this is Brad. We do occasionally request a review examination for someone when we initially see them; for example, someone that has sprained their knee with service connection is under treatment. We think that it may improve in the future, and we assign an initial evaluation and then we schedule a review exam in about five years to look at it.

So this very well could be prostate cancer, been treated, had it for ten years, but we would look at it and see what the current status of it is, and then reduce it. It has nothing to do with treatment for the cancers in terms of that, if it's service-connected. But for benefits-wise we'll look

at it to see how disabled is the man now from his prostate cancer after ten years.

**MR. HODORE:** Well, the thing of it is is that he's been suffering from prostate cancer for the last ten years.

**MR. FLOHR:** Right.

**MR. HODORE:** And they're going to reduce his hundred percent to 20 percent, but yet still he's having psychological aspects from getting his hundred percent decreased because they're going to put an extreme hardship on him. So I was wondering -- he's still suffering from his prostate cancer, it’s going indirectly and reduce his benefits from a hundred percent to 20 percent.

**MR. ENSMINGER:** It's still active.

**MR. HODORE:** But the VA says that it's in remission.

**MR. FLOHR:** Well, we rely on what their doctors tell us. If they say it's in remission, then...

**MR. ENSMINGER:** He needs to go -- who is this, Bernie? I don't need his name. Is he here local?

**MR. HODORE:** No, he's not. He's here local. He's a claim that came across my desk.

**MR. ENSMINGER:** Well, your biggest beef right now is with his doctors. I mean, you've got to get

that straightened out first. I mean, if his doctor's saying he's in remission, and he's not, that's where you need to start this.

**MR. HODORE:** Okay.

**MR. ORRIS:** Hey, Brady, first off, I want to say thank you. I know the difficulty you had trying to make it to the meeting, and I appreciate you calling in. This is Chris Orris, by the way. I know you're going to be going over the -- your claims and denials. I wanted to wrap back one more time to your treating physician report, and thank you for giving that update, and I know we've talked about this several times in the past. I still want to know why there is a question from the physician to list any current morbidities, risk factors or other exposures on that form. I thought we were moving past those since, if they have the condition, they should be eligible for the benefits.

**MR. WHITE:** Yeah, that's -- probably Dr. Erickson can expand on this in a little more detail, but basically again, for the cancers, we really don't need that. It's for more of the other conditions, like the neural behavioral effects, renal toxicity, hepatic steatosis, that the physicians look at the evidence, 'cause there's

some -- and I don't know how much to speak to this, Dr. Erickson, but there's some guidelines in the clinical guidance about looking at that information. So therefore we would look --

**DR. ERICKSON:** Sure. Yeah, this is Erickson. Go ahead, Brady. I'll follow you.

**MR. WHITE:** I was just going to kind of add on, but for the cancers, you know, we don't ask for that since, you know, we don't request smoking history for anybody with lung cancer.

**DR. ERICKSON:** I know there was one point in which there was an older form that we were using that already had on it comorbidities. Probably what's important for folks to know is the treating physician report is something that helps us because the treating physician, who knows that patient the best, is basically providing us a very short summary of what's going on with that patient right now. And even if there are, you know, three inches of medical records submitted, that summary carries a huge amount of weight, then, when the medical assessment is made by the VA physician. And so it really -- it speeds things up, to be quite frank.

**MR. ORRIS:** Okay, but I'm looking at the form right now, and you're specifically asking for a

narrative from the treating physician to go over any comorbidities, risk factors or other exposures that may have also contributed to this illness.

**DR. ERICKSON:** Right.

**MR. ORRIS:** And that information just does not seem to have any benefit to you in a claims process for something that should be awarded if they're sick. It doesn't matter where they got it from.

**DR. ERICKSON:** No, Chris, and you're exactly right. And the end result you'd be satisfied with, in that those -- the answer to those questions do not directly impact the conclusion, okay, the medical assessment comes to.

If you've ever had to work in the federal government, there's this thing about approved forms, and I think we discussed this at one of the previous CAP meetings. To get a new form, a totally new form approved by OMB and everybody else, I mean, you almost have to promise your first born, and it takes a couple years. And as a pragmatic measure, an existing form, and I sort of alluded to this, an existing form was used because it looked close enough that it could help us bypass the two years' wait to get the form approved, and start the process of actually taking care of people. Okay?

**MR. ORRIS:** Thank you.

**MR. PARTAIN:** Brad -- Dr. Erickson, sorry, my brain is fried today here. Question on, you know, earlier you were talking about with the announcement concerning the presumptive service. There are other illnesses that are out there, that in the future we're going to, you know, take a look at, hopefully with the cancer incidence study and stuff. What I'm asking is what type of work do you need to do with the ATSDR to get these other cancers looked at, like for example male breast cancer, which, you know, you got male breast cancer, thyroid cancer, prostate cancer and some of these rarer cancers like male breast cancer and thyroid cancer where there's really never enough to do a formal study, but yet like with male breast cancer, it's appeared at other TCE-PCE sites such as Valcartier Air Force Base in Canada, the IBM Endicott site in New York, I believe the View-Master site in Washington have all had male breast cancer appear after exposure to PCE and TCE, but there are never enough to study -- do a formal study.

So how do you address that where there's not really either not enough scientific studies done or it's a rare cancer but it's showing up at Lejeune in

numbers; how is the VA going to address that with ATSDR? Then I have a second question after that.

**DR. ERICKSON:** You know, we're going to continue this relationship with ATSDR through any number of studies that are currently -- you know, currently planned, ongoing. You know, for those of you that heard Frank say it, he followed through. He gave me a copy of the study protocol for the incidence study. Thanks again, Frank. I haven't had a chance to look at this, Mike, so I don't know that, for instance, the studies that you just mentioned will be adequately covered by this. I need to look at this, to be able to answer that knowledgeably.

I'll tell you that there are any, you know, any number of ways that we can get new information, and it's probably beyond my brain capability to be able to enumerate all those ways, but I'll tell you that, of all the federal agencies that are sort of on the case, ATSDR has mounted some truly heroic efforts here. And my sense is that, given the heightened awareness in our nation of environmental issues -- is that fair, Pat, to say it that way --

**DR. BREYSSE:** Yeah.

**DR. ERICKSON:** -- the heightened awareness of

environmental issues, I suspect we're going to be seeing a proliferation of studies, some of which may be very much related to Camp Lejeune issues in the near future.

**MR. PARTAIN:** Well, going back, you know, when I mentioned the male breast cancer, they're not studies; they were -- other studies that were done that noted that there was male breast cancer present, but the caveat's always there's never enough cases to study. And talking to Frank and Dr. Clapp and Dr. Cantor, one of the issues is that there's just not enough scientific evidence to say either way. And when Frank wrote his report to you all, breast cancer was at the low end. But yet we have, you know, 124 or so men from Camp Lejeune with breast cancer, which is extremely unusual.

And you know, and not just harping on male breast cancer but thyroid cancer. We have a lot of cases of thyroid cancer that there's been, you know, there's no rhyme or reason but we have an extraordinary number of thyroid cancers. So, you know, but again they're too small to study.

And my question is, you know, these people who were affected by this, are we going to wait five, ten years down the road for other things? You know,

what is the VA going to do to be more proactive now that we're starting to get to a point where there is a presumptive and there are other cancers, such as those two I mentioned, that need to be looked at in a way, other than just pushed aside?

**DR. BREYSSE:** Do you mind if I jump in? Do you have something in mind?

**MR. PARTAIN:** As far as what?

**DR. BREYSSE:** About what you think we could do, either ourselves would be to be more proactive?

**MR. PARTAIN:** ATSDR did a male breast cancer study, which, you know, we've discussed this before and everything.

**DR. BREYSSE:** Yeah.

**MR. PARTAIN:** But, you know, it's, you know, what can we do to get these cancers addressed? I mean, like I said, we've got thyroid cluster, a thyroid cancer cluster. We have a lot of people that reported prostate cancer, and unusual numbers with those. So what are we doing with these outlier conditions that there are really not enough numbers to generate a formal study? How do you address that so that these veterans --

**DR. BREYSSE:** Yeah, so they’re part of the cancer incidence study, they'll be captured by that.

And we're constantly with them, I'm sure that the VA is, they're doing the literature, and if something comes up we think is germane published somewhere else that's relevant to the conditions of exposures at Camp Lejeune, we'll highlight it, and we'll discuss it with the VA.

**MR. PARTAIN:** Okay.

**DR. BREYSSE:** So we'll surveil the literature, and then hopefully we'll have a clearer picture of some of these other cancers that are smaller in numbers but -- smaller perhaps because people don't die as much from small issues of mortality study.

**MR. PARTAIN:** It’s the rare cancers, like aplastic anemia is a rare cancer. We have, I know, from talking to Andrea Byron, who had aplastic anemia, I think she said at one time there was like five or six that she was tracking, which it correlates to the high number of men with male breast cancer. So, you know, the fact that it's a rare cancer, it's not conducive to scientific study. How do you address that --

**DR. BREYSSE:** So that's not a Camp Lejeune problem; that's an environmental health problem.

**MR. PARTAIN:** Do we just forget about those people?

**DR. BREYSSE:** No, no, we keep doing our best, and we look for opportunities to do studies where there might be enough cases, if we collect enough cases that we can combine -- if studies get published with small numbers we can do meta-analyses when enough of them accumulate. I'm not saying it's hopeless, but I think you're laying out the challenges to try and sort out --

**MR. PARTAIN:** Well, it needs to be addressed.

**DR. BREYSSE:** -- environmental factors on rare cancers.

**MR. PARTAIN:** And I did have a question from outside, when we were talking earlier this morning and stuff. They wanted to know why the VA and the ATSDR didn't bring up the genetic study that was to the million veterans program, to help record some of this information, you know, like a lost opportunity. Did anyone -- they wanted to know if anyone looked at it or thought about it.

**DR. ERICKSON:** Yeah, this is Erickson. So the million veterans study, which will be ongoing for decades, it's still in its earliest stages. So we're -- you know, the VA's at the head -- the front end of this. We're very much at the front end of, you know, collecting specimens, surveys. You know,

some of you in this room may have, even in the last couple weeks gotten another mailing, asking you to participate. But we're -- you know, we're probably a number of years away from some publications on that.

**MR. ENSMINGER:** I asked this morning about the subject matter expert program and what part of the VA that falls under, which is VHA; you confirmed that. I believe that Dr. Clancy is the deputy undersecretary for health?

**DR. ERICKSON:** This is Erickson. She is one of four individuals who are named as a deputy undersecretary, and she's the deputy undersecretary for excellence --

**MR. FLOHR:** Organizational excellence.

**DR. ERICKSON:** -- organizational excellence. Thank you, Brad.

**MR. ENSMINGER:** And she's supposed to provide oversight of VHA's performance, quality, safety, risk management, systems engineering, auditing, oversight, ethics and accreditation programs.

**DR. ERICKSON:** This sounds right. Yeah, and --

**MR. ENSMINGER:** I'm reading this right off of her job description.

**DR. ERICKSON:** Yeah, that sounds right.

**MR. ENSMINGER:** I would like to know if she has conducted her oversight duties on the subject matter expert program, because there is certainly a breakdown in the quality of that program, because we have seen it. They have cited Wikipedia. We've had veterans with kidney cancer, and the opinion written by the so-called subject matter expert stated that they had reviewed the meta-analysis of two decades' worth of well-conducted scientific studies, they could find no evidence that TCE causes cancer of any kind.

That opinion was written in January of last year, when we all know that the EPA, on 28 September 2011 reclassified TCE as a known human carcinogen. IARC reclassified -- followed suit and reclassified TCE as a known human carcinogen in 2012. And our own national toxicological program, which we have a board member sitting here, reclassified TCE as a known human carcinogen based upon the scientific evidence for causing renal cell carcinoma, a.k.a. kidney cancer.

I got two claims, not just that one, that had that language verbatim. I want Dr. Clancy to tell me what oversight she has provided over this SME program, because it's invalid. And I don't have a

problem with you guys having a subject matter expert program, but you got to have the qualified people to do it. And if you don't have them on staff, then you need to contract them.

**DR. BREYSSE:** I think that's an official request, and I think we can ask Carolyn to provide her thoughts on oversight at the next meeting.

**MR. ENSMINGER:** And does she have a report? Does she fill a report out on these -- this oversight that she conducts on these things? And the ethical side of this thing is that you've got these subject matter experts, that don't even know that PCE causes renal cell carcinoma, challenging veterans' own oncologists and other medical specialists. Where is the ethics in that?

**MS. FRESHWATER:** If I can just follow up, because I had looked into the ethics of one of these SMEs in particular who has a side business which represents industry, many chemical companies and so forth, and I have now found out that there's a -- that the connection that she has with a law firm is the same law firm that wrote the emergency manager law in Flint. So and this is information that we are apparently not allowed to have, so we are just left to search the internet and try and find out

what interest the SMEs are representing. So I would like a follow-up on that as well.

**DR. BREYSSE:** So presumably that would be part of the oversight activity.

**DR. ERICKSON:** Yeah, this is Erickson. I know we've covered some of these topics before. And I know that I'd heard about the Wikipedia twice earlier in this session, that in previous CAP sessions, and I will tell you that there have been a lot of steps taken in the meantime to tighten a number of things up, for instance, the formation of a peer review process for the SMEs who work for disability medical assessment.

I can tell you that the bibliography that you had asked for, I have now provided to Dr. Breysse and to Sheila, and so that's ready to be sent to members of the CAP. I didn't have that earlier today. Somewhere our communication went down in terms of being able to see the action log, or our ^ list. I know it wasn't in my email box, but that thing, what it is, this morning I've been working to try and dig out some of these answers for you. So the bibliography is coming your way.

We've talked about the importance of having a senior representative from DMA come to the next

meeting, and I know that's written on the board. Sheila put that up there.

But to in addition ask Dr. Clancy for her role, what she's done in terms of oversight, certainly very welcome, and I'm sure she'd be able to do that. I think it's a great idea to be able to bring that to the public. And then there's a whole list of things here.

As relates to ethical lapses, I'd certainly heard that before in previous meetings. I will tell you that that accusation was taken forward by name for that individual, and I know that there were some investigators at VA that looked into this, and felt that, according to federal rules, there was not a conflict, okay, for this individual. Now, the last thing that you said, Lori, I hadn't heard before, but if you want to give me the details of if you think there's skullduggery related to Flint, Michigan, please let me know the details of that. We can put that into an investigation as well.

I think it's important that whatever we discuss here is factually based. I think that you in particular noted just how inappropriate it is for bad information to hit social media or to be brought out, and if it's not substantiated, you know, we

probably need to be really careful because there's a lot of reputations that are at stake here, and I would welcome to hear more from you, but to do that offline so that we can get some details.

**MS. FRESHWATER:** I've actually already published on this, so I can give you the story, and everything is substantiated and backed up with integrity of my journalism, so absolutely. I don't put anything on social media or make accusations that I can't back up. Thank you.

**DR. BREYSSE:** Thank you, great. So we're about at the end of the time for the VA updates.

**DR. ERICKSON:** Could we just quickly turn to the slides, Sheila? And Brady, just so you know, we're going to show the slide here for the update of the claims. There's a graph, or a chart, for veterans, there's a chart for family members, I believe. Keep going. Keep going. Keep going. Keep going. Keep going. Keep going. This is just a lot of numbers. Great, stop there.

Okay, so Brady we're showing the slide number 6, Camp Lejeune veteran program. For everybody, this is just a roll-up of the number of veterans who were treated for each of these 15 conditions, and these are data that are through the 17th of March.

And these slides, I think, are available to the CAP, right, Sheila?

**MS. STEVENS:** Yeah.

**DR. ERICKSON:** Okay. And if you go to the -- there's a similar slide for the family members, I believe.

**MR. ENSMINGER:** I got a question about that one and the numbers. Under bladder cancer, the report you released in December had 885 bladder cancer-- active bladder cancer claims.

**DR. ERICKSON:** Okay, was this -- was this Brad's report from VBA claims or was this Brady's from the 2012 law? Yeah, I think this is provision of healthcare under the (indiscernible) legislation.

**MR. ENSMINGER:** Oh, okay. All right, all right, all right.

**DR. BREYSSE:** All right, any questions on the table?

**DR. ERICKSON:** Okay, Sheila, go forward to the family member table. Okay, now Brady, we're looking at slide 8.

**MR. WHITE:** Okay.

**MR. TEMPLETON:** Are we going to get a copy of these, this presentation?

**MS. STEVENS:** Yes. It's on my list of things

to do.

**MS. FRESHWATER:** Sheila, can that include the PHA presentation as well? PHA.

**MS. STEVENS:** (inaudible)

**MS. FRESHWATER:** Okay, thank you.

**DR. BREYSSE:** All right, any questions? I'm trying to be sensitive to the clock 'cause I know people have to take off.

**MR. WHITE:** Yeah, this is Brady. Can I kind of jump in here, just real quick for a couple of things?

**DR. BREYSSE:** Please do.

**MR. WHITE:** It won't take more than five minutes. First of all, I'm sorry I couldn't be there in person. I got caught in that blizzard we had that ran through here in Denver, and had a fun day at the airport all day, trying to get out, but I'm sorry about that. Second thing is --

**MR. ENSMINGER:** (Unintelligible) commuter airplane I saw landing in Oklahoma sideways.

**MR. WHITE:** No, no, it wasn’t me. They had to close their whole airport down, and only the second time in their history they did that. But I was looking forward to seeing everybody, mainly because I wanted to share with you about the family member

program, but also I want to express my appreciation in person for the VA and Dr. Erickson and Brad, and also those of you on the CAP and, you know -- you know I've been dealing with some cancer treatment myself. And the good news is I've completed everything, all the chemo and radiation last month, and I've got a great prognosis.

**MS. FRESHWATER:** Well, we're happy to hear that, Brady.

**MR. WHITE**: Yeah. Thank you. And again it really meant a lot to me for your support, so I appreciate it. The other thing is I'm not sure if he's there yet or not, but ^Micah Gardner, he helps our program through the health eligibility center on the veterans' side. They're the ones that determine veteran eligibility for the various programs. I'm guessing and hoping he might actually be there, somewhere in the back, to help any veterans that might be in the audience that have specific questions about their eligibility. Do you know if he's there?

**DR. BREYSSE:** He's here.

**MR. WHITE:** Okay, excellent. Great. Thank you, Micah, so much for showing up there. And any veteran in the audience that has a question about

their eligibility, please see Micah during a break or after this meeting. And really, that's about it. Any family member questions for me?

**DR. BREYSSE:** Kevin, you wanted to ask a question, Kevin? No, but with -- okay. So we have one question for someone else, Brady.

**MR. WHITE:** Okay.

**MR. WILKINS:** Dr. Erickson, can we revisit that purported VA employee in Biloxi, Mississippi that was posting on social media?

**DR. ERICKSON:** When you say can we revisit it --

**MR. WILKINS:** Y'all talked about -- y'all talked about it earlier.

**DR. ERICKSON:** Right, I mean, I just pulled up that email that Tim had sent. You know, I, for my part, will follow up on it. I have nothing to tell you other than what I shared already.

**MR. WILKINS:** Okay, all right, well, like I say -- I just -- you know, since Brad has a memory problem, I thought I'd just kind of put it on you.

**DR. ERICKSON:** So I've got quite a list of things here, and that's one of them. Thank you.

**DR. BREYSSE:** Should we pitch in and buy Brad some memory-enhancing therapy? Tim, go ahead. I

want to move on.

**MR. TEMPLETON:** One quick question, real quick. Speaking about appeals in the SME, when people get their denials -- I haven't seen anything other than a mention of an SME, but they don't give the SME opinion. Usually a veteran will have to go to their My Healthy Vet or try to get the record through some other means to try to find out what was said.

Now, usually when they're going to try to appeal a decision they're going to need that information upon appeal. That's going to be part of the basis that they would have to at least place the argument under. So is it at all possible for the SME opinion to be part of the denial paperwork that gets sent out to the veteran or family member? Because it's not in there right now. There's nothing that says what their opinion is and what they used and, you know, how they came to their conclusions and all that. They have to go to -- the veteran or the family member has to go through several extra hoops to get that information. And so I'm curious as to whether maybe we could include that as part of the denial paperwork, since they're going to need it anyway, if they're going to appeal.

**MR. FLOHR:** Yes, it’s Brad. Yeah, we don't do

that unless maybe on appeal, if we issue a statement of case, it may have that information at that point. But I can take that back, and we can talk about it, if we can share that, as far as...

**DR. BREYSSE:** Great. So I think we now move to the CAP update and concerns. Now, many of your concerns have been expressed already, as you guys are wont to do, which is fine. But now we have a few -- a little bit of time, if there's something in addition you'd like to raise. Chris?

**MR. ORRIS:** Brady, this is Chris Orris. One last question for you before we move on to this. How quickly can the family member program move forward if and when additional conditions are added? Do you have to go through the same rules process that the VBA goes through right now?

**MR. WHITE:** Chris, this is Brady. That's a great question, and I'm not a legislative expert but I believe the answer to that would be yes. Anything that changes our statute or regulations would need to kind of go through some kind of a concurrence process with OMB to get it republished in the Federal Register. I'm just not sure, you know, what period of time that would cover.

**MR. ORRIS:** Just a final question. The family

member program, is that finalized now or is that still in that pending status? I know you expedited it to get your program going.

**MR. WHITE:** You mean with the final reg published?

**MR. ORRIS:** Correct.

**MR. WHITE:** I don't believe so. I keep pinging our legislative affairs people about that, and they have not let me know that the final determination, final draft was submitted to OMB, or the Federal Register, I'm sorry, for publication. But for all intents and purposes, you know, we're operating, been operating since October, you know, as of last year, and obviously we got room to improve, and we're still trying to, you know, complete our systems. We've got about half of it built now, so there's a lot of work-arounds. But there's an issue of funding right now. They might have taken some of my funding away to complete that. So we're trying to get to the bottom of that.

**MR. UNTERBERG:** Brady, this is Craig Unterberg. Two questions. One, do you have sufficient staffing? And also what is the typical time frame for a bill that's fully submitted to get paid. At least in my case I see a lot of pendings and those

type of things, so what are you seeing on the time frame with the view that some people may really need the money very quickly?

**MR. WHITE:** Sure. And that's an excellent question. Just to let you know, we have -- I'm looking at this specifically. Hold on one second here. As far as time frames go, you know, we've got some performance measures in place. And there's so many aspects to this program, and there's so many other entities that we touch base with, and to make sure things are rolling along. For instance on the administrative side of eligibility, you know, I mentioned Micah and his team help us, you know, to determine, you know, whether the veteran was like -- veteran in good standing or were they in Camp Lejeune during the covered time frame, et cetera, and also they're helping us determine if the family member is on board. And we've got basically every touch point we have a certain number of days that it needs to be completed. And so that's on the application side.

When it comes to the claim side, we have basically contracted with the financial services center, which is a governmental agency, to handle our claims as well as our call centers. And for

claims payment, with the accuracy, our goal is 98.5 percent payment accuracy. And then timeliness, 98.5 percent are adjudicated within 30 days.

**MR. UNTERBERG:** Thank you.

**MR. WHITE:** When it comes to claims, most of the claims we receive, we're actually the last payers. There's actually very, very few family members at this time that we're the primary payers. That means they all have basically other health insurance, so hopefully, you know, most of those bills are being covered by their other health insurance, and then we're just kind of adding on to that, to make sure they don't have any medical expenses for any of these 15 conditions.

**DR. BREYSSE:** All right, thank you, Brady. So shifting to the CAP concerns, anything that we haven't talked about already that you'd like to raise?

**CAP UPDATES AND CONCERNS**

**MS. FRESHWATER:** I have a couple of brief statements. I had brought up yesterday that I would like to ask that ATSDR kind of up their efforts in the social media area as far as letting people know about the meetings and the activities, because I

think it's -- you have a big platform, and it should be used. And, you know, we try and get the word out ourselves, but I think we could have a lot better cooperation between the CAP's social media platforms and the Agency's platforms.

And the other concern -- it's not really a concern; it's just something I'm getting a lot from the community. With Flint, Michigan being such, you know, a huge issue right now, I'm having a lot of people ask what our lead exposure was. So I'm just wondering if someone from the Agency can maybe talk a little bit about how much lead Camp Lejeune children were exposed to, or, you know, and just state some generalities, if you wouldn't mind.

**DR. BREYSSE:** So can we get -- where would we need to go to get the childhood blood lead screening levels from people and children at the base in Camp Lejeune? Okay.

**UNIDENTIFIED SPEAKER:** All right, that was under three (unintelligible).

**DR. BREYSSE:** Yeah, that was a narrower request. Well, we're being asked, I think, to compare the distribution of blood lead levels in children at Flint to children in Camp Lejeune. So obviously we have a lot of information on Flint. I

don't know if we have any data on Camp Lejeune, but can we make that something we can look into, see what --

**MS. STEVENS:** So you're asking for comparison of children at Camp Lejeune to children in Flint, Michigan?

**MR. PARTAIN:** To my knowledge I don't believe there was any blood tests done on the children at Camp Lejeune for lead.

**MS. FRESHWATER:** I'm just asking about lead level. I'm not looking for like a, you know, a concrete scientific report. I just -- I'm really representing the community who has concerns, and says, well, how much lead was in our water, I think, compared to Flint. Do you see what -- do you know what I'm saying?

**MS. STEVENS:** So you're asking for water, lead levels in the water.

**MS. FRESHWATER:** Yes.

**MR. PARTAIN:** Yeah, it's in the public health assessment, but how much -- you know, put a number behind it.

**MS. STEVENS:** Yeah, based off of Rick's presentation today.

**DR. BREYSSE:** Do we have estimates of the

blood -- the lead water levels in Camp Lejeune?

**MR. GILLIG:** We do have some information, I believe, collected post-2005.

**DR. BREYSSE:** So we can compare that to what we're seeing in Flint, is what they're asking us to do.

**MR. GILLIG:** Right, and I haven't seen the information for Flint but I don't know why we couldn't do a comparison.

**DR. BREYSSE:** We got it.

**MR. PARTAIN:** Does that information just go to 2005? Was there anything -- I know in the 90s, I've seen some memos in the documents to where they were talking about NTBs and things like that, that --

**MR. GILLIG:** I believe the data prior to 2005 is -- I know we reviewed it. I didn't think it was -- I don't think it's all that reliable, I mean, the way it was collected. While we have a lot more confidence in the post-2005 data, because it's the most recent data set we've really looked at very closely.

**MR. PARTAIN:** I believe part of the 1.5 million gallons of fuel floating around at the Hadnot Point fuel farm included leaded fuel as well as unleaded. So I -- and we know that benzene, we

know that fuel was in the water, so, you know, making the extrapolation that there was more than likely a lead exposure while that fuel was being pumped and delivered to the families and Marines at Lejeune prior to 1985.

**MR. GILLIG:** And Mike, I don't know what the drinking water -- the entire analysis set of the drinking water shows as far as lead. Again, we'll look into it.

**MS. FRESHWATER:** Well, I appreciate it. I know -- I'm not trying to throw a big job at you guys. I know everybody's really busy here, and you have a lot of pressing things. It's just I'm sure you can imagine how many questions we're getting about this now when they -- because people had not thought about the consequences of lead on children, and so now they're wondering, oh, my God, I had all these other chemicals; did we have lead? And so if you could just give me some sort of, you know, information to give them so that I'm not just talking -- you know, not informed.

**MR. GILLIG:** Starting on page 47 of the health assessment, that's the lead section, and I believe our presentation this morning talked about 14 samples between 2005 and 2013 that were above 15

parts per billion, which is actually a relatively low number.

**MS. FRESHWATER:** Okay.

**DR. BREYSSE:** But I think we can maybe be a little more thorough in that summary of the data, and we can get it to Lori.

**MS. FRESHWATER:** Yeah, I mean, I would love to find out that it's lower. Of course, obviously, you know. Thank you.

**MR. FLOHR:** Hey, Pat. I apologize but Dr. Erickson and I are going to have to leave to get to the airport, especially if there's heightened security there today.

**DR. BREYSSE:** I understand.

**MR. FLOHR:** And if there are any questions from the community here, the public, for us, please jot them down and send them to us, and we will answer them.

**MS. FRESHWATER:** Brad, I'm sorry for getting a little heated earlier.

**MR. FLOHR:** I understand.

**MS. FRESHWATER:** I apologize. I really do. I --

**MR. FLOHR:** I understand, Lori.

**MS. FRESHWATER:** And Dr. Erickson, I would like

to speak with you, just on the cancer registry. It's something that I'm very, very, very interested in, and I have some other people who want to work on that as well. So if we can follow up on that.

**MR. WHITE:** Hey, Lori? Hey, Lori?

**MS. FRESHWATER:** Yes, Brady?

**MR. WHITE:** This is Brady.

**MS. FRESHWATER:** Yes?

**MR. WHITE:** Just real quick. On that issue with the VA employee on the social media. Whoever is the administrator of that page, could you just have them, you know, removed from the page?

**MS. FRESHWATER:** Have the person removed from the page?

**MR. WHITE:** Yeah.

**MS. FRESHWATER:** The CAP kind of formed in and made sure that the record was correct, so I think that's better because it's always better to leave a record that represents truth as opposed to deleting. That's my opinion.

**MR. ENSMINGER:** Well, I told him he didn't know his ass from a hole in the ground. And then, you know, then -- and furthermore, I've forgotten more about Camp Lejeune than he obviously knew. So he shut up.

**DR. BREYSSE:** Okay. But before the VA leaves, I just want to acknowledge, yeah, we've had, I think, a good working relationship, with some give-and-take, back and forth. And I'm happy with where we are right now, and I salute the decisions you guys have made about the compensation presumption.

**MS. FRESHWATER:** Yes, thank you.

**MR. ENSMINGER:** I'd also like to note that, you know, one of our members, Tim Templeton, lost his father the evening before he left to come here, and he still made the meeting.

**MS. FRESHWATER:** And Tim is a very, very hard worker as it is, so yes, I'd like to join in on that.

**MR. ENSMINGER:** We offer you our condolences.

**MR. TEMPLETON:** Thank you, everyone. Appreciate that.

**DR. BREYSSE:** So as the VA are leaving, Sheila, can you review the action items?

**SUMMARY OF ACTION ITEMS**

**MS. STEVENS:** Yes. Okay, so Ray, this is Sheila. So the action items for today were re-invite the disability and medical assessment section

of the VA, so the DMA.

The second one was relook at Camp Lejeune, the VA action items, and make sure that we were working off the same page, and that I didn't make a mistake or it just didn't get there.

Nondisclosure agreement, what was this one exactly? I need some clarification on that one.

**MR. UNTERBERG:** Yes, the question is to ask the government lawyers if we can get a nondisclosure agreement in place.

**MS. STEVENS:** Got it. So it's ask government lawyers for nondisclosure agreement. The second one is explanation why United States Marine Corps will not send uniform rep to meeting, addressed to Marines, and not to the CAP. So Melissa, you got that one.

The second one is United States Marine Corps, follow up on elevated blood lead levels in children.

Next one is cancer incidence protocol. That will be sent out to the CAP, the VA and DoD. Camp Lejeune family member program, request for active versus remission status. Tim, is that correct, Camp Lejeune member active versus remission status, got it? Okay.

Then I'll work with Christian on about -- I've

already talked to him briefly about get the word out on social media. We also will -- we're going to put information out sooner. Like for the August 11th meeting we're going to get that information sooner on our website so people in the audience can register and have a longer period to register for our meeting -- longer than the 30 days we currently have.

And then finally blood levels in Camp Lejeune water compared to Flint is an action item.

**MS. RUCKART:** So I just want to add that I captured some additional action items, so I didn't want people to think that this is the final list, and then I go back and read the transcript and get finer details and really kind of flesh it out, so there will be more than just that list. That's great, just to get started but just so people don't think that's the final list.

**MS. STEVENS:** Okay, so just a reminder --

**MR. ENSMINGER:** What happened to Dr. Clancy and her oversight role?

**MS. STEVENS:** Oh, thank you.

**MS. RUCKART:** Jerry, like I just said, I captured other action items that Sheila doesn't have, and I go through the transcript, and I pull

out any other things, whether they're actually stated as an action item. If it's something that's obviously needing follow-up, I pull that out. That's why I review the transcript, because it's very hard to capture everything that we mention here today. So we do have a more thorough process, and I really get everything. That's why our list is, you know, this long, longer than what we can capture right now.

**MS. STEVENS:** Okay, so just a reminder, August 11th here in Atlanta, so get the word out.

**DR. CANTOR:** I have a request regarding the action item list -- this is Ken Cantor. If you could, when it's finalized and it goes out to the VA, could you distribute that also to the full CAP? Thank you.

**QUESTIONS FROM AUDIENCE**

**DR. BREYSSE:** Great. So now I'd like to open the meeting to questions from the audience. If there's people who are attending who would like to make a comment or ask a question, now is your time.

**MR. BAILEY:** Yeah, my name is Daniel Golf Bailey, Jr. I was a hospital corpsman stationed with the Marines '86 to '88. My question is, I have

a pituitary abnormal functioning, a hypoactive level. The VA --, of course they ran out on us -- did they really before -- anyway, my question was for them, was mine's precancerous. They're taking the see-and-wait approach, 'cause you guys were talking about how if they're diagnosed with the cancer, and then you know, if they're still in remission, that they get the benefits and stuff like that. Well, mine could be pre -- and it is somewhat functioning, playing with my hormone levels. And my concern is on the disability side and also and all of a sudden am I gonna receive a bill from the VA because it's not one of the 15 presumptives that's listed. Thank you.

**DR. BREYSSE:** I'm really sorry; I don't know how to answer that. Brady, are you still there?

**MR. WHITE:** Yeah, I'm here.

**DR. BREYSSE:** Did you hear the question?

**MR. WHITE:** I did but I couldn't quite follow it, to be honest with you. I heard some talk about --

**DR. BREYSSE:** Could you repeat the question, please?

**UNIDENTIFIED SPEAKER:** Yeah, if you have a precancerous condition that's being handled so that

it doesn't get to the cancer stage, is that going to be covered, considering that if he doesn't handle it it'll become cancer, and then it seems like a kind of perverse result.

**MR. WHITE:** Right. Here's my understanding of how the healthcare process works for Camp Lejeune veterans, right? Basically anybody that's been stationed at Camp Lejeune, they have to fill out the form, but then they are signed up as a Camp Lejeune veteran. And what that does for you is it puts you in, you know, our priority groups. We have different priority groups in the VHA. This puts you in the VA -- I'm sorry, the priority group 6, and basically what that gives you is, you know, the ability to be seen in the VA medical center for any health condition. But what the benefit is if you are seen for treatment of one of those 15 conditions, you don't have any copayments. Now, if it's not treatment for one of the 15 conditions, then you could still be treated for that, but there just might be some copayments involved. Does that help?

**MR. BAILEY:** Yes, sir.

**UNIDENTIFIED SPEAKER:** (Unintelligible). I wanted to read this message that came through from

Secretary McDonald to Congressman Sanford D. Bishop, the 2nd district of the state of Georgia, who is my congressman. He said, he just got there, has made lots of improvement (unintelligible) and he did, but still has a lot to do. Let's give him a chance. Also in this (unintelligible) he said he's aware of the issue and very (unintelligible) for the following research report. Remember how long it took for Agent Orange. We are determined that it won't take that on this.

And that -- those are words from the Secretary Robert McDonald to Congressman Sanford D. Bishop, ranking member of the armed forces. Second district of the state of Georgia.

**MR. ENSMINGER:** What's the date of that?

**UNIDENTIFIED SPEAKER:** This was dated to me. I received this transmission right here. I received this transmission to March the 8th at 1:32 p.m., sir.

Now, what position -- I mean, how do we understand what I just read to you, that came from a U.S. Congressman, who is a ranking member, who is talking to Robert McDonald, and also I met and talked to Robert McDonald in Columbus, Georgia at a town hall meeting, and once I brought up toxic water exposure Camp Lejeune, he said I got to go. Well,

what position are we taking? I'm hearing all this rhetoric but I'm not seeing what -- I'm gonna tell you, sir, I have (unintelligible), 48 years I've been.

**MS. FRESHWATER:** Can I just stop you for a second, okay? These aren't the people that -- these are the people that are helping us. Okay?

**UNIDENTIFIED SPEAKER:** Okay, okay.

**MS. FRESHWATER:** I want you to be able to -- listen, I want you to be able to vent what your pain is and what's going on, but I'm just telling you that these are the people who are helping us get what we've gotten so far, okay?

**UNIDENTIFIED SPEAKER:** (Unintelligible).

**DR. BREYSSE:** Ma'am?

**MS. ELLIOTT:** My name's Debbie Elliott, Debbie Love, and I'm here for my husband. He has -- what I've read on the presumptions, one time I see angiosarcoma of the liver, and then the other times I see liver cancer. So my question is, my husband has an angiosarcoma but it's called epithelioid hemangioendothelioma. There's only less than 500 people that have this cancer. Since angiosarcomas are in the lining of the blood vessel, would he be considered -- his has made a home in his liver but

he doesn't have liver cancer. So that's my question, you know, because it's an angiosarcoma. I've seen it two ways and I don't know how you guys are listing it.

**DR. BREYSSE:** Again, we aren't the people who --

**MS. ELLIOTT:** I know, I know. I knew you'd say that.

**DR. BOVE:** Yeah, I mean, it's liver cancer now.

**MS. ELLIOTT:** It's liver cancer -- but --

**DR. BOVE:** Yeah, usually --

**MS. ELLIOTT:** -- but yet his oncologist at the VA won't call it liver cancer because it's not.

**DR. BOVE:** What are they calling it?

**MS. ELLIOTT:** It's epithelioid hemangioendothelioma. It is in his liver but he's already had two calcified (unintelligible) stones removed, and he had a small section of his bowel removed because it had shrunk. You know, the (unintelligible) had shrunk. But it's not really considered a liver cancer.

**DR. BOVE:** Yeah, originally the way the angiosarcoma of the liver came up was that vinyl chloride --

**MS. ELLIOTT:** Right.

**DR. BOVE:** -- is known to cause angiosarcoma of the liver. It was found in industrial work force --

**MS. ELLIOTT:** Right.

**DR. BOVE:** -- years ago, it was a huge cluster; it was obvious, and there's no doubt about it. So Secretary McDonald originally had that as one of the cancers he wanted as presumption, along with leukemia and kidney cancer, and those were the three. When we worked with the VA and briefed them and went back and forth, the VA decided to include other liver cancers --

**MS. ELLIOTT:** Liver cancers.

**DR. BOVE:** -- as well as angiosarcoma of the liver.

**MS. ELLIOTT:** So are they saying angiosarcoma or are they saying both?

**DR. BOVE:** It's the liver cancer --

**MS. ELLIOTT:** Okay.

**DR. BOVE:** -- that's, angiosarcoma of the liver and other liver cancers.

**MS. ELLIOTT:** And other liver cancers.

**DR. BOVE:** Yeah, because trichloroethylene is associated with liver cancer, and so that's...

**MS. ELLIOTT:** I read some of your -- one of your ATSDR's article on toxicology, and in the

references it talks about epithelioid hemangio -- and you know, a couple of the doctors on that. And one was talking -- I can tell you the page numbers and everything, but I have it written down. So that's why I was wondering is it -- you know, whether we keep going or not?

**DR. BREYSSE:** Our VA representative in the back is making notes.

**MS. ELLIOTT:** Okay.

**DR. BREYSSE:** And he'll get back to you about that specific.

**MS. ELLIOTT:** Okay.

**MS. FRESHWATER:** And we'll go back and do our best to make sure that all of your questions get to the VA, and try and get you an answer, and we'll post them on our website or social media. Just to let everybody know your questions, we'll try and follow up for you.

**MS. ELLIOTT:** Okay, I have a question, like on -- when you're talking social media, because I can find stuff, you know, when I go ATSDR. Do you guys have another...

**MS. FRESHWATER:** Okay, look, do you have a pen handy? I'll give you all of our information.

**MS. ELLIOTT:** I'll come over there after --

**MS. FRESHWATER:** Well, I'll go ahead and say it, though. It's camplejeunecap@gmail.com

**MS. ELLIOTT:** At gmail.

**MS. FRESHWATER:** That is our email address. And then if you go onto Facebook and search Camp Lejeune CAP, and --

**MS. ELLIOTT:** I think I did do that.

**MS. FRESHWATER:** -- it's an old logo of Camp Lejeune, you know, kind of a statue, so that will let you know you're at the right place. We have a website, Camp Lejeune.wordpress.com. And so --

**MS. ELLIOTT:** Yeah, at Word Press.

**MS. FRESHWATER:** Yeah, so you've seen that one. And then we also have Lejeune CAP on Twitter. So I'll give you all the information and write it down, but just for everybody listening --

**MS. ELLIOTT:** Oh, okay.

**MS. FRESHWATER:** -- if you -- the easiest one to remember is camplejeunecap@gmail.com, and then we can give you the rest of the information you need.

**MS. ELLIOTT:** Okay, thanks.

**MR. ENSMINGER:** And don't forget to give this gentleman back here your contact information.

**MS. ELLIOTT:** Okay, I'll talk to him. Thank you.

**DR. BREYSSE:** We have time for a couple more?

**MR. EMBERY:** My name's Brad Embery, I'm from Hazard, Kentucky. The ones I want to talk to has left. What I'm worried about is I went to our hospital in Lexington. Went in and asked for information. The clerk at the office looked at me. He said it's not a VA problem; it's not a military problem; it's a civilian problem, and I cannot help you. We need to get the VA to get these people trained to give us the information we need because they are treating us like crap.

**MS. FRESHWATER:** Are you saying -- you said you mentioned Camp Lejeune water.

**MR. EMBERY:** Yes.

**MS. FRESHWATER:** And that's what they said?

**MR. EMBERY:** That's what -- I have filed a verbal complaint and a written complaint. And I know somebody has heard this name: Al Bott.

**MS. FRESHWATER:** Are you a civilian or military?

**MR. EMBERY:** Yeah. I was in the Marine Corps.

**MS. FRESHWATER:** Okay.

**MR. EMBERY:** And that's the way they treat you down there. And when I filed my complaint, I got a call from another former Marine, Al Bott, and he

said -- he started going on, it's all technical issues. All Camp Lejeune is technical issues. But we need to get the VA, somebody needs to get on and get these people trained, 'cause when you go -- do go see a doctor, and you mention the word VA, first thing they say to you: You need to go to psych.

**MS. FRESHWATER:** Could you write down the information of where you went, and as much information as you can, and give it to me?

**MR. EMBERY:** Yeah.

**MS. FRESHWATER:** Thank you.

**MR. WHITE:** This is Brady, I actually am with the VA, although I'm on the family member side, but I did have Micah to be there today, to address these kinds of issues, to hopefully help you with your eligibility, specifically on the -- kind of on the bigger level, though. You know, we have, Micah and his team, they have provided training for the various individuals and physicians that are kind of responsible for this whole effort in all the various medical centers. It sounds like this one might have fallen between the cracks, so I'd be very interested in getting some more details on that because, you know, even though I'm not over that part of the program, I'm trying to hold some people accountable,

and finding out what's going on, so if you could get your information to Micah, and he can probably forward it to me, that would be great.

**MS. FRESHWATER:** We're going to facilitate that, Brady. Thank you.

**MS. HIGHLAND:** My name is Lisa Highland, and I have been coming to a lot of the meetings for years, maybe 19 years, could be, something, you know, very long time.

I have a daughter who was not born in Lejeune but she was in Treasure Island. That military base has been contaminated. Nobody ever did anything to anyone who has been working on that base.

As a Marine my husband went to recruiting office. So my daughter has been sick for so long I don't know what to do with her. I know that there was contamination, radiation, water -- chemicals in the water. And what is the Navy, the Marines, are doing for our kids? I'm seeing my daughter telling me sometimes, let me go, Mommy. This is sad. I cannot accept that when this country has so much money. And everything that our military people do for other people. What are they doing? What is the Marines and the Navy doing for our children? I don't want to see my daughter die.

I went to a hospital, and they don't know how to handle this. I was denied of the military I.D. so I can continue medication when she was only 21, because she had to go to school, and Dr. Cash and the director of the hospital, Dr. Cash and everybody tried to help me by doing letters so I can get another I.D. card. And the director of the hospital denied me that. So that's the punishment that we have to suffer if we are with kids? Because I say things, yes. But I was (unintelligible) expecting to see the Commandant; he never ever has been doing anything for us. He's the one who have to come and talk to us. Not you lady; I appreciate what you do, but that's not your place. We have a Commandant and there’s a moral duty of this country to look at us when we have problems. I am sorry, and thank you so much for everybody who is here, but we have to start working, and stop this, you know, contamination, because after the Navy leave a base, they put all these people cash only, and they also put other homeless and no-income people. This is unacceptable for this country. Thank you.

**MS. FRESHWATER:** Thank you.

**DR. BREYSSE:** Thank you.

**MS. FRESHWATER:** We're going to keep working on

trying to get someone here from the United States Marine Corps. We're going to keep working on it.

**MS. HIGHLAND:** My husband (unintelligible).

**MS. FRESHWATER:** I understand. I just want you to know we're going to keep fighting for it whether they do or not, okay?

**MR. WHITE:** And ma'am, this is Brady with the VA. Just let you know on our side what we've been trying to do is we set this program up, and it's the first of its kind, really. It was with the anticipation that other bases may come online, other groups and family members might be included. And so how can we quickly incorporate them into our existing program, so we're kind of thinking long-term with that effort. But, you know, it's really not up to us to make that happen. I think it's probably up to Congress and, you know, and others.

**DR. BREYSSE:** All right, thanks. Thank you, Brady. So we're at the end of the time. So unless there's something really burning, I'll call the meeting in adjournment.

**MS. STEVENS:** Thank you.

(Whereupon the meeting was adjourned at 2:46 p.m.)

**CERTIFICATE OF COURT REPORTER**

**STATE OF GEORGIA**

**COUNTY OF FULTON**

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of March 24, 2016; and it is a true and accurate transcript of the proceedings captioned herein.

I further certify that I am neither relation nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 24th day of April, 2016.

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**STEVEN RAY GREEN, CCR, CVR-CM, PNSC**

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