

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

TWENTY-THIRD MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE

PANEL (CAP) MEETING

July 26, 2012

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
July 26, 2012.

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

(alphabetically)

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

1 you speak so that we can attribute your comments
2 appropriately. And use the table mikes to speak. So
3 with that, we'll go around and do introductions.

4 As I said, I'm Christopher Stallard with the
5 Center for Global Health here at CDC, and I'm your
6 facilitator. And let's just please have an
7 introduction, your name and your role.

8 **MR. BYRON:** Good morning, I'm Jeff Byron. I'm
9 with the CAP, from Cincinnati, Ohio. Haven't been
10 able to do much lately 'cause I'm starting a new
11 business, and this'll be my last CAP meeting. So I'm
12 hoping there's a good energetic young Marine that'll
13 take over for me and maybe not raise any profanity but
14 raise a little hell, if they don't do what they're
15 supposed to, like they haven't for seven years. Thank
16 you.

17 **MR. STALLARD:** Thank you. Mike.

18 **MR. PARTAIN:** This is Mike Partain from
19 Tallahassee, Florida, member of the CAP meeting -- I
20 mean, CAP panel.

21 **MR. STALLARD:** Welcome, thank you, Mike.

22 **DR. AKERS:** Paul Akers from Columbia, South
23 Carolina, Member of the CAP.

24 **DR. DICK:** This is Wendi Dick. I'm with the
25 Office of Public Health at the VA in Washington, D.C.

1 **DR. PORTIER:** Chris Portier, I'm the Director of
2 NCEH/ATSDR.

3 **DR. BOVE:** Frank Bove, ATSDR.

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

5 **DR. DEARWENT:** Steve Dearwent, ATSDR.

6 **MR. FLOHR:** Brad Flohr, I'm with the Veterans
7 Benefits Administration in Washington, D.C.

8 **MR. MARKWITH:** I'm Glenn Markwith. I'm with the
9 Navy Marine Corps Public Health Center in Portsmouth,
10 Virginia. And some of you guys may know Mary Ann
11 Simmons who recently retired. And I've been assigned
12 to take her place on the CAP. And our command
13 provides risk communication support and community
14 involvement planning and community outreach for the
15 Marine Corps and the Navy worldwide, so I think that's
16 why I'm sitting here today. Thank you.

17 **DR. CLAPP:** I'm Dick Clapp, member of the CAP.

18 **MR. STALLARD:** Welcome. And whom do we have on
19 the phone, please?

20 **MR. ENSMINGER:** This is Jerry Ensminger.

21 **MR. STALLARD:** Welcome, Jerry, where are you
22 today?

23 **MR. ENSMINGER:** Sitting in my dining room.

24 **MR. STALLARD:** Is there anyone else on the phone,
25 please? Was Tom able to call in? Was he on the last

1 meeting?

2 **MS. RUCKART:** I think he was.

3 **MR. STALLARD:** Okay.

4 **MR. ENSMINGER:** Hey, I have a question.

5 **MR. STALLARD:** Yeah?

6 **MR. ENSMINGER:** What was the name of the guy from
7 the Navy Marine Corps Public Health Center again?

8 **MR. MARKWITH:** It's Glenn Markwith,
9 M-a-r-k-w-i-t-h.

10 **MR. ENSMINGER:** You must have drawn the short
11 straw after Mary retired.

12 **MR. MARKWITH:** I think the world of Mary Ann; I
13 would do anything for her. And she's, in retirement,
14 she asked me if I would take this and I said I'd be
15 glad to do so. I'm glad to be here.

16 **MR. ENSMINGER:** Yeah, okay.

17 **RECAP OF PREVIOUS CAP MEETING**

18 **MR. STALLARD:** All right. Well, then moving
19 right along, Perri, would you like to bring us up
20 through our recap of the previous CAP meeting?

21 **MS. RUCKART:** Sure. I handed out to everybody
22 the summary of the last meeting. I'm not going to go
23 over that; you can read about it at your leisure, but
24 I do want to just highlight some of the action items.
25 So at the last meeting, the CAP asked for

1 complete access to the unredacted documents for the
2 water modeling. And since then, we have established a
3 standard operating procedure related to the release of
4 information about locations of active public drinking
5 water system supply wells surface water intakes, and
6 we shared this with you at the end of June, and it
7 includes information on how to request the documents.

8 During the last meeting the CAP also requested
9 that the agency invite the Secretary of the Department
10 of Health and Human Services and the Marine Commandant
11 to the CAP meeting when the results are presented.
12 The Agency's happy to convey your request and will
13 inform the Secretary and the DON of the CAP request ^
14 a roll-out process for releasing the results. The
15 Agency also recommends that you make requests to the
16 Secretary and the Commandant because we feel it'll
17 have more weight coming from you, so it'll be a joint
18 effort there.

19 The CAP asked for a written response from the
20 Agency about whether it's possible for ATSDR to take
21 ownership of the USMC registry. The agency would like
22 you to send a written request detailing why you think
23 the Agency should maintain this listing because
24 currently we're able to get access to the list if we
25 need it. We've gotten access to it to send out the

1 surveys, and as you know, Congress mandated the Marine
2 Corps to have ownership of that.

3 The CAP requested access to view the "For
4 Official Use Only" water documentation and the BAH
5 index of documents. And everyone should be familiar
6 with that request; it was sent on your behalf and the
7 index was provided to you along with a copy of the
8 request and the response in June.

9 Mary Blakely provided Frank with copies of files
10 regarding infant deaths, and she wanted his opinion of
11 them. And Frank will discuss that when we get to our
12 health studies updates.

13 At the last meeting we also had Brad Flohr and
14 Wendi Dick from the VA. They provided their updates.
15 And Brad said he would investigate whether a veteran
16 from Camp Lejeune could get an exam at a VA facility
17 as a precaution. He also said he would look into
18 referencing MSDSs on the training letter for Camp
19 Lejeune. And Wendi said she would look into the
20 reasons why non-veterans can receive care at VA
21 facilities, so you can go into that when it's your
22 turn on the agenda. And that's all we have.

23 **MR. STALLARD:** Great, thank you.

24 **MR. ENSMINGER:** Hey, I have -- I would like to
25 make a point. When somebody's speaking, if you don't

1 speak directly into the microphone, the people on the
2 phone can't hear.

3 **MS. RUCKART:** Okay, so, Jerry --

4 **MR. ENSMINGER:** Perri, you sounded like you were
5 in a cave.

6 **MS. RUCKART:** Okay, well, I'll try to talk more
7 directly next time. Sorry.

8 **MR. STALLARD:** Thank you for the feedback, Jerry.
9 We will speak directly into the microphone.

10 **MR. ENSMINGER:** Anytime, anytime.

11 **CAP UPDATES/COMMUNITY CONCERNS**

12 **MR. STALLARD:** All right, this, this is our
13 opportunity on the agenda where we invite the CAP
14 members to give us an update of the activities they've
15 been involved in since the last meeting:
16 accomplishments, challenges, concerns. And so...

17 **MR. PARTAIN:** This is Mike Partain. Just one
18 quick note about the, with the follow-up that Perri
19 was talking about. Jerry and I had a conference call
20 with Dr. Portier concerning the request to the Marine
21 Corps about access to the documents. Just make a note
22 that, you know, the response that was made back by the
23 Marine Corps was that these documents were available.
24 They didn't directly answer the question whether or
25 not we would be able to view the FOUO redacted

1 documents. I know we're still trying to get that, and
2 like I said, the note I want to make for the record is
3 that the Marine Corps did not answer the question and
4 still has not answered the question. And we'll follow
5 up on that later.

6 **MR. STALLARD:** Thank you, Mike. Steve, do you
7 have something?

8 **DR. DEARWENT:** Yes, this is Steve Dearwent. My
9 recollection of that response was that they would deal
10 with it on a case-by-case basis and not grant kind of
11 collective overall access to everything.

12 **MR. PARTAIN:** Well, correct me if I'm wrong, but
13 the letter that was sent back to Dr. Portier was
14 basically that the documents are already there;
15 they've been publicly available. They did not address
16 the FOUO other than saying that we could write the
17 FOIA request for them, which would take, you know, an
18 inordinate amount of time, and would not be useful for
19 the purposes of the studies the ATSDR is doing and our
20 function as CAP members. So, now, I understand in the
21 intervening time, Congress has taken a large part of
22 this library and made it publicly available but there
23 are documents that are still redacted in that library,
24 and I think Congress is working on that. So I just
25 want to make a note for the record that that response

1 was such that the Marine Corps did not directly answer
2 or examine that question.

3 **MR. STALLARD:** All right. Thank you. So Jerry,
4 let's start with you on the phone. Would you be so
5 kind to give us an update of the past couple months?

6 **MR. ENSMINGER:** Well, I think what's more
7 important is the past couple weeks. The bill that
8 will provide former Camp Lejeune members and their
9 family members healthcare through the Veterans
10 Administration has passed the Senate. It is now
11 sitting over in the House. And those of you who don't
12 understand how Congress works, which is just about
13 100 percent of us, the House of Representatives does
14 not have a unanimous consent motion, like the Senate
15 does, so when the House wants to pass a bill, like the
16 Senate passed this bill, with a unanimous consent
17 motion, they do meet on Tuesdays in the House of
18 Representatives, and they call it a suspension of the
19 rules.

20 So next Tuesday, or this coming Tuesday, the 31st,
21 our bill will be presented in the House and voted on.
22 It will not be debated 'cause nobody -- that's why
23 they suspend the rules, it does away with the debate,
24 and they go straight to a vote. And it's expected to
25 pass the House very easily. So that's about it.

1 I would like to thank everyone on the Senate side
2 who's been involved in this thing and the people that
3 dug their heels in and made this happen. Primarily
4 Senator Burr and members of his staff, Brooks Tucker,
5 David Ward and Maureen O'Neill. They really stuck in
6 there and really helped. And on the Judiciary
7 Committee side, I want to thank Senator Leahy and
8 Senator Grassley and their staffs for the work they're
9 doing on getting these documents released. They are
10 currently looking at all the redacted stuff. And
11 there'll be more to come on that in the near future,
12 so things are moving along.

13 Now that, you know, we're going to have this bill
14 passed, which is a big accomplishment, I will be able
15 to dedicate more time, more of my time, into, instead
16 of dedicating it toward getting a bill passed and
17 getting these people some help, I can dedicate more of
18 my time into actually getting the truth out of the
19 Department of the Navy and the United States Marine
20 Corps on this issue. And I'm calling officially now
21 for Congress to hold the leadership of the Department
22 of the Navy and the United States Marine Corps
23 accountable for all the misinformation and
24 disinformation that they have distributed relating to
25 this issue over the last -- ever since 1984. And it's

1 about time we get the truth. That's my update.

2 **MR. STALLARD:** Thank you, Jerry. Members in the
3 room.

4 **MR. PARTAIN:** I did forget to mention that in the
5 interim we are now at 80 men with breast cancer from
6 Camp Lejeune. So we've got, over the past five years,
7 identified 80 individual men with the single
8 commonality of male breast cancer and exposure to the
9 contaminated water at Camp Lejeune. It seems this
10 number just keeps on going up.

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

12 **MR. BYRON:** Yeah, this is Jeff Byron. It's like
13 I said earlier, this is going to be my last meeting so
14 I want to thank all the CAP members for your
15 dedication. And, you know, we've come a long way, not
16 near far enough yet. And I am concerned with some of
17 the, you know, how the bill for Congress'll be, you
18 know, figured out how healthcare will cover the other
19 than veterans.

20 The VA's always been an avenue for veterans to
21 get healthcare but I don't know that it's been one for
22 dependent family members, and I look forward to seeing
23 how that's hashed out with Congress.

24 But I want to thank the ATSDR people, too, for
25 all the work they've done in this and, you know, to

1 reach out to 160,000 Marines that were at Camp Lejeune
2 when there was only going to be 12,000 of us notified
3 initially with the in utero study, I think is a pretty
4 big accomplishment for the members of the CAP and for
5 ATSDR.

6 But like I said, I think, without the CAP and
7 without the community's participation, none of this
8 would have happened. I think the military would have
9 tried to push this under the rug, and the 12,598
10 families with children in utero, and that would have
11 been the end of it. Thanks to the hard work of Jerry
12 Ensminger; he's been a heck of a mentor to me, and I
13 wish I'd have served under him when I was in the
14 Marine Corps. Didn't have that opportunity but I'd
15 like to thank him personally and Mike Partain for the
16 work you've done over the past few years to bring the
17 timeline to light, and to actually show what happened,
18 you and Jerry, and Major Tom also. He deserves credit
19 for finding documents.

20 And all the CAP members that put their time in
21 here. It really -- they dedicated theirselves to a
22 cause that most people would have thought, when I got
23 involved in this, that you won't have a prayer with
24 the military or the government. And I think we've
25 proven them wrong. I think the people at ATSDR have

1 fought for us. And I dearly want to thank them for
2 their help. And I hope the studies that come out of
3 this will be used in the future to keep this from
4 happening again.

5 And in my own life, I've started a business and
6 I've just recently moved the location. The last
7 meeting I mentioned that we thought there was a cancer
8 in my family on the women's side. That was a false
9 positive so we're very glad to hear that; although,
10 both my daughters and grandson are still experiencing
11 medical issues. My daughter's had to have two iron
12 infusions in the past two weeks. And I'm hoping that
13 the government will be able to help pick up some of
14 the tab for the medical care because this girl just
15 doesn't have the money to be forking it out.

16 I've done it for 30 years now, and I've been in a
17 fortunate position in my life to make enough money
18 that I can be here to help fight. That's one reason
19 why I did it. I knew there were so many families out
20 here that couldn't. And I'll be leaving the CAP and
21 like I said, I hope they find a good young Marine or
22 dependent family member that's interested in carrying
23 this to the finish, and I hope that'll be soon. Okay?

24 I'd like to see the in utero report come out
25 before the mortality studies in that. It's only gone

1 on for 12 years. And I hope that Congress sees that,
2 you know, these illnesses go further than just what
3 the NRC found for sicknesses. We're talking about
4 several chemicals. And for this to stop right here
5 and leave half of the people out of getting healthcare
6 would be a tragedy. And I suspect that that could be
7 the case even in my own family because I think that
8 the document requires that you get your doctor to, you
9 know, say that this occurred at Camp Lejeune. Well,
10 if you can get a doctor to say that and to put his
11 name on it, I got some land that I want to sell to
12 you.

13 But I thank you guys for bearing with me for the
14 past seven years. I been at this 12 years, since I
15 got the letter, and 12 years is enough to dedicate
16 someone's life to try to get justice and now it's
17 about my family and my business. So I hope you guys
18 will excuse me, and I would rather see the job filled
19 out all the way to the end but that's just not going
20 to happen right now because everybody's life changes
21 and you get to a point where you have to make a change
22 for the better. And although this, you know, is kind
23 of a sad time, it's also a joyous time for me. Thank
24 you very much.

25 **MR. STALLARD:** Thank you, Jeff. Did someone join

1 us on the line?

2 **MS. BRIDGES:** Yes. This is Sandy. Sandy
3 Bridges.

4 **MR. STALLARD:** Hi, Sandy. Welcome.

5 **MS. BRIDGES:** Thank you.

6 **MR. STALLARD:** We're just going through CAP
7 member updates, activities that you might have been
8 involved in for CAP business over the last -- since
9 the last meeting.

10 **MS. BRIDGES:** Right. I was on before. I just --
11 I'm sorry to hear that Jeff's leaving. I really am.
12 I'm going to miss you, Jeff. Everyone's going to miss
13 you.

14 **MR. BYRON:** I don't know about the Marine Corps.

15 **MR. STALLARD:** All right. And I'd like to remind
16 those on the phone, if you'd be so kind and if you
17 have a mute function, while you're listening to please
18 engage the mute function.

19 **MS. BRIDGES:** Right.

20 **MR. STALLARD:** Thank you. Mike, did you have
21 anything else?

22 **MR. PARTAIN:** Yeah, just Perri gave me a document
23 that somebody submitted to put as part of the record
24 in the CAP meeting. I just want to acknowledge that
25 it's here and it's from a Mr. Rhodan. It discusses

1 liability and the Safe Drinking Water Act and so
2 forth. I mean, that is -- and the concerns in the
3 letter really need to be brought up between the EPA,
4 the Department of the Navy, and I don't think the CDC
5 or ATSDR has any jurisdiction on what they say or do.
6 So it's noted that it's in here. Lot of it is
7 reinventing the wheel. I mean, go through and read
8 the timeline that we have and things we've done but,
9 you know, we're not simply here -- it's not part of
10 our function here to discuss what the EPA should or
11 should not have done between the Department of the
12 Navy and the EPA.

13 So it's here and I guess you guys make it part of
14 the record but it's not really our function to do
15 that.

16 **MR. STALLARD:** Thanks, Mike. Paul, anything to
17 offer?

18 **DR. AKERS:** Not at this time.

19 **MR. STALLARD:** All right. Thank you. Dr. Clapp?

20 **MR. ENSMINGER:** Yeah, I have something for Jeff
21 since this is his last meeting. Boy, Jeff, when I
22 heard you sitting there talking about healthcare, you
23 sounded just like a Democrat and it made me proud.

24 **MR. BYRON:** I'm never going over to that side,
25 though, so just so you know. I'm pure conservative,

1 redneck.

2 **MR. STALLARD:** All right. Thank you. Let's hear
3 from Dr. Clapp.

4 **DR. CLAPP:** Yep, I think the most relevant thing
5 was I was part of a briefing, a Congressional staff
6 briefing, on May 18th, that was organized by Senator
7 Lautenberg. It was mainly about the Safe Chemicals
8 Act, but it was cosponsored by Senator Lautenberg as
9 the sponsor of that bill. But I did talk about Camp
10 Lejeune and I did talk about the health studies for
11 people in the audience, this was Congressional staff.

12 And then I subsequently went around to meet with
13 two Senate staff, Senator Brown, one of my senators
14 from Massachusetts, and Senator Burr's staff, and
15 Congressional staff in their office. And again talked
16 about both the need for TSCA reform, as they say, and
17 also what the story -- what the current status of the
18 health studies at Camp Lejeune is and what they might
19 tell us. Those are the main things.

20 **MR. STALLARD:** Great. Thanks. Yeah, sure,
21 Perri.

22 **MS. RUCKART:** I just want to ask that all the
23 audience members sign the sign-in sheet in the back of
24 the room, please.

25 **MR. STALLARD:** Loud and clear. Thank you.

1 Glenn, since you're new to the group, would you just
2 maybe give us a brief, you know, what you bring to the
3 table, your experience and whatnot?

4 **MR. MARKWITH:** Yeah. Like I said earlier, one of
5 the primary functions of the Navy and Marine Corps
6 Public Health Center is to provide risk communication
7 support to the Navy and Marine Corps. We're
8 essentially another tool in the toolbox for Camp
9 Lejeune to use for community outreach, community
10 involvement, and that's what the majority of our work
11 is that we do there at our command. And that's
12 basically it.

13 **MR. STALLARD:** Okay. Great. Thank you. Very
14 good. Thank you. All right, let's move then -- we're
15 moving ahead, then, very quickly this morning.

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

17 **MR. STALLARD:** So this is the period in the
18 agenda where we're going to have a Q&A session with
19 our colleagues from the VA.

20 **DR. DICK:** I can go first, if you don't mind,
21 Brad, 'cause I think I have a shorter, a shorter
22 answer than you will have for your items.

23 So at the last meeting people were interested to
24 learn that in some cases family members can get care
25 from the VA or through the VA. This program is called

1 CHAMPVA, and it stands for Civilian Health and Medical
2 Program of the Department of Veterans Affairs. It's
3 administered out of Denver. And to be eligible as a
4 family member for a CHAMPVA healthcare benefits, well,
5 first of all they can't be eligible for TRICARE. So
6 the coverage would be for a spouse, a widower or
7 children who are, you know, dependent, of a veteran
8 who is permanently and totally disabled through a
9 service-connected disability, and that's probably the
10 most common category. There are a few others for
11 veterans who die in an active duty status, and that
12 could include when their -- when that was during
13 training.

14 There is some cost sharing if the family members
15 have other health insurance, so they would bill that
16 other health insurance first. And as far as where the
17 CHAMPVA family members get the care, it depends. Some
18 of the care can be provided at VA medical centers but
19 only on a space-available basis after the needs of,
20 you know, veterans have been met. And that list of
21 medical centers changes all the time, so there is a
22 website that you can look up to see if your local VA
23 offers that. And if anyone would like any information
24 on the CHAMPVA program, I have fact sheets and
25 brochures and I'd be happy to just leave them with

1 anyone who may be interested. Does anyone have any
2 questions?

3 **MR. BYRON:** Yes, I do. You say that the veteran
4 himself has to be 100 percent disabled before their
5 children can get care through the VA CHAMP service?
6 That, you know, to me, for me, I'm not experiencing
7 health effects but, say that Congress mandates that
8 CHAMPVA takes care of -- well, number one, I got a
9 daughter who's 27 years old and handicapped. She
10 doesn't work, she lives with me. And, and her son
11 both live with me. I'm not disabled. I haven't
12 claimed any disability. Was I sick during my time in
13 the Marine Corps? Yes, over two issues. Has it
14 affected me to this date? Well, maybe. I don't know,
15 you know but that's what these studies are for. But
16 if I'm not disabled and my daughter has been by what's
17 occurred here, how -- is there an avenue for that or
18 not?

19 **DR. DICK:** Is she -- does she have TRICARE
20 benefits?

21 **MR. BYRON:** She's on Medicaid, that's it. I
22 don't have insurance. I can't get it. I couldn't
23 afford it if I wanted to with all her medical issues.
24 And my daughter, as I said, my oldest daughter's had
25 to have the iron infusions. And she just had to hand

1 out \$1,200 cash. I mean, how long should the young
2 people that have been, you know, the dependent family
3 members and actually the veterans' families, too. How
4 long are we supposed to just keep putting out money?
5 And I know several families who have been economically
6 bankrupt and had to file bankruptcy because of their
7 illnesses. I don't think that's right. I think it's
8 wrong totally that even my children, you know. One
9 reason why I'm starting a business is so I can
10 vocationally train my daughter and my grandson.
11 'Cause I know the public school system isn't going to
12 do anything for them.

13 **MR. STALLARD:** So the question was, do you have
14 to be a --

15 **MR. ENSMINGER:** I have some information about
16 this healthcare thing in this bill, and how this is
17 going to work. Once the bill passes it's going to
18 come down to the VA and different scientific
19 organizations, such as the CDC, to come up with how
20 this healthcare's going to be administered.

21 Now, I do know this much, that VA, under this
22 current bill, will be the payer of last resort, which
23 means if a person applying for healthcare benefits
24 under this bill for Camp Lejeune, they will be
25 required to -- their healthcare will be billed before

1 the VA does anything. So my suggestion to anybody who
2 wants healthcare under this provision, to cancel your
3 private insurance. Plain and said and done.

4 **MR. PARTAIN:** Well, Jerry --

5 **MR. ENSMINGER:** Furthermore, I didn't like that
6 provision. But they really dug their heels in and I
7 had to make a compromise. Gee, Dr. Portier, I do
8 compromise, see?

9 But anyhow, we have people out there who don't
10 have any kind of insurance, that didn't retire out of
11 the Marine Corps because of pre-existing conditions,
12 because they couldn't afford it, whatever. We had
13 people out there who were having to make the difficult
14 choice of life or death, and losing everything they've
15 ever worked for in their entire lives. And at least I
16 know that this bill, in its present state, will stop
17 that from happening again. And that's what I had to
18 think about. So and I didn't like it. You know, I
19 don't like being put in a position where I have to
20 make decisions like that for an entire community but,
21 you know, somebody had to.

22 **MR. PARTAIN:** Hey, Jerry --

23 **MR. ENSMINGER:** But how this is going to be
24 administered has not been completely, completely
25 hammered out yet and all the particulars aren't done,

1 so...

2 **MR. PARTAIN:** Hey, Jerry, this is Mike Partain.
3 If I heard Wendi correct, and my knowledge of
4 insurance where I work, when you're talking about the
5 payer of last resort and when she was describing CHAMP
6 there, if there is a primary insurance in effect at
7 the time, like for example my health insurance, that
8 would bill first, and then the CHAMPVA would pick up
9 secondary, including, I would assume, any out-of-
10 pockets or deductibles and things like that. So
11 before anyone would cancel their insurance to go on
12 this, I would recommend they find out what exactly --
13 what provisions are there.

14 **MR. ENSMINGER:** No, not the way it was explained
15 to me. If you have private insurance, they will not
16 compensate you for your out-of-pocket expenses to you
17 that are required through your private insurance
18 either.

19 **MR. PARTAIN:** Okay. We'll have to find out.

20 **MR. ENSMINGER:** So you would have to totally
21 immerse yourself into whatever the VA is offering
22 before they would take anything.

23 **MS. BRIDGES:** Jerry, can I ask you this, what
24 about dental?

25 **MR. ENSMINGER:** No, there's no, there's no dental

1 on this.

2 **MS. BRIDGES:** Our children that were in utero,
3 they all have problems with their teeth. And I mean
4 bad problems.

5 **MR. ENSMINGER:** You guys can beat the hell out of
6 me later, okay? Once the bill passes.

7 **MS. BRIDGES:** We're not beating the hell out of
8 you; we're thankful --

9 **MR. ENSMINGER:** I mean, you know, hey, whatever.
10 You know. I've done what I can do.

11 **MR. STALLARD:** And Jerry, we appreciate it.
12 Jerry, let's -- Wendi would like to provide some
13 comments here.

14 **DR. DICK:** I have a question, Jerry. You
15 probably know this bill better than anyone in the room
16 or on the line. And what I was understanding is that
17 the veterans, they're -- if they have other health
18 insurance, it wouldn't be billed for the conditions
19 related to Camp Lejeune, but for the family members,
20 if they had health insurance, that health insurance
21 would be billed first for conditions associated with
22 Camp Lejeune. Is that --

23 **MR. ENSMINGER:** Yeah, I mean, that's for the
24 family members only.

25 **DR. DICK:** Right, okay.

1 **MR. ENSMINGER:** You're right, Wendi. Once they
2 get taken in under the umbrella of the VA, they're
3 taken care of totally.

4 **DR. DICK:** Right.

5 **MR. ENSMINGER:** But not the family members. The
6 family members, they just have to have no insurance.

7 **MR. BYRON:** Hey, Jerry, it's Jeff. I know you
8 had to make compromises, that's what negotiation is
9 about and getting something accomplished is about.
10 Like I said, I've got some concerns about it. We can
11 talk about it later but as far as, you know, what
12 people --

13 **MR. ENSMINGER:** Well, I just wanted to lay that
14 bit of information out now, I mean, because Wendi was
15 talking about CHAMPVA and that spurred me into
16 discussing some of the stuff that I did know about
17 this bill and to be quite frank with you, all the
18 rules and how this is going to be administered, it
19 hasn't even been worked out yet. I mean, that's part
20 of the bill. The bill directs that. And once the
21 President signs it into law, then all the particulars
22 have to sit down and discuss this and how it's going
23 to work. So.

24 **MR. STALLARD:** So there's work to be done.

25 **MR. BYRON:** This is Jeff again.

1 **MR. ENSMINGER:** Yeah. Yeah, yeah, there's still
2 a lot of work to be done on this bill before it
3 becomes a reality.

4 **MR. BYRON:** This is Jeff. Just one comment
5 before you leave, and I hope people in Congress are
6 listening. I hope the people in Congress are
7 listening. I think it's tragic that they would throw
8 medical care on insurance companies when they're the
9 perpetrator, the responsible party. And that, you
10 know, if you have insurance and you bill them first,
11 and then if they don't cover it, then the VA picks it
12 up. Though, it's not the VA's fault; it's the Marine
13 Corps and the Department of the Navy; it's actually
14 the United States government. And yeah, I find that
15 tragic that instead of being first to step to the
16 plate and take care of health issues, they want to be
17 last. Thank you.

18 **MR. ENSMINGER:** Well, you know, and the same
19 thing goes with the veterans, Jeff. I mean, hell, the
20 VA has been underfunded since after Korea. I mean,
21 when it was first developed after World War II, it was
22 a great program but as years went by, you know, that
23 funding became less and less of a priority, and the VA
24 has been, excuse the phrase, sucking hind tit ever
25 since.

1 So it's not just this program, it's even for the,
2 for the warriors who served this country and protected
3 it. It's a bad situation. I mean, and our Congress,
4 they have different programs that they want to funnel
5 money to and they all love to go out there and speak
6 about how important all these people our warriors are
7 in protecting this country, but you know as well as I
8 do that that's -- a lot of that's smoke and mirrors
9 and pure rhetoric.

10 **MR. STALLARD:** Thank you, Jerry. Thank you for
11 that colorful farm reference.

12 **DR. AKERS:** I would like to ask a question.

13 **MR. STALLARD:** Sure.

14 **DR. AKERS:** I've been told by a former VA
15 administrator that the CHAMPVA program has an age
16 ceiling on the veteran. I've been told it was 65. In
17 other words when the veteran reaches age 65 not only -
18 - well, his family no longer has CHAMPVA coverage. Is
19 that true?

20 **MR. ENSMINGER:** Well --

21 **MR. STALLARD:** Hold on, Jerry.

22 **DR. DICK:** It depends on when the beneficiary
23 turned 65. So when the family member, I think it's
24 the spouse, turns 65.

25 **DR. AKERS:** So it's the family member and not the

1 veteran.

2 **DR. DICK:** That's what I understand. It's the
3 family member.

4 **DR. AKERS:** 'Cause the way it was explained to me
5 it was the veteran who had -- once he or she reached
6 65, the coverage ended.

7 **MR. STALLARD:** All right, remember, one speaker
8 at a time. Thank you. Is that it -- Wendi, is that
9 it for your...

10 **DR. DICK:** Yes.

11 **MR. STALLARD:** Okay. Brad?

12 **MR. FLOHR:** As long as we're talking about this
13 legislation we -- there's one other caveat for
14 dependent care, and that is the law or legislation
15 links that to appropriations that would be available
16 for that treatment by VA. What that means, I don't
17 know. Congress is going to provide some specific
18 funding for that.

19 The insurance part only applies to treatment of
20 family members, not to veterans themselves under this
21 bill. They're eligible for care for one of those 14,
22 actually 15 conditions. It's the 14 conditions in the
23 NRC report plus the non-Hodgkin's lymphoma that was
24 added. So any veteran who has one of those 15
25 conditions, some of those being one infertility, one

1 miscarriages, it's on that list -- or will be eligible
2 for care through VA.

3 And it's good news it's going to be passed this
4 week, we hope -- or next week. I know that the
5 Veterans Health Administration is very busy right now.
6 What Congress does quite often, when they pass
7 legislation, they leave a lot of holes in it for the
8 Agency to fill through regulations. For example the
9 bill calls for someone who was at Camp Lejeune for 30
10 days or more between the period of 1957 to 1987; it
11 doesn't say that that has to be 30 days consecutive or
12 it could be multiple periods reaching 30 days. That's
13 something that the VA will have to work out.

14 Also in terms of the dependents and age for
15 veterans benefits purposes, a veteran who is
16 service-connected at 30 percent or more gets
17 additional compensation for their spouse, also for
18 dependent children. And that's defined in law and
19 regulations as children between the ages -- or up to
20 the age of 18, 18 to 23 attending school or if they
21 become helpless prior to age 18. That's for benefits
22 purposes. How that's going to be healthcare for, for
23 dependents under this legislation that's something
24 that nobody knows at this point in time, so we're
25 going to have to work it out. As Jerry said, work it

1 out. Maybe have some conversation with Senator Burr's
2 staff or whoever as we work through this.

3 But it's going to be interesting anyway. It's as
4 I told Jeff last night, it's a start. It's more than
5 we had. It's a good place to begin.

6 We've done a lot in the last, as Jerry said,
7 couple weeks. In the last couple months, in December,
8 we have been providing on a regular basis to Senator
9 Burr's staff, to Senator Hagan's staff, to Congressman
10 Brad Miller's staff, data on claims processing that
11 we're doing in Louisville. And in December we
12 provided them an update, and we got a request for
13 additional data that -- and more granular data that we
14 were not capturing in Louisville on their spreadsheet.

15 So in order to satisfy Senator Burr's request, we
16 had to go down to Louisville. We sent three or four
17 of our physicians from the Veterans Health
18 Administration and three people from my staff went to
19 Louisville, worked over the weekend reviewing every
20 cited claim that Louisville has done since we
21 consolidated claims, and which is about 1,200 to
22 1,300, something like that. Go over them and capture
23 the data that Senator Burr's staff had asked for.

24 And we did that. We're going to change the
25 tracking mechanism in Louisville to capture that data

1 going forward. I can tell you, and you may know
2 because we briefed Senator Burr's staff, Senator
3 Hagan's staff, Congressman Miller's staff just a few
4 weeks ago on the results of our review, give them the
5 data that they wanted. I think it will be interesting
6 to share with you some of that data, if you haven't
7 already seen it. And I think maybe Brooks Tucker
8 might have forwarded it to you. But the categories of
9 breast cancer, bladder cancer, kidney cancer,
10 leukemias, Parkinson's disease, the decisions made on
11 those claims have been over 50 percent favorable. So
12 Jeff I can tell you there are physicians who are
13 willing to put their name on the positive medical
14 opinion. For example, bladder cancer, 71 percent of
15 claims of bladder cancer that have been awarded so far
16 have been granted.

17 So but what we found, we were looking at the
18 medical opinions provided to determine if they were
19 actually citing to, to relevant information --

20 **MR. ENSMINGER:** Hey, Brad, speak into your mike.
21 I'm having a hard time hearing you.

22 **MR. FLOHR:** Is that better, Jerry?

23 **MR. ENSMINGER:** Yeah.

24 **MR. FLOHR:** We looked at the medical opinions to
25 see if they were really good. We know we've had --

1 Mike has shared some concerns about consistency in
2 some of the decisions so we're looking at a way to
3 improve that.

4 VHA has identified a list of about 30 subject
5 matter experts in environmental occupational medicine.
6 We have briefed it to our Secretary as going forward
7 that medical opinions will be sent to those particular
8 physicians instead of shot-gunned around to all VA
9 medical centers, to ensure that we get the best --
10 these are experts who are up to date with all the
11 known information on the contaminants and any
12 associations between them. And that's going to be
13 happening probably in September.

14 But the first thing that we're going to do is
15 send six or seven of those physicians to Louisville to
16 try to work back the inventory of opinions that they
17 have pending, cases they have pending, to get those
18 down to a manageable level and get decisions out to
19 veterans sooner than what they are now.

20 Then going forward we'll institute this
21 particular idea. Should be better for everyone. Be
22 better for veterans, better for VA. That's a good
23 thing.

24 So Perri, you said I would investigate whether a
25 veteran from Camp Lejeune could get an exam at a VA

1 facility as a precaution. That's really not my area.
2 That's VHA's area. But at this point there are
3 certain categories of veterans who can go in for a
4 one-time examination. By statute, radiation exposed
5 atomic veterans. There's, what else would it be?

6 **DR. DICK:** Okay so, Agent Orange registry exam.

7 **MR. FLOHR:** Agent Orange registry.

8 **DR. DICK:** Also SHAD.

9 **MR. FLOHR:** Project SHAD.

10 **DR. DICK:** Depleted uranium, Gulf War.

11 **MR. FLOHR:** Right now, Camp Lejeune veterans are
12 not in one of those registries. I don't believe you
13 can just walk in and get an exam; although, you might
14 be able to. It depends on where you go.

15 **DR. DICK:** SHAD doesn't have a registry but they
16 can have a clinical evaluation to talk about their
17 exposure.

18 **MR. BYRON:** This is Jeff Byron, and what I know
19 about the SHAD Project, this is another criminal act
20 that the military perpetrated against veterans. Would
21 you like to explain what that means? Shipboard hazard
22 and detection. They were spraying nerve gas out in a
23 cloud over the ocean and then taking our ship through
24 it to determine whether they could detect it or not.
25 At the same time we were in a war with the Vietnamese.

1 I suggest if you want to test chemicals, test it on
2 the enemy, not on our own people.

3 I have some other concerns about the healthcare
4 that's, you know, hopefully coming towards us. My
5 daughter's 27 years old. She was born in 1985. So
6 there's not going to be any children 23, that are in
7 college, and there's not going to be any that are
8 under 25 at this point. So that'll cover none of
9 them, zero.

10 The most vulnerable group, as I've been told over
11 and over and over, the children that were in utero and
12 children that were recently born and developing. I'm
13 not seeing that type of health, and what I want to
14 know here from ATSDR is when you finish your in utero
15 study, will that list of diseases be broadened or will
16 it just be kept at 14, because I know that's not the
17 end of it, okay?

18 And speaking to the issue of doctors willing to
19 sign off that your illness came from Camp Lejeune,
20 well, my problem right now is I have two individuals
21 with a chromosome deletion; we've spoken about that.
22 And through all my years in this CAP, it's proven to
23 me, in my mind, that my family's illnesses came from
24 Camp Lejeune. Now, to get a doctor to agree with
25 that, that's a totally 'nother story. They tell me

1 the chromosome deletion is random.

2 I finally got them to at least acknowledge that,
3 okay, so if the illness is random, and she was still
4 in utero at the time, don't you think that would have
5 any effect? Oh, yeah, it's a compounder. Well, yeah,
6 okay. Well, how about writing that in the record so
7 that my daughter and my grandson can get some help.

8 So Congress has got a lot of work to do. And I
9 don't want to really see any of this 23 years old, 18
10 under, you know, parents care. That doesn't cut it.
11 We're talking about people who cannot provide
12 themselves a living, okay? IQ of fifth grade in every
13 subject matter. What am I supposed to do, as a
14 parent, with that? And her son even worse off, okay?

15 What, as a Marine veteran, can I tell my family
16 when I go home here, or even if it's six months, a
17 year from now, when the studies are done? And I'd
18 also like to know whether, you know -- first off, when
19 you're going to give the results so that even though
20 I'm not going to be a CAP member, I'll probably come
21 here because I'm the one who asked for the Secretary
22 of Health and Human Services to be here. I believe
23 I'm the one that asked for the Marine Corps Commandant
24 to send the letter.

25 So, yeah, I'd like to -- I've wanted to see this

1 to the end but I'm not prepared to sit through more
2 years of more studies that the Marine Corps,
3 Department of the Navy and even more so, the U.S.
4 government can delay healthcare to the victims. And
5 believe me, what they're offering is, if you're
6 talking about a foot, they've offered one inch.

7 **MR. STALLARD:** Thank you, Jeff. Let me remind
8 you we're in this question and answer for our VA
9 colleagues right now so let's focus on any questions
10 and answers we might have for them.

11 And I'd like to welcome Mary Blakely has joined
12 us, for those of you on the phone.

13 **MR. ENSMINGER:** Hey, Chris, I got a question for
14 Brad. Hey, Brad, when are you going to be back in
15 your office?

16 **MR. FLOHR:** Friday. Tomorrow.

17 **MR. ENSMINGER:** Tomorrow?

18 **MR. FLOHR:** Yes.

19 **MR. ENSMINGER:** I've got a guy that is stage
20 three kidney cancer. He got a response back from
21 Louisville that there's a delay in the processing of
22 the claims and he's going to have to wait. And I
23 mean, come on. Stage three kidney cancer? The guy
24 spent four years at Camp Lejeune during the 70s. That
25 should be cut and dry. And, you know, I want to talk

1 to you. I'm going to provide you with some of the
2 stuff from his case.

3 **MR. FLOHR:** Okay. That'd be good. I'll take a
4 look at it and I'll get with Louisville. I don't know
5 why there would be a delay unless they're waiting for
6 this change-over but they shouldn't be waiting for
7 that.

8 **MR. ENSMINGER:** Okay. We'll take that up later.

9 **MR. FLOHR:** Okay.

10 **MR. ENSMINGER:** This is a specific case.

11 **MR. FLOHR:** Okay. That's good. Perri,
12 representing MSDS. Refresh my memory; what is MSDS?

13 **MS. RUCKART:** I think this is something that Jeff
14 asked about. It's a material safety data sheet.
15 Someone here asked about a --

16 **DR. AKERS:** Actually I asked about it.

17 **MS. RUCKART:** Paul. Okay, maybe you want to
18 speak more about your request?

19 **DR. AKERS:** Well, --

20 **MR. STALLARD:** Into the microphone, please.

21 **DR. AKERS:** My question was based on the fact
22 when I read the training letter, MSDSs were not
23 mentioned as the source of information for the
24 evaluating physician. I believe it was they were
25 chemical data sheets but they weren't the MSDSs, and I

1 canvassed a number of colleagues, some of which are VA
2 employees and others are physicians who actually
3 worked for the VA, and they all felt that the MSDS
4 would have been more informative. That was the reason
5 for the question.

6 **MR. FLOHR:** Who generates those data sheets?

7 **DR. AKERS:** Individual companies. By federal
8 law, when a new product is introduced into the work
9 place, it requires an MSDS accompany that product. I
10 can give you, actually, a chronological order of the
11 development of the MSDS from a talk that was given a
12 number of years ago. But the MSDS will go through
13 such stages as chemical composition, shipping,
14 handling, safety, combustibility, toxicology and there
15 are other entries in the MSDS, including degradation
16 products, such as TCE breaks down to chlorine phosgene
17 nitrogen chloride gas. And so does TCE.

18 **MR. FLOHR:** Trying to think how that would be of
19 use in our training letter. But it sounds like
20 something for people providing medical notes rather
21 than for our adjudicators, which is what the training
22 letter really is for. But we are in the process of
23 revising the training letter based on what's coming,
24 the legislation, the changes we're making in
25 Louisville in terms of getting medical opinions, so

1 we're working on revising that.

2 **MR. BYRON:** Phosgene is the first gas used in
3 World War I, okay, to poison troops. One other thing
4 I did want to mention, I agree with Sandy that these
5 dental issues that these victims have incurred,
6 believe me my family's experienced it and it has cost
7 me tens of thousands of dollars to try and keep up
8 with it, and they still lost their teeth.

9 And I believe that the Congress, VA should be
10 pressing that matter. And the health survey should
11 definitely discuss that.

12 And one other issue, I know that somebody handed
13 out a VA report on male breast cancer. And it spoke
14 about increased risks, and I am definitely at an
15 increased risk based on their literature because of
16 having epididymitis. And I'd kind of like to know how
17 many men have that that are, you know, saying that
18 they have male breast cancer or not saying.

19 The ones that have male breast cancer, do they
20 report these medical conditions that went through
21 diabetes, obesity, epididymitis, Klinefelter's
22 syndrome, and I think one other, were listed as an
23 increased risk. I'd like to kind of know, since we're
24 doing a health survey, how many of these guys reported
25 those conditions prior to, or were seen by the Marine

1 Corps or VA prior to their diagnosis of male breast
2 cancer.

3 **MR. PARTAIN:** Well, speaking of male breast
4 cancer, Brad, you know, when you were talking about
5 the 14 conditions that are being recognized, and I
6 bring this up as kind of a tongue-in-cheek thing, but
7 it is something that probably will happen. The NRC
8 report talks about breast cancer. Is the VA going to
9 recognize male breast cancer as well because, you
10 know, like for me treating, going in, you know, pink
11 rooms, florals. And I've had an insurance company
12 reject coverage on something because they don't have a
13 category for male breast cancer.

14 **MR. FLOHR:** Well, Mike, that's what I said. In
15 Louisville, the claims for breast cancer, which are
16 male generally from Camp Lejeune, we've granted
17 62 percent of those claims.

18 **MR. PARTAIN:** I'm just saying that --

19 **MR. FLOHR:** So we do recognize it.

20 **MR. PARTAIN:** -- point in the procedure. Okay.

21 **MR. BYRON:** Well, they're part of the problem.
22 Mike is not a Marine; he's a dependent family member.
23 So I think there's probably some concerns there.

24 And then the question is is the NRC, is this the
25 same panel that pretty much, you know, just kind of

1 shuffled us off to the side? I don't know, do any of
2 you CAP members feel that comfortable with what the
3 NRC did while they were here? I don't, from what I
4 saw. And then like I said if this is limited to 14
5 illnesses, and then VA's my last resort? VA should
6 not be -- I'm not saying the VA should be the one
7 paying for our illnesses. It should be the government
8 through the -- they provided an avenue for the VA to
9 do that for veterans. But 14 illnesses? I doubt that
10 half of these victims here that have been sick are
11 even covered under those 14.

12 **MR. FLOHR:** Well, no, Jeff, I think, and Jerry
13 probably can speak to this more than I can, but I
14 believe, you know, there was a lot of resistance in
15 the Senate and the House to any bill on Camp Lejeune,
16 and I think this is a compromise. To get those 14,
17 plus they added non-Hodgkin's lymphoma, so there's 15.
18 It's just, it's all about compromise.

19 **MR. BYRON:** Well, I just hope that it's a start,
20 and not an ending. Okay.

21 **MR. ENSMINGER:** Well, let me add something there.
22 Something Brad just addressed. This bill, there was a
23 lot of resistance for getting anything for Camp
24 Lejeune.

25 As a matter of fact the reason that this bill has

1 an HR on it is because it originated over in the
2 House. And the House Veterans Affairs Committee tried
3 to sneak a bill past. They took it up over in the
4 House, they passed it and it went over to the Senate
5 and luckily Senator Burr and his staff caught it. And
6 Senator Burr dug his heels in and said hell no. If it
7 doesn't include Camp Lejeune, nothing's going through.

8 So then the compromising started, okay? That's
9 how we ended up with this bill and that's how that HR
10 bill ended up over on the Senate side and got passed
11 in the Senate before it got passed in the House.

12 So that's just a little bit of the history for
13 you. I mean, you're just getting a glimpse into my
14 life on a day-to-day basis. So anyhow, go ahead.

15 **MR. BYRON:** Well, this is Jeff again, and I think
16 it's a hell of a shame when veterans who served their
17 country or patriots have to compromise, and the United
18 States government just signed off \$125 million to AIDS
19 research overseas. What the hell? They're handing
20 away my tax dollars and won't take care of us? The
21 people that serve this country? I don't know about
22 you but, you know, I feel the patriots and the
23 veterans deserve it.

24 **MR. ENSMINGER:** Well, Jeff, hey, I don't think
25 anybody on this call will disagree with you. And, you

1 know, that's something we're going to have to take up
2 at a later time. I mean, we're not going to cure it
3 all that here, unfortunately. But, you know, I hear
4 you. You know, we all hear you. And you're right.
5 By the way, Mike, I bought you a pink hat, a pink
6 scarf and pink gloves for this winter, so...

7 **MR. PARTAIN:** As long as you made the appropriate
8 donations to Komen so they give you credit for it.

9 **MR. STALLARD:** All right, do we have anymore
10 questions for our colleagues at VA?

11 **DR. DICK:** I just had a comment. I wanted to
12 step back a minute for something that Brad and I were
13 discussing earlier. If somebody is, let's say, a Camp
14 Lejeune veteran and they don't -- they need treatment
15 for a condition that isn't one of those conditions on
16 the list of 15, VA has something called enrollment
17 priority groups. And so for example the first
18 priority, the top priority, would be for those
19 veterans who are service-connected, with at least a
20 50-percent disability. The lowest priority group is
21 priority 8, and those are the veterans who make too
22 much money for the VA threshold, and who have no
23 service-connected conditions. Category 6 includes the
24 SHAD veterans, the ionizing radiation, the Gulf War
25 and Vietnam veterans. So if they make too much money

1 and they're category 8, however they were a Vietnam
2 War veteran, then they move up to category 6. And if
3 someone would like this list, I'm happy to give it out
4 to you. It's online, too.

5 **MR. STALLARD:** Yes?

6 **DR. CLAPP:** I want to ask Brad, you mentioned
7 the, I think you said 30 environmental medicine
8 experts that you've asked to get engaged, is that a
9 list that's public and could people --

10 **MR. FLOHR:** No, that's just being generated.

11 **DR. CLAPP:** Okay.

12 **DR. DICK:** And Brad, they're already working for
13 the VA, these --

14 **MR. FLOHR:** Yes.

15 **MR. BYRON:** This is Jeff. Frank, you know, I
16 brought up that, you know, the in utero study, what
17 recommendations -- I mean, you guys have seen the
18 info, you've had it for a long time. I mean, I still
19 can't get an answer, an opinion, from somebody in the
20 scientific community, what's going on? Okay? Why
21 can't anything be released?

22 Well, I realize the studies aren't finished, but
23 when the study is finished, will there be illnesses
24 that are added to this list for the children, for
25 those that were in utero or what do you think will

1 happen here? I mean, will you guys be making
2 recommendations to Congress or are we just going to
3 put out a report and that's the end of it?

4 I don't know. That's why, kind of why I wanted
5 Secretary Sebelius here to tell me what's next, you
6 know. I want to look at 'em right in the face and
7 hear it from 'em.

8 **DR. DICK:** VA is very interested in what comes
9 out of the various health study reports from ATSDR, so
10 we're definitely following that closely and we'll look
11 at it very intently.

12 **MR. STALLARD:** All right. It seems that we are
13 concluding our question and answer period for --

14 **MS. RUCKART:** Mary has a report --

15 **MR. STALLARD:** Does she?

16 **MS. BRIDGES:** May I say something?

17 **MS. BLAKELY:** Well, I'd like to apologize for
18 being late, first, but my two GPSs didn't get me here.
19 It took me to the other CDC. That was interesting.
20 They were nice. They sent me here.

21 As far as Jeff's question about recommendations,
22 in the first study I actually bought that book, if you
23 want to call it that. And in it they do have
24 recommendations. And I was going to ask if the ATSDR
25 and the scientists would recommend further studies,

1 especially for the surviving children who have
2 illnesses that aren't listed in that 14 category.

3 Because one of the reasons that I was late is
4 because I'm late everywhere. I have two GPSs. I have
5 a learning disability. I actually brought my test
6 results. I don't know how my lawyer will feel about
7 this but I'm going to give them to you and let you
8 look at them, because -- I have a good life. I've
9 been blessed but there's a lot of victims out there
10 who are like me, who have learning disability and
11 memory deficit, who don't have the means that I have.
12 And they are suffering. They can't afford to go get
13 tested. They have no idea why they are the way they
14 are. And the knowledge of knowing what has caused me
15 to struggle my whole life, the way I have, has
16 empowered me, has motivated me to stand up and shout
17 for people like me.

18 And you have a position in our government that
19 you can recommend that these studies be done. And I
20 don't think it's wrong for me to request that of you,
21 from the children, the surviving children who aren't
22 dying of cancer. The children who are struggling and
23 can't make it into colleges. We're all getting older.
24 But you know what? We've passed it on to our
25 children. My daughter's just like me and she gets

1 lost going around the block. She struggles. She
2 worked hard in school. She has learning disabilities
3 also. And her daughter, she turned six yesterday.
4 She's just like me.

5 Now there needs to be more studies. We don't
6 need to be shoved under the rug. Neurological effects
7 from those chemicals are spread far and wide. And if
8 you just look at our society as a whole, the
9 children's testing is so screwed up that everybody's
10 on medicine because they either have some sort of
11 social problem or they have a learning disability.
12 Now, what is that from?

13 This needs to be done and you have the power to
14 do it. And I feel like it's not wrong for me to
15 request that. You put it in writing.

16 **MR. STALLARD:** Thank you, Mary. Any other
17 questions for our colleagues from the VA?

18 **MR. PARTAIN:** Actually just kind of tag onto what
19 Mary was saying. Jerry -- actually this is going to
20 go to Jerry but it's pertaining to the healthcare.
21 So, but with the bill, Jerry, you know, like for
22 example Gloria out in Arizona where her, I think,
23 grandchild was born with cancer. Her child was born
24 at Camp Lejeune. Does the -- the bill doesn't
25 address, you know, the dependents -- dependent

1 children, does it? Am I making sense here?

2 **MR. BYRON:** In other words Jerry, it doesn't go
3 into the third generation, correct, like my grandson?

4 **MR. ENSMINGER:** No, this'll only pertain to
5 people that were directly exposed while they were at
6 Lejeune. Okay? So. You know, like both of your
7 daughters, Jeff. Like Mike, you know, that's who
8 this'll cover.

9 I mean, yeah, you got to realize something here.
10 We're having a hell of enough time just getting our
11 bureaucracy to help the people that were directly
12 exposed. I mean, hell, the Department of the Navy and
13 United States Marine Corps still sit out there and
14 deny that there were any kind of (indiscernible) due
15 to their neglect of the people that were directly
16 exposed, let alone extending it and going out to
17 children who were born subsequently away from the
18 base.

19 You know, it's like I said, you can do what you
20 can do, and I'll tell you it's a quagmire up there,
21 and trying to work through -- and then you've got
22 different political parties involved in this thing. I
23 made the statement last week to one of the
24 congressional staffers, I said, you know trying to get
25 this bill passed was like playing a game of volleyball

1 in a damn mine field. And you -- one of your team
2 members sets you up for a beautiful spike, and you
3 spike the ball, but when it hits on the other side it
4 explodes. I mean, God knows. I mean, it's -- I tell
5 you what, it's a hell of an experience. I've had one
6 hell of an experience in the last 15 years, I'll tell
7 you that.

8 **MR. STALLARD:** You should make a movie about
9 that.

10 **MR. PARTAIN:** Hey, Brad, I do have a follow-up
11 question. Once the -- provided the bill's passed and
12 we have this legislation in place, the veterans who
13 have been previously denied -- I've had a couple of
14 male breast cancer guys ask me this question and some
15 other people with kidney and bladder cancer and stuff,
16 those veterans who have been previously denied, once
17 the bill is passed, is that system with an appeal or
18 how does the VA look at that? I know you probably
19 haven't really thought that process out but that's
20 something we're starting to get now.

21 **MR. FLOHR:** Well, the legislation really only
22 pertains to healthcare and not to benefits. It's
23 healthcare regardless of whether or not somebody's
24 been determined to be disabled due to actually to
25 their military service. So how that's going to impact

1 claims and certainly someone could, who had been
2 denied could come back to VA, say, you know, I wanted
3 to look at it again possibly but there's no tie
4 between healthcare and disability benefits.

5 **MR. PARTAIN:** And I'm not sure -- yeah, I'm not
6 sure how the VA process works since, you know, outside
7 of that, but my understanding is you usually have a
8 year to make an appeal or what have you.

9 **MR. FLOHR:** Correct.

10 **MR. PARTAIN:** Now, if they're beyond that one
11 year, the bill's passed now, does that open the window
12 back for them to make an appeal again?

13 **MR. FLOHR:** No, no.

14 **MR. PARTAIN:** They're not.

15 **MR. FLOHR:** What -- they can always provide new
16 evidence.

17 **MR. PARTAIN:** Okay.

18 **DR. DICK:** This is Wendi and I just wanted to --
19 Jerry was talking about children, and what I
20 understand from the bill is that if there was a child
21 who was not born at Camp Lejeune but the child was
22 conceived or was in utero for at least 30 days while
23 the mother was at Camp Lejeune, stationed or living
24 there, then if that child had -- has any of those 15
25 conditions, those -- healthcare related to those

1 conditions would be covered. So 30 days in utero also
2 is in the bill.

3 **MS. BLAKELY:** What about if it's the father? My
4 ex-husband was a civil servant in the print shop when
5 I got pregnant with my daughter, and would that
6 include them?

7 **DR. DICK:** The civilians -- civilian employees
8 are not included in this bill; only the service
9 members and their family but not the civilian
10 employees.

11 **MR. ENSMINGER:** And hey, Wendi, I'm glad you
12 brought that up because there have been newspaper
13 articles ever since the Senate passed this bill and TV
14 spots, and there are a bunch of former civilian
15 employees and their dependents asking about, well,
16 what about us? And you know, I passed this word out
17 on our website, I've passed it over to the other
18 website. It's like talking to a brick wall. But
19 anyhow, beside the point, there is a program in place,
20 it is called the Federal Employees Compensation Act.
21 The acronym is FECA. I won't go into that.

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

23 **MR. ENSMINGER:** But anyhow it is administered to
24 the Department of Labor, and I went over and looked at
25 it, and it's basically like the VA for federal

1 civilian employees. And it looks like a great
2 program.

3 Now, I don't know, because to be honest with you,
4 in my 15 years' involvement in this situation, I have
5 never had one former civilian employee tell me that
6 they have even applied for that. Now, and let alone
7 somebody coming to tell me, like the veterans do, that
8 I applied but I've been denied. I haven't heard of
9 anybody even applying for that.

10 So go look it up. It's -- I went and found it on
11 Google. I just did a Google search and boy, right
12 there it was. It took me right to the Department of
13 Labor, and I read up on the program, and it looked
14 like a great program. I mean, it even has widow
15 benefits for a former employee, widow or widower. So
16 I'm glad you brought that up, Wendi, because you
17 reminded me that, you know, that's why civilian
18 employees are not covered in this bill.

19 **DR. DICK:** Thanks for that background.

20 **MR. ENSMINGER:** (Indiscernible) better programs
21 than what our dependents are getting.

22 **MS. BLAKELY:** Yeah, but the civil servants don't
23 know about that program. I spoke with a civil servant
24 in Jacksonville at the showing of *Semper Fi*, and she
25 said that she has learned just for herself about

1 programs like what you mentioned. But for the norm,
2 civil servants have no idea what kind of benefits that
3 they could possibly have because nobody has shared
4 that with them.

5 **MR. ENSMINGER:** Well, the question is -- let me
6 tell you something, Mary. They have a union and their
7 union hall is right out there on Gum Branch Road. And
8 if they have any questions about what they rate, all
9 they have to do is contact their union. I mean, I've
10 been to their union hall probably -- I've been there
11 three times. Some of the documentary was filmed in
12 that union hall.

13 **MR. STALLARD:** Hey, Jerry, we need you to talk
14 into the phone, please. Your volume is fluctuating a
15 little bit.

16 **MR. ENSMINGER:** Can you hear me now?

17 **MR. STALLARD:** Better.

18 **MS. BLAKELY:** Well, can we request that somebody
19 from either that union or somebody, you know, in
20 charge of the civil servants be at these meetings? I
21 mean, how many more of these meetings are there going
22 to be?

23 **MR. STALLARD:** That is to be determined. I can
24 answer that question for you. We don't have an end
25 date per se, but the CAP will probably at some point

1 discuss their role into the future.

2 **MR. ENSMINGER:** Well, and you know, let's take a
3 look at the statements made by the United States
4 Marine Corps about how important the health, safety
5 and welfare of their former Marines, sailors, their
6 family members and their civilian employees. Why
7 doesn't the Marine Corps notify their civilian
8 employees of the availability of these programs?
9 Well, gee.

10 **MR. STALLARD:** So it sounds like that's a whole
11 different issue in terms of what is the procedures
12 that federal employees would have to go through in
13 order to identify work-related, being assigned, you
14 know, like at Camp Lejeune and working there, years
15 later. I'm sure it has its own time-consuming
16 process, so thank you for bringing it up. I think
17 perhaps at some point it would be helpful to know to
18 advise, and who would be the appropriate proponent to
19 do that.

20 **MR. ENSMINGER:** That would be their union, Chris.
21 And they have a union hall that's manned out there
22 24 -- not 24/7, but every day of the week to assist
23 these people with filing claims like that. And
24 furthermore, if there are any civilians listening, the
25 former civilian employees that were affected by this,

1 our website, The Few The Proud The Forgotten, is not
2 just for veterans. And all that evidence and
3 documentation that we have on that website is readily
4 available and there for them as well, to support their
5 claims.

6 **MR. STALLARD:** We heard a beep. Is there someone
7 who's joined us on the phone and hasn't had a chance
8 to announce themselves?

9 **DR. DAVIS:** Hi, this is Devra Davis, I've been on
10 for a bit.

11 **MR. STALLARD:** Welcome, Devra.

12 **DR. DAVIS:** Thank you.

13 **MR. STALLARD:** Okay. Anymore questions for our
14 VA during this question and answer period, colleagues?
15 We have a choice.

16 **MR. PARTAIN:** We were nice to you today, Brad.

17 **MR. FLOHR:** It's always appreciated, Mike.

18 **MR. STALLARD:** I think you always comport
19 yourselves very well.

20 **MR. BYRON:** I do have one thing. Still, like I
21 said, the way that the legislation sounds like it's
22 written to me, no children as dependent family members
23 are going to get help because they're too old. Am I
24 correct or am I wrong?

25 **MR. FLOHR:** Jeff, I think it has to be

1 determined. The same rules that apply to dependency
2 for veterans compensation benefits may not be the same
3 that apply for this particular legislation. It hasn't
4 been determined, I don't think.

5 **DR. DAVIS:** This is Devra Davis. I wanted to
6 follow up on that because as you are all aware, there
7 is clear evidence that there are effects on pregnancy
8 but there are also effects on male reproductive health
9 so that men who would be exposed while working there,
10 might have produced children that would have defects
11 associated with their exposures, and that's very
12 important issues that needs to be addressed.

13 **MR. BYRON:** So would you consider epididymitis
14 one of those diseases?

15 **DR. DAVIS:** Yes, but I don't think you need a --
16 that's a -- as you know, that's a male reproductive
17 disease. But I'm talking about the fact that there's
18 a phenomenon called male mediated teratogenesis, and
19 that refers to the fact that where fathers work or
20 exposures that they have in the four months prior to
21 producing a conception that results in a child, has an
22 effect on the health of the child they produce and
23 whether or not they can produce any.

24 And there's a literature on this relating to
25 solvents, relating to pesticides and their effects on

1 men and the health of the children that those men
2 produce. Male or female children. Epididymitis, of
3 course, is just a male effect.

4 **MR. BYRON:** Yes, but my daughter being disabled
5 after me drinking the water is kind of indicative that
6 I had the problem. Yes or no?

7 **DR. DAVIS:** That is exactly what I'm talking
8 about, your daughter.

9 **MR. BYRON:** And so my request for doing genetics
10 testing, and I was told no way because, you know,
11 first off, the people wouldn't do it, that it wouldn't
12 prove anything so it sounds to me like, like I said
13 through all these meetings, you just verified
14 everything I've thought, and not dispelled any of it.
15 Come on, guys, let's hear something.

16 **MR. STALLARD:** We also -- excuse me -- in a
17 minute, Devra, we are going to hear something from the
18 ATSDR. In the afternoon session we're talking about
19 updates, cancer studies and you'll see the agenda, so.

20 **MS. RUCKART:** Later this morning.

21 **MR. STALLARD:** Later this morning. Okay, later
22 this morning.

23 **MR. BYRON:** This is Jeff again. You guys seem
24 mighty quiet today. What's up? Somebody hit you with
25 a stick?

1 **MS. RUCKART:** Nobody's trying to dispel your
2 statements that you've made. We just can't really
3 speak about that right now. We're going to give our
4 updates later, and then, you know, we always have a
5 Q&A session, and you can ask us really specific
6 detailed questions at that point.

7 **MR. STALLARD:** Yeah. We're -- okay, so next on
8 the agenda is Morris, actually. And we're supposed to
9 take a break at 10:30. Given that this is live
10 streaming and whatnot, are you okay if we take a break
11 now and then bring him back?

12 **MS. RUCKART:** Yeah, we're -- we don't have that
13 restriction anymore. They continually stream. They
14 used to stream in three-hour chunks but -- we
15 previously had a restriction that we could only stream
16 in three-hour chunks. If we took the breaks
17 differently it might affect our streaming but I think
18 we continually stream so we can break early.

19 **MR. STALLARD:** Okay. Great. So let's please be
20 back. We're going to adjourn for 15 minutes. So
21 please be back and seated and ready to go at 15
22 minutes from what your watch says.

23 (Break, 10:22 a.m. until 10:38 a.m.)

24 **MR. STALLARD:** All right, well, let's resume.
25 We're going to now -- Jerry, give us just a moment or

1 two. We have about four people that might be in
2 conference in the hallway.

3 All right, this is the session that we have set
4 aside time for Morris to provide us with an update on
5 the water modeling. Morris, please speak directly
6 into the microphone. Jerry has asked that we...

7 **WATER MODELING UPDATE**

8 **MR. MASLIA:** Okay, good morning. It's my
9 pleasure again to bring you up to date on the water
10 modeling activities and associated reports.

11 The Chapter A report, which is summary and
12 findings and contains eight supplements with
13 supporting information, all analyses have been
14 completed. Division management is reviewing Chapter A
15 and supplements. The next steps are to response -- to
16 response to review comments, submit the report to the
17 Office of Science for peer review. And the Office of
18 Science selects the peer reviewers and submits the
19 reports and supplements for external review.

20 The Chapter D report, which reports on RCRA site
21 histories and ground water contaminants from above
22 ground and underground storage sites. Their report is
23 in the final stage of agency clearance. The next step
24 is the staff will respond to comments and the staff
25 will submit a final laid out report to the Office of

1 Communications for release. And that's my report.

2 **MR. STALLARD:** Okay. Any questions for Morris?

3 **MR. PARTAIN:** Well, Morris, when is the expected
4 date for the water model to be released for the public
5 and the CAP and everybody to hear and see?

6 **MR. MASLIA:** I'll have to defer that to someone
7 who makes those decisions.

8 **MR. ENSMINGER:** Who's that?

9 **MR. PARTAIN:** I think Frank got slipped the fish
10 on that one, so Frank?

11 **MS. FORRESTER:** This is Tina Forrester and I'm
12 the Acting Division Director for Community Health and
13 Investigations Proposed. We have a timeline to be
14 complete by November 15th.

15 **MR. PARTAIN:** Okay, when you say complete, is
16 that for public release to where it's out?

17 **MS. FORRESTER:** Yes.

18 **MR. PARTAIN:** Now, is there going to be a time
19 where, as far as the CAP's going to be involved in
20 knowing or having an opportunity to understand the
21 water model before it's concluded as far as, you know,
22 us to have a say-so in it?

23 **MS. FORRESTER:** I don't know at this time if a
24 decision has been made on that. I will talk to
25 Dr. Portier.

1 **MR. PARTAIN:** All right. Is the water model
2 going to be provided to the Department of the Navy and
3 the Marine Corps for comments and reviews prior to its
4 release as well?

5 **MS. FORRESTER:** I'm not sure about that either.
6 I'm not sure.

7 **MR. PARTAIN:** Okay, well, I will state for the
8 record if that is the case -- hold on, Jerry. I said
9 I would state for the record that if it is in the
10 intent of the ATSDR to provide this water model for
11 the Marine Corps and the Department of the Navy to
12 review prior to release, that we the community be
13 allowed that same opportunity. And it would be a
14 disgrace if that was to occur.

15 **MS. FORRESTER:** I will definitely talk to
16 Dr. Portier about both of your questions.

17 **MR. BYRON:** Yeah, this is Jeff --

18 **MR. ENSMINGER:** I thought Dr. Portier was there.

19 **MS. FORRESTER:** He stepped out of the room
20 momentarily. I'm sure he'll be right back.

21 **MR. ENSMINGER:** Oh, gee. Right when the water
22 modeling issue comes up.

23 **MR. STALLARD:** Well, I'm sure we have --

24 **MR. ENSMINGER:** Wasn't that convenient?

25 **MR. STALLARD:** We have more time today, Jerry,

1 and if you feel the need to circle back to that...

2 **MR. ENSMINGER:** All right, when can we expect
3 Chapter D?

4 **MS. FORRESTER:** All I can tell you currently
5 is -- what?

6 **MR. MASLIA:** I was just going to repeat what I
7 said.

8 **MS. FORRESTER:** Okay.

9 **MR. MASLIA:** It is -- Chapter D is currently in
10 the final stages of Agency clearance.

11 **MR. ENSMINGER:** Yeah, but I mean Agency
12 clearance, Morris, is a damn mystery hole that nobody
13 really understands, except for a small circle of
14 people I understand you're not even included in. So,
15 you know, what is internal clearance? Where in the
16 hell is it?

17 **MR. MASLIA:** It is in electronically in the
18 ATSDR, what's referred to as the documentum clearance
19 system.

20 **MR. STALLARD:** And Jerry, Dr. Portier is back in
21 the room, if you have a question you wanted to direct
22 to him.

23 **MR. ENSMINGER:** Yeah, I mean, where is Chapter D,
24 Dr. Portier? Where is it in your internal clearance
25 process and when can we expect to see that report?

1 **DR. PORTIER:** Well, it's within our internal
2 clearance procedure. Every, you know, we have, Jerry,
3 we have the right, but not just the right, we have the
4 responsibility to make sure this document is as
5 accurate and correct as it possibly can be before we
6 let it go out the door. Letting a substandard
7 document out the door would not do you any good nor
8 anyone else. So that document is still in clearance
9 until we're satisfied that it is of high enough
10 quality and meets our standards that we are willing to
11 release it.

12 **MR. ENSMINGER:** Well, I mean, you know, we
13 reviewed that chapter. We were given a specific time
14 frame to do the review, and that was researching all
15 the documents and going back through every document
16 that was in that thing, and we met our deadline. And
17 so I just don't understand what's taking so long for
18 people who don't even really understand that issue to
19 do their review. I mean, what are they looking for?
20 To make sure that the spelling's correct or what?

21 **DR. PORTIER:** You're absolutely correct, Jerry.
22 You guys met your deadline; you did it extremely well
23 and you did a great job, and we really do appreciate
24 that. Sometimes it is difficult to get documents
25 cleared through a complex organization like CDC, and

1 it takes time and effort for the people who want to
2 review and make sure that document is correct to get
3 through it. And it's just a matter of sitting and
4 waiting for them to be finished.

5 **DR. DAVIS:** This is Devra Davis. In the interest
6 of transparency, it would probably be helpful if you
7 were to name the individuals that are on that internal
8 review committee and tell us what the deadlines are
9 that they're going to be working with, and then I
10 think that would solve some of these concerns that
11 Jerry's raising.

12 **DR. PORTIER:** Devra, I can only give you a broad
13 stroke of how review goes on within CDC and ATSDR.
14 For issues that are extremely important to the
15 Agencies, like the Camp Lejeune issue, the review goes
16 from the scientist himself who put together the
17 document, all the way up to the Office of the Director
18 at CDC, so there are a large number of people --

19 **DR. DAVIS:** So it's intended to go to the
20 Secretary at HHS?

21 **DR. PORTIER:** If the director, if Dr. Frieden's
22 staff feels that it should go to the Secretary's
23 office then it will go to the Secretary's office. So
24 these documents take time and effort for people to
25 read. Chapter D is 400 pages, give or take?

1 **MR. MASLIA:** More or less.

2 **DR. PORTIER:** Yeah. Different reviewers take
3 more or less time as they review it. That's the best
4 you're going to get out of me.

5 **MR. ENSMINGER:** Well, when you use the word, when
6 you have important documents, I think a better choice
7 would be something as controversial as Camp Lejeune
8 is, would be a better choice of words.

9 And I have another question, has OMB got their
10 fingers in this, too? Are they reviewing these
11 reports?

12 **DR. PORTIER:** Up to this point OMB has not
13 reviewed any of our reports. Again, I will point out
14 that sometimes for these reports, it depends on what
15 the Secretary's office might do. We have no
16 indication that this report is going to the
17 Secretary's office or anywhere else other than CDC.

18 Everybody who is touching this report knows the
19 importance of this report, they know the importance of
20 getting it out in a timely fashion; they are all aware
21 of it. My chief of staff personally calls and checks
22 to make sure where the document is on a routine basis,
23 to keep track on it. So we're trying our hardest to
24 get this thing out as quickly as we can.

25 **DR. DEARWENT:** This is Steve Dearwent. One

1 question that came up while you were out of the room,
2 Dr. Portier, was whether or not we would provide, once
3 all the reviews have been completed within HHS,
4 whether or not we would provide an informational copy
5 to Navy or Marine Corps for their review prior to
6 release or how that process works.

7 **DR. PORTIER:** That process is outlined in our
8 memorandum of understanding. There's a specific
9 statement in the memorandum of understanding as to
10 what sort of lead time the Department of Navy gets for
11 any of our documents that are going out of the CDC. I
12 don't know if -- I don't remember the exact time
13 frame.

14 **MR. PARTAIN:** Well, Dr. Portier, if the Navy and
15 the Marine Corps are going to be given an opportunity
16 to review the water model prior to release, what have
17 you, is that same opportunity going to be afforded to
18 the community?

19 **DR. PORTIER:** If I remember the wording of the
20 memorandum of understanding, they do not get an
21 opportunity to review. They get an opportunity to ^
22 the document in advance. That's all. They get a
23 head's up.

24 **MR. ENSMINGER:** Hell, no. The damn perpetrator
25 gets all the damn benefits.

1 **MR. PARTAIN:** Well, then, Dr. Portier, are we
2 going to have an opportunity to see the document, the
3 water model, prior to its release as well? I take the
4 review question out of it.

5 **DR. PORTIER:** Mike, I will take that under
6 consideration, I honestly will. I'll talk to my staff
7 about the pros and cons of doing that, and I'll take
8 it under consideration.

9 **MR. PARTAIN:** Okay, 'cause, as a CAP member, I'd
10 like to make a formal request that, since they are
11 going to be provided -- they being the Department of
12 the Navy and the Marine Corps, not be review -- I
13 mean, not -- I'm sorry -- to see your work prior to
14 its release, to make sure we're using the correct
15 operational terms here, that the CAP also be provided
16 that same opportunity. And I think it's something
17 that, in the interest of transparency and appearance,
18 I think we should be given that same right, too.

19 **DR. PORTIER:** I'll review the memorandum of
20 understanding over lunch, and I will pull my staff in
21 and I'll give you an answer this afternoon.

22 **MR. PARTAIN:** Thank you.

23 **DR. DAVIS:** This is Devra Davis, just with a
24 scheduling question, because I -- could you just
25 confirm for me what time you're planning to discuss in

1 more detail the methodology and design for the case
2 control, case, case study?

3 **DR. DEARWENT:** Are you referring to the male
4 breast cancer study?

5 **DR. DAVIS:** Yes. Yes, sir.

6 **DR. DEARWENT:** That would be 1:00 o'clock, right
7 after lunch.

8 **DR. DAVIS:** That'll be at 1:00.

9 **DR. DEARWENT:** Yes.

10 **DR. DAVIS:** All right, I'm going to arrange my
11 schedule so I can be available for that.

12 **DR. DEARWENT:** One, Eastern.

13 **MR. STALLARD:** Any other questions related to the
14 water modeling? No? Okay, let's move into --

15 **MR. FLOHR:** I have one.

16 **MR. STALLARD:** Okay.

17 **MR. FLOHR:** Morris, this last weekend there was
18 apparently thousands of pages of documents released by
19 DOD on Camp Lejeune. Will that not have any impact on
20 Chapter A, which is in the final stages?

21 **MR. MASLIA:** No. We have all the documents from
22 the DON and anyone else, Marine Corps and things like
23 that, and so those documents, to my knowledge, are not
24 anything that we do not have.

25 **MR. FLOHR:** Oh, okay.

1 **MR. STALLARD:** All right, then, thank you. Let's
2 move on in the agenda.

3 **UPDATES ON HEALTH STUDIES**

4 **BIRTH DEFECTS AND CHILDHOOD CANCERS**

5 **MR. STALLARD:** Perri is our next presenter.
6 Speak clearly into the microphone so Jerry can hear
7 it.

8 **MS. RUCKART:** I'll try my best to project my
9 voice very loudly. So anyway, I'm going to be giving
10 you an update on our health studies. A lot of this
11 information just presenting to get everybody up to
12 speed, make sure that everybody understands what we're
13 doing. There are a few new things that I do want to
14 share with you. And I have some slides, just for the
15 benefit of that.

16 Okay, so everybody knows about our health study
17 on birth defects and childhood cancers. I'm just
18 going to go through this very quickly just to make
19 sure we're all starting from the same point here.

20 So you know we had that previous survey to
21 identify the population. And we surveyed 12,598
22 children born to mothers who were at the base 1968 to
23 1985. From that survey we got 106 reported cases of
24 neural tube defects, oral cleft defects or childhood
25 cancers. As you know we tried to ascertain some

1 additional diseases. We were not very successful so
2 we moved forward with these.

3 We were able to confirm 52 of them. The others,
4 they were either confirmed to have something else,
5 they refused to participate in that process, they were
6 ineligible for a variety of reasons, and six of those
7 we couldn't confirm one way or the other, and I will
8 tell you in a little bit what we're going to do with
9 those. So that breaks down to 15 neural tube defects,
10 24 clefts and 13 cancers. And we interviewed the
11 parents to get more information about potential risk
12 factors in 2005.

13 Okay. So as you can see this is just a more
14 detailed breakdown of the cases, because neural tube
15 defects encompasses anencephaly, spina bifida and
16 cleft defects are cleft pallet or cleft lip, and the
17 two cancers, so as you can see we're able to interview
18 everybody except one cleft.

19 **MR. ENSMINGER:** Hey, Perri?

20 **MS. RUCKART:** Yes?

21 **MR. ENSMINGER:** How many -- I thought you had 19
22 confirmed cases of childhood cancers.

23 **MS. RUCKART:** No, it's 13. Thirteen confirmed.
24 There were --

25 **MR. ENSMINGER:** Damn.

1 **MS. RUCKART:** I'm trying to see how many were
2 reported.

3 Excuse me, I have to go log into the computer
4 again. Somehow the presentation just disappeared. So
5 give me a minute. Frank, can you add up all the
6 cancers?

7 **DR. DAVIS:** Maybe you can clarify the numerator
8 and the denominator here.

9 **MS. RUCKART:** Of what?

10 **DR. DAVIS:** Of these cases, of the 13 or 14 out
11 of -- from what population were they drawn? Was this
12 just self-reporting? I'm a little unclear.

13 **MS. RUCKART:** Well, Devra, we had an extensive
14 process to identify all the births on base during that
15 time period as well as births that occurred --

16 **DR. DAVIS:** No, that's what I'm asking you just
17 to clarify this. I know the dates of the population
18 that you're looking at. That's what I'm asking.
19 From --

20 **MS. RUCKART:** Nineteen --

21 **DR. DAVIS:** All children born from as of this
22 time to that time.

23 **MS. RUCKART:** Right, 19 --

24 **DR. DAVIS:** You actually have the data on all
25 births that took place on the base, and have been able

1 to follow all those children up to the first 20 years
2 of their lives?

3 **MS. RUCKART:** No, that is not really the case.
4 What happened is we have information on the births
5 from 1968 to 1985 for those births on base.

6 Now, there is really no good source to identify
7 the births off base, and we anecdotally were told
8 there were about three- or 4,000 births that occurred
9 off base. That's because the people at the hospital
10 think that's how many mothers they saw during that
11 time period but didn't deliver there. So we have
12 ascertained -- now, given that that, we only have a
13 rough estimate of those births off base, we have an
14 estimated participation rate of about 80 percent for
15 this survey from which we got the cases.

16 So there were about 12,493, I think, births on
17 the base during that time period, and an estimated
18 three- to 4,000 off base. That's about 17- to 18,000
19 total. We ascertain 12,598, and from that we got 106
20 reports of the cases, and then I described to you how
21 that shapes up. Does that help?

22 **DR. DAVIS:** And I appreciate how difficult it is
23 to do that. I'm not trying to give you a hard time
24 but I'm just trying to make clear, and I think
25 everyone understands is, for the record, is this is

1 not complete ascertainment at all.

2 **MS. RUCKART:** Yes, I was just trying to go over
3 this part fairly quickly because most people are
4 familiar with it, but of course stop me if you have
5 questions. Okay, my presentation will be up here
6 momentarily.

7 **DR. DAVIS:** Is there any way I can access it
8 remotely since I'm not at the meeting?

9 **MS. RUCKART:** Yes, it should be -- well, when it
10 comes back up here, up here in a minute, it should be
11 streamed as well.

12 **DR. DAVIS:** All right, thanks.

13 **MR. ENSMINGER:** And by the way, while you're
14 waiting on that, Perri, I have the MOU up on my
15 computer screen here.

16 **MS. RUCKART:** Wait, we have this back up. Do you
17 want to stop and break for that or do you want me to
18 continue because we do have the presentation back up.
19 And by the way, Devra, there's a slight delay for the
20 streaming, so you should have it streamed momentarily.
21 About one minute I'm told.

22 **MS. BLAKELY:** Perri? I'm confused, please
23 forgive me, but are you saying that these numbers are
24 just from the study or are you saying that the Marine
25 Corps provided how many children were born on the

1 base?

2 **MS. RUCKART:** The Marine Corps did provide this.
3 We have birth certificates from Onslow County, where
4 the base is located, and from that there was a study
5 in 1998, the one that we talk about the adverse
6 reproductive outcomes. So from that study there were
7 12,493 births that were identified from the birth
8 certificate from the county as having been born to
9 parents who lived on the base.

10 And then the naval hospital anecdotally, and I
11 was not involved back in the early to mid-90s, when
12 this -- when these discussions were taking place, but
13 they estimated that there were about three- to 4,000
14 births that occurred off base, but that they knew
15 about these pregnancies that had come through and been
16 seen at the hospital there.

17 So that gives us approximately 17- to 18,000
18 births during this time frame where any portion of the
19 pregnancy occurred on the base. So from that we were
20 able to survey 12,598 people, that's about 80 percent,
21 that's pretty good. You look like have a further
22 question.

23 **MS. BLAKELY:** So you got the number from the
24 other study you're saying? I'm sorry.

25 **MS. RUCKART:** Well, that was the basis for the

1 births that were on base who had birth certificates.
2 So that -- but let me say, out of the 12,598, it
3 wasn't like it was 12,493 of those births are in our
4 study. You know, I think it's 10,500 or so are part
5 of this study on birth defects, and the other 2,500 or
6 so are from the off-base births.

7 **MS. BLAKELY:** Is there a way to access how many
8 actual births took place in a county? Like, would the
9 state have a record of that?

10 **MS. RUCKART:** You can go to the vital statistics
11 office.

12 **DR. AKERS:** Actually it's the Center for Health
13 Statistics in Raleigh. The chairman of that is a
14 Mr. Matt Avery, who's in charge of those records. And
15 regarding the three- or 4,000 births off base, what
16 was happening, at least in the early 60s, is that
17 high-risk pregnancies were transferred to Portsmouth
18 Naval Hospital. And infants that were born that were
19 at high risk, multiple defects, what have you, they
20 were transferred either to Bethesda or to Portsmouth,
21 at least in the early 60s, as far as the location for
22 those individuals.

23 And according to, again Matt Avery or a
24 Mr. Robert Meyer, birth certificates are a very poor
25 source of information. And the study you mentioned in

1 the late 90s, was that the one that was done by Wendy
2 Kaye?

3 **MS. RUCKART:** No. Okay, first of all, I think
4 there's a lot going on here so there's some confusion.
5 In 1998, the Agency published a study, so it was
6 conducted, you know, in the early to mid-90s about
7 adverse reproductive outcomes in the births that we
8 knew about because of the birth certificates. The
9 parent lived at the base when the child was born.

10 Doesn't say anything about how long they were
11 there because they could have come in the last month.
12 So that study looked at small for gestational age and
13 preterm birth and low birth weight. And I'll be
14 talking about that in the minute. We're going to be
15 doing some reanalyzing of that study.

16 Then, as Paul mentioned, the birth certificates
17 are not a good source of identifying birth
18 certificates -- birth defects, I'm sorry. The birth
19 certificates are not a good source of the birth
20 defects. Obviously, you can't get cancer information
21 off of that.

22 So this is why we did the survey, to ask people:
23 Did you have a child with a birth defect? And then we
24 followed up to get medical records confirmation. So
25 that's what I'm talking about.

1 So in 1999-2002, Wendy Kaye did lead the effort
2 to do the survey from which we got these 106 reported
3 cases. So 2005 -- so then beginning in 2003,
4 continuing on for several years, we began the very
5 extensive process of trying to get medical records
6 confirmation because these were things that happened a
7 long time ago; it's hard just to get the records. So
8 that's why out of the 106 cases, we confirmed 52.

9 Now, it's not that the other 54 are unknown.
10 Thirty-two of those were confirmed not to have the
11 condition that for some reason was reported during the
12 survey and some of the people became ineligible.
13 Further checking into them we found out that, a, the
14 pregnancy wasn't really on the base or they lived in
15 Midway Park that's actually off the base, or the
16 pregnancy did not occur between 1968 and 1985.

17 **MR. BYRON:** Hold on just a minute. What'd you
18 say about Midway Park? It was off the base?

19 **MS. RUCKART:** Part of Midway Park is off base and
20 part is on base, and we've had -- Frank and I did an
21 extensive effort to identify exactly where the mother
22 lived during every month of her pregnancy and the
23 first year of the child's life and a few months before
24 the pregnancy. And in doing that, we found out that
25 part of Midway Park is actually off base and part is

1 on base, and there's a way it's listed that lets you
2 know which is the case. So anyway, and then, like I
3 said there are six cases --

4 **MR. PARTAIN:** Well, hold on, Perri, a second.
5 When you're talking about Midway Park, when you say
6 off base, on base, for purposes of clarification,
7 Midway Park is identified --

8 **MR. ENSMINGER:** Hey, let me clarify that because
9 I'm right down here in the area. Midway Park housing
10 area, which is the military housing area, is part of
11 the base. However, there is also a Midway Park
12 civilian -- they have a civilian post office.

13 (Dog barking.)

14 **MR. STALLARD:** Can you translate that for us,
15 Jerry?

16 **MR. ENSMINGER:** Midway Park -- whose dog is that,
17 damn it?

18 **MR. STALLARD:** I thought it was yours but that's
19 a good reminder.

20 **MR. ENSMINGER:** No. Hell no. Somebody needs to
21 mute their phone.

22 **MR. STALLARD:** Yes, I would say so.

23 **MR. ENSMINGER:** But anyhow, Midway Park has a
24 post office. It is a civilian -- there's a civilian
25 Midway Park is what I'm trying to explain. Okay. Go

1 ahead, Perri, I'm sorry.

2 **MS. RUCKART:** That's okay. So my point is we
3 were able to determine who was in that park and who
4 was actually on base.

5 And then there were six births defects or
6 childhood cancers that were reported, six conditions
7 where we couldn't get medical records confirmation one
8 way or the other, and those we are including in our
9 sensitivity analyses, I'll explain to you in a minute
10 what that means. So anyway, my point of showing you
11 this is to show you how the 52 cases breaks down, the
12 52 that the main analyses focused on, and you can see
13 which specific subtype of defect they have, and the
14 other six, you know, where they would fall in there as
15 well.

16 **MS. BLAKELY:** Do you have their names?

17 **MS. RUCKART:** Well, we have their names but we
18 can't release them. Did you have something, Mike?

19 **MR. STALLARD:** Moving on.

20 **MS. RUCKART:** So this is some new information
21 that I wanted to share with you. And this gets into
22 what we were talking about before, about how we have
23 information on those who were born on base, we have
24 their birth certificate; and information on those who
25 were born off base. They were identified from a

1 referral process.

2 So as you can see more controls were born on base
3 than the cases. And more cases were identified
4 through the word of mouths, the referrals, they were
5 self-selected. So we will use this information to
6 evaluate selection bias in our sensitivity analyses.
7 We'll see if the fact that more cases were identified
8 through word of mouth than the controlled biases the
9 results, meaning change it for -- masking a
10 relationship or changing it.

11 Okay, this is also some new information I want to
12 share with you. It was collected during the
13 interviews in 2005. This table shows some of the
14 potential risk factors that we will consider in the
15 analyses because these risk factors showed some
16 association with the birth defects or cancer
17 independent of the exposure. And these are maternal
18 age, maternal education, child had a sibling with the
19 birth defect and father smoked around the time of
20 conception.

21 **MR. BYRON:** Pardon me, what does education level
22 have to do with exposure to chemical releases?

23 **MS. RUCKART:** It has nothing to do with exposure.
24 These are risk factors that are shown to be linked or,
25 you know, have some association with these conditions

1 independent of the exposure, having nothing to do with
2 the exposure, these are some potential risk factors
3 that may influence the relationship because they
4 appear to have some relationship with these
5 conditions. So we put them in our model, meaning we
6 consider the exposure, and then we say, well, maybe
7 the maternal age is also impacting it. Let's look at
8 both exposure and age and see what we get when we do
9 that, how does it change just when we have -- just the
10 exposure in the outcome.

11 **DR. AKERS:** Perri, let me ask you a question. Do
12 you have a group of individuals that are both control
13 and cases, where all those factors are the same except
14 for the exposure?

15 **MS. RUCKART:** Well, that's what I'm showing you
16 here. We asked a lot of questions in the survey based
17 on what the literature has shown to, you know,
18 potentially be affiliated with these birth defects.
19 So out of a whole series that we have, this slide and
20 the next slide, which I'll get to in a minute, show
21 the potential risk factors where maybe there is a
22 difference, and that's why we want to investigate it
23 further. If they were the same, then it wouldn't add
24 any information.

25 **DR. AKERS:** The additional conditions you've

1 mentioned are known risk factors to neural tube
2 defects: age, education, exposure to cigarette
3 smoking, what have you. So what I'm asking is: Is
4 there a control group that has those same risk factors
5 as a case group, except for exposure to chemicals?

6 **DR. BOVE:** We did not match. What we do is
7 instead we test for it in the models. That's how we
8 test for it, for possible confoundings.

9 **DR. AKERS:** Well, that would, seems to me it
10 would be plainer if you could have a control and a
11 case group where everything was the same except for
12 the exposure to the --

13 **DR. BOVE:** That's not necessary. You can adjust
14 for it in the models.

15 **DR. AKERS:** We'll see.

16 **DR. BOVE:** No, no, you can. But the actual --
17 the issue is this. I mean, there will not be any
18 problem. They could be very different in these risk
19 factors as long as the risk factor isn't related to
20 the exposure itself. If the risk factor is not
21 related to the exposure, it won't affect the outcome
22 at all. But those two things have to happen. There
23 has to be a risk factor first of all, which these are
24 well-known, except for smoking and neural tube
25 defects, it's stronger for clefts actually.

1 **MS. RUCKART:** Frank, let me just add these, when
2 I have these up here, these are for all the case
3 groups. I'm not saying that all of these are for each
4 outcome. These are -- I am just showing you some
5 aggregate. All of these cannot be looked at. First
6 of all we have some small numbers that we can get
7 into, but this is just giving you some sense. I am
8 not saying that all of these are going to be
9 considered for each outcome, just to make that point
10 clear.

11 **DR. AKERS:** But there are known risk factors with
12 the neural tube defects among other birth defects.

13 **MS. RUCKART:** Some of the ones I'm showing you,
14 and as Frank said, some of them are for the cancers
15 and some are for the clefts, and I can move on to the
16 next slide after Dr. Portier interjects.

17 **DR. PORTIER:** I just get a feeling Jeff feels he
18 didn't get his question answered.

19 **MR. BYRON:** No, no, no.

20 **DR. PORTIER:** And I want to make sure Jeff got
21 his question answered and he's happy with the answer.
22 Jeff, what happens in these types of studies is you go
23 and look at the literature, the scientific literature
24 that's out there. You find everything that people
25 have already found that appear to be associated with

1 this disease. Then when you go and do your analysis,
2 you want to make sure that those things aren't also
3 associated with the people who are exposed versus
4 those who are not, 'cause if it is, then the effect
5 might be due to that thing and not the exposure. So
6 you make sure you correct for all these other things
7 before you look for the effect of the exposure.

8 In the case of maternal education, it's probably
9 a surrogate for socio-economic status, and that is
10 likely associated because of nutritional differences,
11 because of other things in socio-economic status that
12 play a role.

13 **MR. BYRON:** Okay. That clears it up.

14 **MS. RUCKART:** Okay, so let me show you the next
15 slide I have, just some additional risk factors.
16 Again, this is for the group, not necessarily for each
17 specific -- or for all of the defects or cancers.

18 **MR. BYRON:** Can you go back one? I need to see
19 one thing.

20 **MS. RUCKART:** What's that?

21 **MR. BYRON:** Child siblings have birth defects.
22 Was that not calculated or did you look at that and
23 it's zero?

24 **MS. RUCKART:** I don't know what you mean. I'm
25 showing here --

1 **MR. BYRON:** Child siblings have birth defects.

2 **MS. RUCKART:** Right, yes or no.

3 **MR. BYRON:** I don't see anything in that column.

4 **MS. RUCKART:** No, child sibling has birth defect,
5 yes/no.

6 **MR. BYRON:** Oh, I'm sorry, I'm sorry.

7 **MS. RUCKART:** It's just like a header.

8 **MR. BYRON:** Look a little further down, huh.

9 **MS. RUCKART:** Okay. But these are just some of
10 the additional things that we're going to be
11 considering for some of these conditions.

12 First of all, are there any questions before we
13 move on, about the birth defect study? I do want to
14 add that I am fast and furiously analyzing that data.
15 I'm very, very far along, so as Jeff has mentioned,
16 it's taken us a very long time to get to this point
17 but I am very, very close to having a final draft
18 report to start our clearance process, very, very
19 close.

20 Just doing -- there's a lot of just sensitivity
21 analyses, just things that I'm checking just to make
22 sure I'm not leaving any stone unturned but I would
23 say it's like 99 percent, 95 percent ready to start
24 the clearance process. So any questions about the
25 study before we move on?

1 **MR. ENSMINGER:** Yeah, is ATSDR going to make any
2 type of strong conclusions about the findings of this
3 report or are you just going to throw the blanket
4 statistically insignificant on it and move on?

5 **MS. RUCKART:** I'm going to submit a report for
6 clearance. And I can't say what'll happen at that
7 point but I will let Steve say. Oh, I'm sorry, you
8 looked like you wanted to say something.

9 **DR. DEARWENT:** I was just going to say we will
10 interpret it like we do any other study. I think
11 there's no effort to whitewash or, you know, minimize
12 or maximize it. We will, you know, interpret it as
13 the results indicate. And we're actually working
14 with -- I've got some internal oversight, working with
15 a couple of professors over at Emory, Kyle Steenland
16 and Dana Flanders, who are, you know, kind of looking
17 over Perri and Frank and my collective shoulders to
18 make sure things are being done correctly and
19 interpretation isn't overly strong in one way or
20 another.

21 **MR. STALLARD:** Jeff?

22 **DR. PORTIER:** Jeff had a whole bunch of
23 questions.

24 **MR. STALLARD:** Hold on just a minute, Jerry, we
25 have a speaker.

1 **DR. PORTIER:** Jeff had a whole bunch of questions
2 about providing him preliminary findings from the
3 study before we get it through clearance and put it
4 into final say.

5 Again, we have the responsibility to make sure we
6 say it exactly right when we say it. I'm going to ask
7 Dick to comment on this, being a scientist, to publish
8 his papers. It's quite common for scientists to be
9 very reticent to release anything before the final
10 report is written, for a lot of reasons. But in our
11 case, it's we want to say it exactly right. We want
12 to make sure it's in proper context.

13 **DR. CLAPP:** Well, if that was a question for me,
14 you know, it's true that scientists have, sort of,
15 conventions as to how things are stated, and I'm sure
16 that ATSDR and Drs. Steenland and Flanders will apply
17 those conventions.

18 There's still broad data in tables sometimes that
19 a person looking at the article can say, well, I don't
20 actually agree with the way they wrote this up but I
21 think the data themselves say this. So there will be
22 places where there might be differences in
23 interpretation, but again, I think the scientists that
24 I'm familiar with, some of whom are sitting here in
25 this room and some of whom were just mentioned, are

1 top quality and will do the job as it's best done,
2 given our scientific conventions.

3 **MR. STALLARD:** Thank you. Let's move on.

4 **MR. PARTAIN:** And what -- all right, Dr. Portier,
5 what is the anticipated release date for the in utero
6 report out? I know some of this we've already talked
7 about, but for the record.

8 **MR. ENSMINGER:** When the water model comes out,
9 Mike.

10 **DR. PORTIER:** They should coexist in space pretty
11 closely, in space and time. I've given the program a
12 drop-dead date where they'd better have it to me by a
13 certain date. But again, because clearance for this
14 type of document is going to be -- people are going to
15 scrutinize it very carefully, I can't give you an
16 exact date. I'm hoping well before the end of the
17 year.

18 **DR. DEARWENT:** This is Steve. I think in our
19 recent congressional briefing, we indicated the water
20 model out at the end of 2012, and at least the two epi
21 studies of birth defects and mortality at the start of
22 the second quarter in FY '13, so right at the turn of
23 the calendar year.

24 **MS. RUCKART:** I want to assure you that I have
25 every intention of meeting that deadline, and I am

1 very far along, and I've been waking up at five in the
2 in the morning thinking about extra things I want to
3 do to this data. I am leaving no stone unturned. And
4 as Steve said, we've been meeting with Kyle and Dana,
5 and we just met with them Wednesday. They suggested
6 something I have not heard of and ^, you are not
7 familiar with it.

8 But anyway we are really looking at it. We don't
9 want to -- I mean, my personal feeling is, I mean,
10 it's going to be reviewed, and when you give it to
11 someone to review, people always make comments, but I
12 don't want to feel like a deer in headlights. I want
13 to say, yes, I have looked at that; yes, I have
14 considered that. I mean, I can't even imagine at this
15 point what somebody could say. I mean, I'm sure they
16 will but my point is just to tell you, I am thoroughly
17 looking at this. I am very far along. I am totally
18 expecting to meet deadlines barring any catastrophic
19 occurrence so please, please know we are working just
20 so diligently on this. I don't know what else to say.

21 **DR. DEARWENT:** This is Steve. Just to give a
22 little insight into, for you guys, in our last couple
23 meetings that we've had with Drs. Steenland and
24 Flanders, I think one of the biggest points of, not
25 contention, but discussion is which tables to submit

1 for publication, 'cause at this point Perri's probably
2 created a hundred --

3 **MS. RUCKART:** Five hundred. No, no, five
4 hundred.

5 **DR. DEARWENT:** And so, you know, she's looked at
6 it many ways but at some point we have to distill it
7 down to what is the most cogent to present both to the
8 lay community and the scientific community.

9 **MR. STALLARD:** All right. Thanks.

10 **MS. RUCKART:** And I have done that.

11 **MR. STALLARD:** With so much discussion about
12 deadlines and drop-dead dates, are we ready to talk
13 about mortalities?

14 **MORTALITY STUDY**

15 **MS. RUCKART:** What a segue. See, we kind of make
16 the meetings while serious also lighthearted. But
17 seriously anyway.

18 So as you know we're conducting the mortality
19 study, and again, I just want to remind everybody
20 again, so we're all on the same page, who is included
21 in that study. We had information from the Defense
22 Manpower Data Center, DMDC. This is data that
23 identified people systematically. This is from the
24 military records that started in the second quarter of
25 1975, unfortunately they didn't have electronic data

1 before then, and we go through December '85. That is
2 153,131 Marines or Navy personnel at Camp Lejeune, and
3 we also have the caveat they started active duty on or
4 after April '75 so that we know where they were. You
5 know, that we wouldn't miss somebody being at Lejeune
6 before that 'cause, you know, we wouldn't know.

7 And then that also includes 4,713 civilian
8 employees. The DMDC had data a little earlier for
9 them, starting a year before. And we also have
10 comparison populations from Camp Pendleton.

11 So I did report this last time but I just wanted
12 to share this with you again. From 1979 to 2008,
13 recall that we started our follow-up in 1979 because
14 we were using deaths identified from the National
15 Death Index, and that's when they start. And 2008 was
16 the last year of the complete data - by the time when
17 we finished collecting all of our data. And there
18 were 18,818 deaths, that's for both Camp Lejeune and
19 Camp Pendleton, former active duty combined. And as
20 the slide shows, 2,180 deaths were due to cancer as
21 the underlying cause. When you consider underlying or
22 contributing cause, we have 2,317, and there were
23 16,638 deaths with other conditions listed as their
24 underlying cause.

25 And for the mortality study we are going to be

1 looking at cancers specifically, individually and, you
2 know, the certain diseases that we discussed before.

3 And this basically just shows you the same
4 information for the civilians, 1,413 deaths, that's in
5 both Pendleton and Lejeune, and you can see up there
6 the cancers and the other deaths. Frank, did you want
7 to say more about what you're doing with the mortality
8 study and where you are in that process?

9 **DR. BOVE:** Hopefully I won't drop dead but there
10 has been a lot of work that was required for this
11 study that we probably didn't anticipate when we
12 started. The DMDC data was not in as good a shape as
13 we thought it was. The ability to match between the
14 Marine Corps information from the DMDC data, the
15 personnel information, and the family housing records
16 was difficult, more difficult than -- well, we knew it
17 was going to be difficult because we asked the DMDC to
18 do this several years ago and they threw their hands
19 up and said it was impossible.

20 We had our contractor to make at least three
21 attempts using different kinds of probability
22 matching, because what you -- the way you have to
23 match here is that you have only -- in the family
24 housing records, all you have is full name, which
25 could be misspellings; you have rank and you have the

1 time period they're in the house and that's it, okay.
2 So you can't match on Social Security Number, which
3 would have been a breeze. You have to match on name
4 pretty much.

5 And Westat, our contractor, did match on, they
6 tried to incorporate the period of time they were
7 there and to a much lesser extent, used rank, 'cause
8 they had some difficulties using the rank variable
9 from the DMDC data.

10 So after the third attempt, I thought that it
11 would require, in addition to this kind of probability
12 matching, it would be good to try to match as many
13 people as possible by hand at Tarawa Terrace in
14 particular, because that's, during the time period
15 we're talking about, which is for those people who
16 started active duty in '75, or any time after that up
17 to '85, Tarawa Terrace is the key family housing unit
18 that's being exposed at that point.

19 So I took it upon myself to do a hand-to-hand
20 match as well, to try to match as many as I could, and
21 I think I was able to match about 90 percent of people
22 at Tarawa Terrace. And the reason I couldn't match
23 some was that, the reason of -- one of the ways we --
24 this data set was created was the DMDC itself and the
25 Marine Corps, I tried to identify those units that

1 were stationed at Camp Lejeune and those stationed at
2 Camp Pendleton. Apparently they had to do a
3 historical research to come up with a unit list. They
4 had done it once before, in fact, a couple years ago,
5 made mistakes, and this was the second attempt, from
6 what I understand.

7 But they still made some mistakes because I found
8 some people at Tarawa Terrace housing, most of them in
9 the Navy, that were not in the DMDC databases that we
10 have at all.

11 So, and we also found from the survey, which
12 Perri will talk later, that some people have said, we
13 thought that we were stationed there at Camp Lejeune,
14 told us in the survey that they were never at the
15 base. So there are some mistakes, not -- I think that
16 for the most part, this is a good data set. I mean,
17 and it's a large data set, but there are some
18 mistakes. Okay.

19 So I think it took me at least two months to
20 review some two-, 3,000 records by hand. And that was
21 in addition to about 2,000 that I had done before,
22 earlier on. So it's taken longer to do this study
23 than we thought.

24 But I'm furiously analyzing the data as we speak,
25 and hope to meet the deadline, which is to try to have

1 a draft report ready for clearance sometime in
2 September. So that's -- now, I could go into how I'm
3 going to analyze it if you're interested in different
4 approaches; that's up to you. But that's basically
5 what's going on with mortality study. We're looking
6 at it, again, similarly as the case control study for
7 birth defects. We're looking at it in various
8 different ways, taking into account different latency
9 periods for the cancers and the chronic diseases.
10 We're looking at, as Perri said, individual cancers as
11 well as groupings -- like a grouping of what we call
12 hematopoietic cancers, which is leukemia and non-
13 Hodgkin's lymphoma, Hodgkin's disease and multiple
14 myeloma; and also looking at diseases such as
15 cardiovascular disease, ALS; I don't think we can look
16 at Parkinson's because we have so few; and male breast
17 cancer, we have so few. And cervical cancer is
18 another one where we have so few because they're in --
19 among the Marines, I think there are about 8,000
20 women and the number of cervical cancers is not large.
21 But we'll look at it if we can, okay? And as well as
22 female breast cancer. And kidney and liver diseases
23 besides the cancers.

24 **MS. BLAKELY:** What about lung cancer?

25 **DR. BOVE:** Lung cancer is part of the cancers,

1 yeah. Oh, yeah. Oh, definitely.

2 **MR. PARTAIN:** Frank, how many male breast cancers
3 did you come up with?

4 **DR. BOVE:** I'm trying to remember 'cause I --
5 there are some at Pendleton and -- I think there are
6 less than five during this period for this group. If
7 you take into account all of the cohort, which
8 includes people who started before '75, and include --
9 and also including Pendleton in that, too, there may
10 be a few more than that. But there really is very
11 few.

12 Well, we thought -- we knew this going in. I
13 anticipated somewhere between two and three male
14 breast cancers at Lejeune who started in '75 to '85,
15 and that's basically what we're finding, roughly about
16 that much. So I knew the mortality study was not the
17 study to look at male breast cancer.

18 **MR. PARTAIN:** Yeah, 'cause typically you don't
19 need breasts to survive.

20 **DR. BOVE:** One of the issues about this and is
21 that it is a young cohort. They're all younger or
22 most -- almost all of them are younger than me. And
23 so, you know, and so -- but seriously, you know, the
24 good thing about this study is that there are large
25 numbers of people to study. The bad thing is that

1 they are young. And so, you know, if it was an older
2 population you'd see more Parkinson's, for example,
3 than we're seeing.

4 There was some confusion, actually, among our
5 experts that said why are you seeing more ALS than
6 Parkinson's? It should be the other way around.
7 That's true if you're looking at an older cohort but
8 it's not true with this -- with a younger cohort. And
9 so Parkinson's is going to be -- it's pretty much not
10 going to be able to be evaluated in the mortality
11 study because we have one or two or three.

12 **MR. PARTAIN:** Well, there's also significance,
13 too, you bring up the younger cohort of age and
14 diagnosis with male breast cancer. It's typically not
15 found in young men. It's typically found in men 70
16 years of age.

17 **DR. BOVE:** That's right. That's why I
18 anticipated two or three in this cohort back then.

19 **MR. PARTAIN:** 'Cause it's five out of 153,000.
20 That's --

21 **DR. BOVE:** It's very small -- well, that's
22 including Pendleton and all.

23 **MR. PARTAIN:** Okay.

24 **MR. STALLARD:** Mary has a question.

25 **MS. BLAKELY:** Have you looked at how many died of

1 suicide?

2 **DR. BOVE:** I haven't been focusing on trauma or
3 suicide. On the other hand the program that I'm using
4 kicks it out for all causes, so you could look at
5 suicide; you could look at trauma as well.

6 **MS. BLAKELY:** Well, the reason I ask is because
7 of the neurological aspect of suicide, you know, could
8 be because of that.

9 **DR. AKERS:** Is there any information on
10 individuals who may have been stationed both places
11 during this time period?

12 **DR. BOVE:** Yeah, yeah, yeah.

13 **DR. AKERS:** Which category are they going to fall
14 under? In other words --

15 **DR. BOVE:** Lejeune trumps. Lejeune trumps.

16 **DR. AKERS:** Lejeune trumps, so if you were at
17 Lejeune and then were transferred to Pendleton but
18 were diagnosed at Pendleton --

19 **DR. BOVE:** Doesn't matter where you're diagnosed.
20 The DMDC data tells me -- well, whether you were at
21 Pendleton or Lejeune or both places, again, based on
22 the unit you're in, and that's how the research was
23 done. There are quite a number of people who were at
24 both bases, they're trying to say about 20 percent,
25 something around that. And so I take into account

1 when they're at Lejeune and also when they are at
2 Pendleton in the analysis. It's a complicated process
3 that I can talk to you offline, or if you're really
4 interested, I can go into it.

5 **MS. RUCKART:** I didn't add this when we were
6 talking about who was in the mortality study 'cause I
7 was just trying to get to the new stuff, but to be in
8 the comparison population at Camp Pendleton, that
9 means you were only at Camp Pendleton and not at
10 Lejeune, and that's why we started with -- so the
11 people who were there from April '75 to the end of
12 1985, but they had to start on or after April '75 so
13 they wouldn't have somebody showing up as Pendleton
14 but they started before and they were at Lejeune. So
15 we know if they were at Pendleton in April '75 or
16 later, they were not at Lejeune before that. So that
17 that Camp Pendleton group can be -- we can be sure
18 that they were not at Camp Lejeune, just at Pendleton
19 or elsewhere, but not Lejeune.

20 **DR. AKERS:** So they're purer samples then.

21 **MS. RUCKART:** Okay. If there's no more questions
22 about the mortality study, we can go on or if you
23 think of them later.

24 **MS. BLAKELY:** I have one. So is this study
25 complete then or you're just giving us an update?

1 **DR. BOVE:** Yeah, we're just giving you an update.
2 I'm analyzing data right now.

3 **MS. BLAKELY:** Well, can I request that you look
4 at suicide?

5 **DR. BOVE:** I'll do that.

6 **MS. BLAKELY:** Okay.

7 **MS. RUCKART:** See, this is why we talk to you
8 when we're in progress.

9 **ADVERSE PREGNANCY OUTCOMES**

10 **MS. RUCKART:** Okay, so this is the study that I
11 was talking about before the first study in ^ on the
12 adverse pregnancy outcomes, these are the 12,498 or so
13 births that we had birth certificates from, parents
14 lived on base. And this study evaluated potential
15 maternal exposure to the contaminated drinking water
16 in preterm births, small for gestational age and mean
17 birth weight. Now, of course we didn't have our water
18 modeling data at that time so it was just based on you
19 lived in an exposed housing area, you were considered
20 exposed; if you lived in an area that was not exposed
21 you were not exposed.

22 But since that time we found out that births
23 before 1972 at Holcomb Boulevard were incorrectly
24 classified as unexposed, and this makes a big
25 difference and I'll show you that in a minute. And

1 we're also going to reanalyze this data because, as I
2 mentioned, this just used the crude, yes/no exposure
3 based on your housing area, but now that we are going
4 to have -- or we have the water modeling data, we're
5 going to be doing a more specific analysis of their
6 levels of contamination. So.

7 So this shows you how the people changed from the
8 previous analysis in 1998 to the current analysis
9 considering we know what happened at Holcomb
10 Boulevard. So based on this new exposure information,
11 about 1,200 fewer people were categorized as
12 unexposed, so you can see previously there are over
13 5,700 considered unexposed, and that drops down to
14 4,530. So where do those people go? They mainly get
15 added to the TCE exposed group. So it goes from 31 to
16 1,342. There was a couple -- I mentioned 1,200 births
17 moved, roughly, but we have more than 1,200 additional
18 births from TCE because upon further checking, some
19 other people at Tarawa Terrace got moved slightly.

20 Anyway, the right-hand column shows our numbers
21 and, given that we're going to have so many more
22 births for TCE, that'll give us a lot more power to
23 find something. And so we can evaluate it, you know,
24 a lot more thoroughly at this point. Now, as far as
25 our timeline, as you know, we're very, very focused on

1 the birth defects study and the mortality study, so we
2 will be analyzing -- they're a high priority and this
3 is our third priority. So once I finish the birth
4 defects study, childhood cancer study, shortly, I will
5 begin analyzing this, and then Frank will start
6 analyzing this as well when he finishes up with the
7 mortality study. Any questions about this one?

8 **DR. CLAPP:** I have a question about -- this is a
9 published study that you're going to -- will you
10 submit this to the same journal as the update? Is
11 that the plan?

12 **MS. RUCKART:** I'm not sure what journal that was
13 in. Do you know, Frank? Well, we had talked about
14 submitting these three, the birth defects/childhood
15 cancer, mortality study and the adverse reproductive
16 outcomes as a package to Environmental Health
17 Perspectives. I'm not really sure at this point where
18 it will go, but that's our current thinking, it will
19 be good to have a package.

20 **MR. BYRON:** Yeah, hi, this is Jeff. The two
21 weeks for the shutdown at Holcomb Boulevard plant,
22 didn't we dispel that by saying that -- didn't we find
23 out that they were watering the base golf courses and
24 that the valves were being open?

25 **DR. BOVE:** Actually I was going to say something

1 but since you're bringing this up. These numbers will
2 change because some of the people who are unexposed
3 during entire pregnancy, nonetheless might have been
4 exposed for a month or two or three during the summer
5 months at Holcomb Boulevard, so -- and since we
6 analyze this data by trimester, I do anyway, I would
7 take that into account. So that 4,530 -- I mean,
8 these numbers will change. The key message of this
9 chart is that there's a substantial shift where we
10 couldn't really not look at trichloroethylene exposure
11 in the previous study because we only had 31 births we
12 thought were exposed to trichloroethylene with any
13 levels to speak of. And so now, that's drastically
14 changed so it's a different study now.

15 **MR. BYRON:** I'm going to go back a little bit,
16 okay, 'cause now that I've seen this. So my daughter
17 Andrea had aplastic anemia. Is that one of the
18 hematological diseases? Is that outside of the in
19 utero study? That would be outside of the leukemia
20 end of it?

21 **DR. BOVE:** Yeah.

22 **MR. BYRON:** So that would have nothing -- then
23 we'll drop that.

24 **DR. BOVE:** No, but I am looking at aplastic
25 anemia in the mortality study and we also ask about it

1 in the survey, yeah. So we are in the larger health
2 survey.

3 **MR. BYRON:** Okay. I'll talk to you after.

4 **DR. BOVE:** Yeah.

5 **HEALTH SURVEY**

6 **MS. RUCKART:** Okay, so moving on to the health
7 survey, I want to tell you that in June of this year
8 we mailed out the additional about 58,000 surveys to
9 the registrants who registered with the Marine Corps
10 by June 30th of last year. So far about 11,000 have
11 been returned, that's 18 percent, so that's some good
12 news. Jeff, you know what I'm talking about?

13 **MR. BYRON:** I was hoping it would be more.

14 **MS. RUCKART:** Okay. I wondered if you had a
15 question. So right now we're beginning the process of
16 confirming the diseases that were reported in the
17 health survey that we're interested in following up on
18 by getting medical records or confirmations from
19 cancer registries.

20 And so we're trying to confirm 5,777 cancers and
21 14,315 other diseases. This is a total of
22 20,092 conditions in 15,058 people, keeping in mind
23 this includes the Camp Lejeune and Camp Pendleton.
24 And I can let, if anyone would like me to, I can let
25 you know specifically which conditions we're following

1 up on. Anyone? Yeah? All right.

2 So the cancers include bladder, brain, breast,
3 cervical, colon, esophagus, kidney, leukemia, liver,
4 lung, lymphoma, multiple myeloma, pancreatic, rectal,
5 small intestine and soft tissue. And the other
6 diseases include kidney disease, liver disease, lupus,
7 scleroderma, Parkinson's disease, MS, ALS, aplastic
8 anemia, persistent skin rash with hepatitis,
9 infertility, and endometriosis. We're also going to
10 be looking at miscarriage but we're not going to be
11 seeking medical confirmation for that.

12 **MR. ENSMINGER:** Hey, Perri, what about
13 Parkinson's?

14 **MS. RUCKART:** I said that. Yes, yes. Yes, we're
15 going to be looking at that. As Frank mentioned, he
16 can't really evaluate that in the mortality study but
17 we will be looking at that in the health survey. We
18 are seeking confirmations, medical confirmations for
19 that. Do you have a question, Mary?

20 **MS. BLAKELY:** Yeah, maybe Richard could help me
21 with this one. What other diseases from a
22 neurological aspect would cause somebody to die, that
23 we could ask them to look at?

24 **DR. CLAPP:** I think they're all on her list.
25 Yeah, I can't think of any that she just read that

1 should be included that weren't there.

2 **MR. PARTAIN:** Perri, do you have this in paper
3 form to give out to us? I hadn't looked through it.

4 **MS. RUCKART:** I didn't give this out but I have
5 to find out from Dr. Portier if this -- you mean the
6 presentation or of the cancer --

7 **MR. PARTAIN:** Yeah, the numbers that you read.

8 **MS. RUCKART:** Well, is this something I can email
9 out, the numbers of diseases we're following up on?

10 **DR. PORTIER:** Just the general demographics that
11 we saw this many of this and this many of that, I
12 don't see why not.

13 **MS. RUCKART:** Just the total number of cancers
14 and total number of diseases among both Lejeune and
15 Pendleton?

16 **DR. PORTIER:** Sure.

17 **MR. BYRON:** I've got one question, too. It just
18 hit me. Has there been any diagnosed cases of toxic
19 shock syndrome as far as the deaths are concerned?
20 Have you looked at that as far as being a cause?

21 **DR. BOVE:** No, I don't even know if there's an
22 ICD code for that. No, I can't look at -- we can't
23 look at that. No, I just -- we just don't have --
24 our -- there's no code for that as far as I know, and
25 our source of information on cause of death would be

1 death certificate information that is at the National
2 Death Index, and they wouldn't have coded that so we
3 wouldn't have that information.

4 So if -- but we're able to look at a wide range
5 of diseases here, including -- as we're not just
6 looking at underlying, we're looking at contributory
7 causes. So if someone died of that, there may have
8 been a contributory cause that we would pick up.

9 **DR. CLAPP:** Again, I don't think there's a code
10 for that. It might be called septicemia but it
11 wouldn't be specific to toxic shock.

12 **MR. BYRON:** But you can clearly die from it,
13 right?

14 **DR. BOVE:** Yeah.

15 **DR. CLAPP:** Sure.

16 **DR. BOVE:** Yeah, yeah. I -- there are 119
17 disease classifications in this program I use. It's
18 NIOSH's, National Institute of Occupational Safety and
19 Health's program to look at comparing the exposed
20 population, or any population, with the U.S.
21 population, okay? And so you -- so I can look at 119
22 categories of different causes of death, yeah.

23 **MR. STALLARD:** So Perri, would you take us
24 through the last few slides?

25 **MS. RUCKART:** Sure. This is all review so we can

1 go through this quickly. But I just want to remind
2 you that health surveys were mailed to 283,972 study
3 participants or their next of kin. The overall
4 response rate was 27 percent, that's 76,026 surveys.
5 Now we had to have a data collection endpoint so that
6 we can move forward so this is as of the middle of
7 February this year.

8 Now, the former civilian employees from both
9 bases have higher response rates than the former
10 active duty.

11 **MR. PARTAIN:** Hey, Perri, I forgot to ask you, on
12 the diseases and reports you got back, anything about
13 thyroid conditions and thyroid cancers, thyroid
14 problems, anything showing up? 'Cause I know we
15 get -- we hear a lot about it.

16 **MS. RUCKART:** You know, with those health survey
17 data, we're just really at the beginning stages. We
18 haven't analyzed that or really looked at that. We're
19 typically focusing on the other studies.

20 **MR. PARTAIN:** Okay. I thought that's what you
21 were reporting from?

22 **MS. RUCKART:** No, I was -- this is what the
23 contractor told me, the conditions that they're
24 following up on, based on what we've seen -- it was
25 like a collaborated effort. This is what's reported

1 based on what we had in the survey, you know, because
2 specifically indicate they had. And then we went
3 through that and decided which ones we're going to
4 follow up on. And when we're more likely to see
5 something if there is something.

6 **DR. DAVIS:** And to take the example of thyroid,
7 there are many different factors that are suspected of
8 playing a role there. And you're not going to be able
9 to look at all of those as well, so I'm not sure
10 how -- what one can do with it.

11 **DR. BOVE:** We had a list of diseases that, for
12 the survey, that we, after a literature review, we
13 thought had some evidence. Didn't have to be strong
14 evidence, some evidence of an association with solvent
15 exposure; it didn't have to be just TCE or PCE; it can
16 be pretty much any solvent. In an occupational
17 setting where most of these studies are done, and also
18 from drinking water studies. And thyroid cancer isn't
19 one of those. I can, of course, look at thyroid
20 cancer in the mortality study. Just, it's one of
21 those 119 conditions, but as far as I know there
22 hasn't been any research linking thyroid cancer to
23 solvent exposure.

24 **DR. DAVIS:** That's correct. What I was going to
25 raise, which I know is a methodological nightmare, is

1 the following. While there is not much evidence on
2 thyroid cancer and solvent exposure, there is some
3 evidence on other common military exposures.

4 (multiple speakers)

5 **DR. DAVIS:** There's no way we're going to be able
6 to deal with that.

7 **DR. BOVE:** Right.

8 **MR. PARTAIN:** Well, my point in bringing it up
9 is, like I said, we get a lot of reports and we've had
10 numerous families contacting us with thyroid problems,
11 and including thyroid cancer. And, you know, I guess
12 we just need to ask the question, is there something
13 out there? And, you know, if the data's there and
14 it's been reported, you know, are we going to ignore
15 the, you know, the reports and just focus on what
16 you're saying there. I guess my question would be:
17 If there is a presence of an abnormal number of people
18 with thyroid cancers at Camp Lejeune, is that going to
19 prompt ATSDR to ask the question why?

20 **DR. BOVE:** Well, again, I mean, I can look at it
21 in the mortality study to the extent that it's worth
22 looking at. I mean, thyroid cancer is another one
23 that doesn't necessarily kill you. But, you know, I
24 can look at it in the mortality study.

25 As for the survey, we ask for all -- any cancer

1 the person might have. And we're going to check with
2 the cancer registries to confirm those. Again, we
3 have a list of ones we're primarily concerned with
4 because there, you know, there's some evidence that
5 thyroid cancer is among those candidates, but again,
6 if a person reported it we could send that to the
7 cancer registry as well.

8 **MR. PARTAIN:** And I'll just point out real quick,
9 one of our former CAP members, Denita McCall, was a
10 parathyroid cancer survivor, and I don't know if her
11 passing is part of the database that's being collected
12 on the mortality study. She passed in June of 2009.

13 **MS. RUCKART:** No. It only goes up to 2008.

14 **MR. STALLARD:** Yes, Dr. Portier?

15 **DR. PORTIER:** Yeah, so Mike, when you do these
16 types of studies, one of the reasons you search the
17 literature in advance and decide what you're going to
18 look for, specifically, is it gives stronger
19 confidence that you found something real. Because
20 you've laid out the hypothesis before doing the study,
21 you're not fishing for something new. You're actually
22 trying to strengthen evidence that already exists. So
23 that's what they have done to this point.

24 However, you can also do some fishing as a
25 separate issue of this type of thing. And they will,

1 and if they see something, then we will try to go
2 after the necessary resources to validate the whatever
3 it is and bring it back into the study. But it will
4 have less strength to it because there will be no
5 other literature supporting it. Okay?

6 **MR. PARTAIN:** I just want to make sure that if
7 something's there or seeing that we're asking that
8 question. We don't want to leave the white elephant
9 sitting in the corner of the room there.

10 **DR. DAVIS:** And I just want to add a comment to
11 what Dr. Portier just said. It seems that we're --
12 the study is largely a study of solvents and their
13 effects on health, and not other military exposures.
14 And I just think if that is the case, we need to make
15 that clear because thyroid cancer doesn't usually kill
16 people, and so it would be unlikely to show up in the
17 mortality study; it may show up in the survey. And it
18 has, you know, many different potential causes
19 including x-rays have been associated with it,
20 diagnostic x-rays for example or therapeutic x-rays.
21 So we're not able to evaluate all of these different
22 things, which may have occurred in greater exposures
23 to the military population. And it seems as if the
24 study is increasingly a study of solvent effects and
25 not on other things at all. And that is correct --

1 I'm asking the question -- is that correct?

2 **DR. DEARWENT:** Absolutely. It is only about
3 solvent exposure.

4 **MS. RUCKART:** Drinking water, drinking water.

5 **DR. BOVE:** These particular drinking water
6 contaminants.

7 **MR. STALLARD:** Okay, Perri.

8 **MS. RUCKART:** Just, just very briefly, this is
9 not new information so I don't think we can spend a
10 lot of time on it. I presented this last time, the
11 participation rates and the overall of 27 percent.
12 There's another way you could think about this, the
13 cooperation rate. I mean, this number, 27 percent, is
14 just we mailed out this many surveys, we got this many
15 back, we calculate, you know, it was 27 percent.

16 But then you have to keep in mind that we know
17 that not all the surveys actually got to the intended
18 person even though we tried to find a good address for
19 everybody. Maybe it didn't work out or the person
20 never opens it or there's all kinds of reasons that
21 when you factor in all these reasons, and we do have
22 some information about which ones couldn't be
23 delivered and things like that, the cooperation rate,
24 which it's called, could be as high as 37 percent, and
25 we can discuss that when we get to that point of

1 writing up the study.

2 **DR. AKERS:** I'd like to add something to what
3 Dr. Davis mentioned, the therapeutic and diagnostic
4 x-rays. There was a common practice in medicine years
5 ago that acne was treated with x-ray, especially acne
6 on the chest and face, this sort of thing. So we were
7 in essence exposing our patients to levels of
8 radiation that they didn't need but it was at that
9 time a common medical practice.

10 **MS. RUCKART:** And also on the refusals, just want
11 to let you know that we do have some information on
12 people who actively refused. In the second survey
13 mailing, we included a postcard for people to indicate
14 why they didn't want to participate, if they didn't
15 plan to. So those are called active refusals. Many
16 of the people who just never responded at all, we know
17 they're a refusal, but for those that we actually
18 could find out the reasons for not wanting to
19 participate, these are the codes from the first 901
20 postcards we received. About a third didn't have any
21 health problems; a third didn't want to provide
22 personal information; 21 percent: waste of government
23 money; 10 percent: it would take too much time and
24 effort; and 7 percent: didn't think the survey was
25 important. That just gives you a snapshot of the

1 reasons for refusal. That's all I wanted to update
2 you on.

3 **MR. STALLARD:** All right. We're about ready to
4 eat into your lunch period.

5 **MR. BYRON:** Okay, I'm going to ask one question.
6 I hate to keep running back to Midway Park but I got
7 concerns. Because I'd like to know from you guys
8 right now, were any children excluded that were in
9 Midway Park that were in the in utero study because
10 you did not know about the contamination until about a
11 year and a half ago?

12 **MS. RUCKART:** No, no.

13 **MR. STALLARD:** Okay, then. That concludes our
14 morning session. We're going to go to a lunch break
15 now and we will start at 1:00 o'clock with the male
16 breast cancer update. Please be back and seated,
17 ready to go or be back on the phone for 1:00 o'clock.
18 Thank you.

19 (Lunch recess, 11:54 a.m. until 1:00 p.m.)

20 **MR. STALLARD:** All right, folks, please take your
21 seats; we're about to commence.

22 Okay, may I remind you of our guiding principles.
23 Thank you so much for your willingness to support
24 those in our endeavors thus far. I remind you to
25 please turn off your cell phones or put them on stun,

1 if you have used them during the break.

2 And as promised, at 1:00 o'clock, we're now going
3 to get into our male breast cancer. Yes?

4 **DR. PORTIER:** Just very quickly, I wanted to
5 address Mike's question to me. Mike, the answer's
6 yes.

7 **MR. PARTAIN:** Okay.

8 **MR. STALLARD:** Wait, what was the question?

9 **DR. PORTIER:** The question Mike asked was whether
10 or not we would give the CAP a copy of any of our
11 reports at the same time we bring them over to the
12 DON, and the answer is yes.

13 **MR. PARTAIN:** Thank you very much.

14 **MR. ENSMINGER:** What was that?

15 **MR. STALLARD:** The answer was yes. To what
16 question?

17 **MR. ENSMINGER:** Yeah.

18 **DR. PORTIER:** I'll repeat it, Jerry. Mike had
19 asked if we would be willing to give the CAP copies of
20 any of our reports at the same time we gave them to
21 the DON, and the answer to that is yes, they will be
22 embargoed so you won't be able to share them with
23 anyone else but it will give you time to read them and
24 understand them prior to our final release of those
25 documents. And that way, if there are questions to

1 you, you'll be prepared to be able to answer them.
2 Seems appropriate to us.

3 **MR. ENSMINGER:** Yeah, because I noticed in the
4 MOU that, under the guide or the rules of the MOU,
5 you've got to provide them your draft reports, and
6 they have the opportunity to comment.

7 **DR. PORTIER:** Actually what it says in the MOU is
8 when appropriate, we would do that. And in this case
9 I have deemed that providing them a draft copy to
10 comment prior to release of the document would not be
11 appropriate; hence, we will not be doing that, but we
12 will be working with them to provide them --

13 **MR. ENSMINGER:** Oh, oh, good.

14 **DR. PORTIER:** -- with the document in advance of
15 our release, so they are well aware of what is in the
16 document.

17 **MR. ENSMINGER:** Well, okay. Well, I applaud your
18 decision that it's not appropriate. Thank you.

19 **MR. STALLARD:** All right. Whom do we have on the
20 line, please? Besides Jerry?

21 **MS. BRIDGES:** Sandy Bridges.

22 **MR. STALLARD:** Hello, Sandy. Welcome back.

23 **MS. BRIDGES:** I'm sorry I couldn't be there.

24 **MR. STALLARD:** Well, it's hot and sweltering here
25 so enjoy where you're at. All right, then Steve, if

1 you're ready --

2 **MS. BRIDGES:** I know it's hot. I was surprised
3 to see Jeff's hair. He's as gray...

4 **MR. STALLARD:** Yeah, he's as handsome as ever.
5 Thank you for pointing that out. May I remind you
6 please, those on the phones, to put your phones on
7 mute when you're not speaking. Thank you. Steve?

8 **MR. ENSMINGER:** Yeah, well, you know it must be
9 hot and sultry down there but I'll bet it's not over
10 at the pool there in the hotel, huh?

11 **MR. STALLARD:** No comment.

12 **MR. ENSMINGER:** And I have a question. If
13 Partain went in the pool, is there any water left in
14 it?

15 **MR. STALLARD:** He did a cannon ball, and they're
16 refilling the pool.

17 **UPDATES ON MALE BREAST CANCER STUDY**

18 **DR. DEARWENT:** Boy, that's a tough act to follow.
19 Okay. So I'm going to discuss the male breast cancer
20 study today and updates.

21 Before I do, though, I'd like to introduce
22 myself, since this is -- I'm new to the table, I
23 guess. I observed at the April 2nd meeting and it's my
24 first time to actively be involved in the CAP. I'm
25 Steve Dearwent, I'm Chief of the Environmental

1 Epidemiology Branch. As many of you know, we have or
2 still are undergoing a reorganization. It's not, you
3 know, finalized yet but as part of that
4 reorganization, the entire portfolio of Lejeune
5 epidemiologic work was transitioned into our branch.
6 So we're now working with Perri and Frank and Eddie,
7 and this is, I guess, my first time to officially
8 participate. So nice to meet you guys.

9 So first of all, I know we briefly discussed the
10 male breast cancer study at the last meeting and
11 didn't have a lot of substance to update you on. I
12 think we have more substance this time around. So
13 it'll be a little bit lengthier and more in-depth
14 presentation. So for today's discussion, first of
15 all, going to revisit some of the things that Eddie
16 Shanley discussed at the April meeting, and then give
17 you an update on what's occurred in the last three to
18 four months in terms of the NPRC assessment, where
19 Eddie Shanley went to St. Louis for almost a full week
20 in late May to look at a subset of those records,
21 assess if this was going to be a feasible study or
22 not. And then also I'm going to give you an update on
23 our study protocol. And then following those updates,
24 we'll go in and do an overview of the proposed study
25 protocol and then provide you with a list of next

1 steps.

2 Just to go back to the last CAP meeting in April,
3 Eddie talked about breast cancer cases that were
4 reported to the VA, to their central cancer registry;
5 that is the source of all cases and controls for this
6 study. Currently the VA cancer registry is indicating
7 they have 61 male breast cancer cases. That's from
8 the start-up of the VA registry, which was in 1995
9 through the end of calendar year 2010. That is the
10 current number that they've given us but our
11 qualification is that that, for study purposes, is an
12 estimate right now.

13 First of all, there will be, you know,
14 inclusionary, exclusionary criteria so some of those
15 cases may fall out because they don't meet the
16 inclusionary criteria. There may also be additional
17 cases that are, that are added to this that just
18 haven't, you know, weren't collected in this total
19 number.

20 The deal with cancer registries is they usually
21 do close-out on a year about 18 months later, so if
22 we're, you know, midway through 2012 the, you know,
23 the final data that they have for any one year will
24 only go up through 2010. And that's -- so we'll
25 probably be, you know, limited to this time frame,

1 from 1995 through 2010 for inclusion of cases.

2 So that 61 right now is an estimate. That's what
3 the VA has told us they currently have. As indicated,
4 there could be additional cases that have come in
5 since we've gotten that estimate, and then we'll have
6 to apply the study criteria, and so some of those may
7 fall out. So that's kind of a, you know, a rough
8 estimate right now. It'll fluctuate a little bit.

9 As you guys know, Eddie Shanley's the lead on
10 this project. Since all the Lejeune work has been
11 transitioned into our branch, I'm working with Eddie,
12 as is Frank and Perri. And we're working through the
13 protocol right now; we'll probably be involved in some
14 of the abstraction of the data, and they've
15 reviewed -- and we have all reviewed the protocol and
16 provided comments. They will help with analysis, what
17 have you, so we're, you know, we're treating this as a
18 team effort, as you've seen with all the studies here.

19 So in late May, Eddie went to the NPRC in St.
20 Louis. What we did is we started with a subset of
21 records, a total of 21 records. And that subset was
22 defined using different time periods and I believe
23 different ranks also. I know there were a couple
24 criteria that we used to try to get a somewhat random
25 smattering across time frames and ranks and what have

1 you, to see, you know, how the records, if they were
2 available, if they were sufficient for our needs, what
3 have you.

4 And after about a week out in St. Louis of
5 abstracting the records, we concluded that they do
6 contain the information necessary for assigning
7 exposure levels. And, you know, the way we were doing
8 that is basically the times you were on base and where
9 you were on base when you were there.

10 So some of the records in the NPRC or at the NPRC
11 that are relevant here are obviously your records of,
12 you know, your service, training, your dates of
13 separation or date of separation depending on your
14 specific scenario.

15 And this next slide, I believe, will give you an
16 idea of some of the specific document types that Eddie
17 was looking for. I think the vast majority of them
18 were on microfiche, which is challenging in and of
19 itself. But you can see, you know, he was trying to
20 identify for these 21 individual Marines whether there
21 were documents at NPRC that dealt with separation,
22 that gave some chronology of their service and any
23 indications of deployment or training, and also
24 information on the family or, you know, dependents
25 status. So for the most part, you know, those records

1 are available, specifically for unit codes and dates
2 of service, which are the big two that we have to
3 have; knowing, you know, when they were there and how
4 long they were there. Those are the, you know, the
5 criteria which we will use to then assign exposure
6 based on the water modeling that Morris has done.

7 So following the trip to St. Louis back in May,
8 when, you know, we were able to see that this was
9 feasible using those records, Eddie came back to
10 Atlanta, revised the protocol accordingly. Frank,
11 Perri and I reviewed, provided comments. And at this
12 point we are doing some of our required administrative
13 review in tandem to expedite the process. By law,
14 based upon the superfund legislation or enabling
15 legislation, we have to have external peer review done
16 for all health studies for both the protocols as well
17 as the final publications. And so the study protocol
18 has gone out. By law it has to go to, I think,
19 somewhere between three and five disinterested,
20 uninvolved scientists, you know, third-party
21 scientists to provide us peer review and comments
22 back.

23 We're then required to respond to all of those
24 comments, adjust the protocol accordingly, if we
25 agree, and if we don't agree with the comments, state

1 why we don't. And that entire package, both the
2 protocol, all the external peer review comments that
3 come in from extramural scientists as well as our
4 responses, that entire package goes up through the
5 center for clearance.

6 At the same time that we're doing this external
7 peer review and clearance of protocol, we're also
8 putting it through the CDC's IRB, which is required
9 whenever you're dealing with human subjects, so these
10 are kind of two different required administrative
11 reviews, but we're doing them in tandem for, you know,
12 for the sake of timing.

13 For the external peer review, ironically just
14 this morning I got an email from our Office of Science
15 indicating that it has gone out. We are not allowed
16 to indicate who the three external peer reviewers are.
17 We have to protect their privacy, just so they know
18 whatever the comments they make to us about the
19 protocol, whether it's thumbs up, thumbs down or
20 somewhere in between, that that's kind of confidential
21 information from them. And I think that's a good
22 thing because it basically allows them to say whatever
23 they think without having to worry, you know, if there
24 will be some public review or perception or what have
25 you, so I think it frees them up to really speak to

1 the science and the, you know, methods and what have
2 you, and give us strong feedback.

3 **MR. ENSMINGER:** I have a question on that point.

4 **DR. DEARWENT:** Yes, sir.

5 **MR. ENSMINGER:** So you say you're not going to
6 reveal the names of your peer reviewers; however, do
7 you reveal their comments to the public?

8 **DR. DEARWENT:** On protocols, I don't think that
9 we do. I think we typically, when we release a final
10 document, we do provide to the public the external
11 peer reviewers' comments and our responses to the
12 final, you know, publication. I don't think we do
13 that for protocols, though. But as indicated we do
14 have to, you know, address each one of those comments,
15 and that's part of the package that goes up through
16 clearance and internally. It's kind of a QA/QC
17 process.

18 Now, I can speak --

19 **MR. ENSMINGER:** Well, at least you guys, you
20 know, release your peer reviewers' comments. I mean,
21 the National Academy doesn't do that, I mean, so how
22 the hell you know anybody even peer reviewed it?

23 **DR. DEARWENT:** I will say for three external peer
24 reviewers, all three of them are at academic
25 institutions, all three have published on breast

1 cancer and solvent exposure, and in, I think, at least
2 one case, it was specific to male breast cancer. So
3 they are subject matter experts. And Dr. Portier has
4 a comment.

5 **DR. PORTIER:** Yeah, Jerry, just to make it clear,
6 this is on the protocol. We always, for documents
7 that ATSDR releases, when those documents get peer
8 reviewed, those comments are captured and when we
9 release the documents we release the peer review
10 comments, our response to them and who the commenters
11 were.

12 For protocols it's slightly different but in fact
13 we would be foolish not to pay attention to scientific
14 input on our protocols because if the protocols are
15 wrong, the study in the end will be criticized
16 extremely heavily. So these will be looked at with
17 great scrutiny.

18 **MR. ENSMINGER:** Well, you know, I'm glad to hear
19 you guys do release your peer review comments and your
20 peer reviewers; that's great, I mean, that's
21 noteworthy. But, you know, it doesn't seem to hurt
22 the National Academy of Sciences -- well, I mean,
23 nobody makes them have more transparency. I mean, how
24 can anybody even consider them a legitimate scientific
25 body anymore? But, I mean, that's another story. Go

1 ahead.

2 **MR. STALLARD:** Yes, Jerry, that is.

3 **DR. DEARWENT:** Another story for another day.
4 One thing that Frank just pointed out to me, it's a
5 really valid point, is if something comes up in the
6 peer review, the protocol, that is, you know,
7 concerning, that, you know, challenging to address,
8 what have you, I think that's open game for us to come
9 to the CAP or at a minimum to talk with Dr. Clapp and
10 Dr. Davis about, you know, their thoughts and get some
11 other perspectives on, you know, how to address
12 whatever those concerns may be.

13 So in terms of the external peer review, it's
14 gone out, the due date to have comments back from peer
15 reviewers is, I think, August 20th or 21st, so it's,
16 you know, it's a pretty quick turnaround time. I
17 would expect us to have something back from our IRB by
18 the end of August, since that's usually a four to six
19 week review process on their part. So by late August,
20 early September, we should have, you know, all of this
21 stuff back with us, and at that point we'll have to
22 respond to peer review comments and put the full
23 package through internal clearance.

24 While that's going on and we've gotten the
25 sign-off by CDC's IRB, we'll then go to the VA IRB.

1 That'll be the next step in the process 'cause we also
2 have to get their approval.

3 So, you know, the way things time out here, it
4 will be probably sometime this fall before we've got
5 the IRBs from CDC and the VA approvals as well as our
6 external peer review and internal clearance. Once
7 those three things are done, the VA will then be able
8 to provide us -- or actually their cancer registry
9 will be able to provide us all the participant data,
10 and that's both the cases and controls, the cases
11 being the male breast cancer cases in the VA cancer
12 registry, and the controls being another set of
13 cancers as yet to be identified. And we'll get to
14 that. We've got some thoughts on what other cancers
15 that we'll consider.

16 But once we have all the participant data back,
17 at that point, we'll have to go back to St. Louis,
18 that's probably going to be, you know, about 300
19 individuals that we're going to have to start doing
20 data abstraction on from the various records in NPRC.
21 So I gather Eddie's going to be spending a lot of time
22 in St. Louis in early 2013.

23 So I'm just going to quickly go over the current
24 proposed study protocol, talk about the design, the
25 purpose and the methodology.

1 So in the foundation for the study design, and,
2 you know, I don't mean to speak down to anybody here.
3 A lot of this'll be painfully obvious. I just want to
4 make sure we're all on board and understand exactly
5 what's happening. You know, the study will evaluate
6 the association between male breast cancer and
7 exposure to drinking water contaminated with VOCs,
8 specifically TCE, PCE, vinyl chloride, DCE and
9 benzene. So all five of our VOCs of concern.

10 So the case control study, generically it enables
11 you to compare one group to the other. Your cases in
12 this case will be male breast cancer cases, and our
13 controls, the comparison group, will be participants
14 with other cancers, but obviously not breast cancer.

15 In this situation, you know, we'll already know
16 the outcome. Working through the VA cancer registry,
17 we'll identify the cases, the male breast cancers and
18 the controls being, you know, other non-solvent
19 related cancers. So the difficult part is then going
20 back and assigning exposure to those individuals.
21 And, you know, obviously the exposure is from Morris's
22 water modeling combined with the residential location
23 and time of residence that we'll get from the NPRC
24 data.

25 **MR. PARTAIN:** Question on the other cancers.

1 What type of cancers are you looking at to use as your
2 control?

3 **DR. DEARWENT:** We've got quite a laundry list,
4 and I know, I think there's even been some emails in
5 the last month between Frank and Dr. Davis on, you
6 know, possible, you know, choosing this one versus
7 that one. I think in the protocol at this point we've
8 provided a list of say eight to ten to 12 possible
9 cancers, and I'm hopeful that some of the input we get
10 back from peer review is, you know, you should look at
11 this one versus that one. And I've got a couple
12 slides that gets into that list of possibilities.

13 So the study purpose to evaluate the odds of
14 being a case, how that varies between your levels of
15 drinking water contamination, while you lived at
16 Lejeune, that's the primary one. And the other one is
17 to compare the odds of being a case stationed at
18 Lejeune versus not being there, the Pendleton group.

19 **DR. BOVE:** Well, just any other base.

20 **DR. DEARWENT:** Well, not just -- yeah, not just
21 Pendleton but not -- non-Camp Lejeune Marines.

22 **DR. DAVIS:** Just to clarify, so the comparison
23 cases will be non-Camp Lejeune cancer cases?

24 **DR. DEARWENT:** Correct. And which cancers those
25 are is yet to be determined. And that's, you know,

1 and we're about to get to kind of the laundry list
2 that we'll obviously have to select from. And it may
3 not be all inclusive; there may be others that we've
4 yet to identify. So the study population: male
5 Marines; they must have been born between -- or before
6 January 1st of '69, and that is to make sure that
7 someone was, what, 17 or 18 -- they were of age to
8 have been a Marine and served at Lejeune before 1985.

9 **DR. DAVIS:** So this will exclude anyone who might
10 have developed breast cancer from prenatal exposures?

11 **MS. RUCKART:** Unless their mother --

12 **DR. DEARWENT:** Unless their -- no, because they
13 wouldn't be in the VA cancer registry.

14 **MR. PARTAIN:** Yeah, technically I would -- if I
15 had joined the Marine Corps I would be one of the
16 ones --

17 **DR. DEARWENT:** Yes, if you were born after '69.

18 **MS. RUCKART:** Yes.

19 **MR. PARTAIN:** I was born in '68, and if I had
20 joined the Marine Corps, I could potentially have
21 been --

22 **DR. DEARWENT:** Yes.

23 **MR. PARTAIN:** There's a lot of families where --
24 and, you know, and I don't know if you guys have
25 identified that, but there are families where you have

1 grandpa was a Marine, dad's a Marine, son's a Marine,
2 you know, generations. So I guess keep an eye out for
3 that.

4 **DR. DEARWENT:** Okay.

5 **MR. STALLARD:** You have a question?

6 **DR. PORTIER:** Steve, let me clarify something.
7 Can you back up one slide, just for a second? Steve,
8 isn't it, evaluate the odds of being exposed?

9 **DR. DEARWENT:** Absolutely, yes.

10 **DR. PORTIER:** Getting their case and the -- okay.

11 **DR. DEARWENT:** Yes, yeah.

12 **DR. PORTIER:** I just want to make sure my -- our
13 scientific colleagues were paying attention and don't
14 claim we're kind of a little bit off the mark here.

15 **DR. CLAPP:** That's pretty good for a toxicologist
16 to pick up.

17 **DR. DAVIS:** He's not an ordinary toxicologist.

18 **DR. DEARWENT:** He's special. Yes, you're right.
19 Thank you for that clarification.

20 So, yes, this bottom line, male Marines, born
21 before January of '69, and the sticking point is you
22 have to be diagnosed or treated for cancer at a VA,
23 after -- between the '95, 2010 time frame.

24 So, you know, for cases, they must be diagnosed
25 and histologic confirmation of male breast cancer,

1 which is what you get when you deal with a cancer
2 registry; you'll get that data.

3 For controls, your controls have to come from the
4 same population; that's why we're, you know, Mike,
5 obviously your list of 80, we will have individuals
6 that you've identified that won't meet these criteria.
7 So the controls have to come from the same population
8 from whence the cases do, which is the theoretically
9 from Marines, but Marines who were seen by the VA,
10 diagnosed and captured within the VA cancer registry.

11 **MR. PARTAIN:** Let me ask you, with the list that
12 I have, the -- I know there are Marines who have gone
13 through the VA process, with male breast cancer, that
14 I have on the list. Is there any way we can
15 cross-check those to make sure that everyone was
16 captured through the VA system?

17 **DR. DEARWENT:** I think it might be kind of a
18 one-way cross-check.

19 **MR. PARTAIN:** Yeah, I know that.

20 **DR. DEARWENT:** We can take your list but we can't
21 go back and say, yes, no, yes, no on your list to you.
22 But if you're willing to supply that to us, we'd love
23 to have that.

24 **MR. PARTAIN:** Yeah, we'll talk about that.

25 **DR. DEARWENT:** Okay.

1 **MR. PARTAIN:** Yes, and the only thing I would ask
2 is just, I know you can't tell me who or what, but
3 when if there are any additions that are added that
4 weren't captured, I would like to know about that.

5 **DR. DEARWENT:** Okay.

6 **MR. BYRON:** So this is Jeff. So this is only
7 cases that are captured through the VA from '95 to
8 2010?

9 **DR. DEARWENT:** Correct.

10 **MR. BYRON:** Can you explain that?

11 **DR. DEARWENT:** Well, the VA cancer registry
12 started in '95. So that's, you know, and actually
13 most state-based registries started in the mid-90s.
14 It was a big effort by CDC to get state-based
15 registries. There are some states, probably
16 Massachusetts being one of them, it might be the best
17 example, that have been around for a long time. What,
18 30s, 40s, 50s?

19 **DR. CLAPP:** That's Connecticut but Massachusetts
20 was '82.

21 **DR. DEARWENT:** Oh, okay. I knew there was one of
22 those in the Northeast that's been around forever.

23 Okay, and you know, for inclusion, those with
24 cancers not known -- for the controls, to be a
25 control, you got to have a cancer not known to be

1 associated with VOC exposure and never stationed at
2 Lejeune.

3 At some point we're going to get to a table.
4 There we go. So, you know, the question is: What
5 cancers to use for our control series? These are all
6 cancers not known to be associated with VOC exposure.
7 For those that know the incidence or prevalence for
8 some of these conditions, some of them would not be of
9 much utility; mesothelioma is such a rare cancer.
10 You're not going to have enough controls to really
11 make that, you know, worthwhile. Prostate's probably
12 on the other end of the spectrum where they'll be, you
13 know, there are plenty of prostate cancers but, you
14 know, we probably would not want to focus specifically
15 on a specific cancer or just one cancer to use as a
16 control. And this is one of those areas where, you
17 know, we'll hopefully get some feedback during the
18 external peer review as well as from Drs. Clapp and
19 Davis.

20 **DR. BOVE:** Let me say one or two things. One is
21 that we may also include on that list other skin
22 cancers depending on what the VA actually captures in
23 terms of skin cancers. Cancer registries vary on how
24 they capture skin cancers or melanoma.

25 The other thing is that the cases are all male

1 breast cancers among Marines, doesn't matter what base
2 they're in. The controls are also all Marines with
3 these other cancers, doesn't matter what base, okay?
4 Then we look and see which cases come from Lejeune and
5 we compare them to -- and which controls come from
6 Lejeune as well, and compare them to cases and
7 controls on other bases. That's roughly how it's
8 done, okay.

9 But then we're also going to look at different
10 exposure levels. But just keep that in mind. The
11 problem here is that the term control is sometimes
12 used in the context of, like say toxicology studies
13 where it means that the rat that didn't get the dose,
14 okay. But in case control methodology, it's basically
15 a sampling method. Controls are not those who are
16 unexposed; controls are just the comparison
17 population. And you can do it fairly swift. What
18 you're trying to do, and this came up in a discussion,
19 I think, with you, Mike, during the briefing a couple
20 of weeks ago. Trying to get a handle on what the
21 characteristics are of this population that gave rise
22 to these breast cancers, okay?

23 And by taking a sample of that population -- we
24 don't really know what that population is. We're not
25 sure who the VA covers, and it's a population that

1 changes, probably constantly. People coming into the
2 VA system, people going out of the VA system, people
3 going other places for healthcare and so on. So it's
4 a changing population.

5 But we can take a sample of it, even if we
6 didn't -- can't define it very well. We can take a
7 pretty good sample of it by looking at other cancers
8 that aren't related to solvents and using that as the
9 sample, because these people, if they had a cancer, or
10 one of these cancers, would have gone to the VA and
11 would have been captured by the VA cancer registry.
12 So by looking at other cancers that aren't related to
13 solvents, we get a handle on this underlying
14 population, the denominator that we don't have with
15 your population, basically, okay?

16 So that's the -- so the cases come from all the
17 Marines in the VA cancer registry; the controls come
18 from all the other cancers that aren't related to
19 solvents, and that's how it's done. Is that -- is
20 everyone... okay.

21 **DR. DEARWENT:** I think, in a perfect world, every
22 Marine would have always been seen by the VA for life
23 and all of them would be captured in the VA cancer
24 registry, but that's not how it works, unfortunately.

25 So this is our kind of the list to start from,

1 then we'll have to narrow it down a little bit at some
2 point.

3 **DR. DAVIS:** And I'll be providing you with
4 detailed comments but I can just tell you right now
5 that two cancers that are in the list may well not be
6 in the list, and that is testicular cancer and
7 prostate cancer.

8 Testicular cancer's been identified in analyses
9 of men who work in the aerospace (phone line
10 interruption) and the solvents to be increasing in men
11 with solvent exposure. And prostate cancer's been
12 identified with studies of people exposed to something
13 called Stoddard solvent has increased as well, so I
14 think that they're not likely to make it onto the
15 final cut, but I appreciate this is an iterative
16 process, and I'm looking forward to working with you
17 constructively on it.

18 **DR. DEARWENT:** Great. That's exactly the type of
19 feedback we're looking for. Thank you.

20 And so the long list of those that have been
21 excluded already, unfortunately there are a lot of
22 cancers associated with VOC exposure, and so, you
23 know, after going through the lit review for PCE, TCE,
24 VC and benzene, you can see that many of the cancers
25 and many of those that are the most incident or

1 prevalent are going to be excluded.

2 Another data source that we'll be relying on is
3 the VA's patient treatment files, and the reason for
4 this is there is information that we will need that's
5 not available in the VA cancer registry. We need to
6 look for other conditions that are associated with an
7 increased risk of male breast cancer, and here some
8 examples are Klinefelter's, gynecomastia and obesity.

9 **MR. BYRON:** This is Jeff. That's what I was
10 talking about earlier, the VA report that identifies
11 risk factors. But yeah, I'm interested and I hope
12 that, even though I'm leaving the CAP, if I have to
13 pay for the results of the study so I'll be glad to.

14 **DR. DEARWENT:** But I think we already have a plan
15 in place, you know, as these things come out, to make
16 sure they're disseminated far and wide and, you know,
17 with you guys as well, so God forbid you have to pay
18 for it. You've already paid for it with your taxes,
19 among other things.

20 **DR. DAVIS:** This is typically a very small point
21 but I notice that about .1 percent of your cases are
22 reported as transsexuals, and I suspect you want to
23 exclude them from this analysis because people who are
24 formally identified as transsexuals typically go
25 through massive amounts of hormone treatment in order

1 to grow breasts, which are in fact known to increase
2 the risk of breast cancer. It's a small number of
3 cases but I just would point that out. You want -- I
4 think you probably want to exclude them from the
5 study.

6 **DR. DEARWENT:** Okay, thank you. So for exposure
7 assessment, you know, as indicated we'll, you know,
8 have to assess personnel records, identify, you know,
9 when participants were stationed at Camp Lejeune, and
10 if so, where and for how long.

11 We then take the estimated monthly VOC drinking
12 water contamination levels, and using that combined
13 with their residential history on the base, we'll be
14 able to assign the monthly exposure to each
15 participant, each case and control. And then you've
16 got a listing there of some of the personnel records
17 and who maintains them, the different data sources
18 we're relying on.

19 So just to be clear in our exposure assessment,
20 Marines that are not stationed at Camp Lejeune are
21 assumed to be unexposed to VOC contaminated drinking
22 water. And those that are stationed at Lejeune will
23 require additional data abstraction, as I discussed a
24 few times here, for their location of residency, and
25 yeah, that includes barrack locations for enlisted

1 single Marines, officers' quarters for some single
2 officers and family housing records for married
3 Marines.

4 So it's going to be -- I guess the sticking point
5 in all this it's going to be trying to link up a lot
6 of disparate data sources, a lot of data abstraction
7 off of microfiche in St. Louis. I shouldn't minimize
8 how challenging that will be, and I think it'll mirror
9 some of the stuff that, you know, that Frank and Perri
10 have dealt with dealing with some of these data sets
11 that, you know, aren't perfect by any means.

12 **MR. ENSMINGER:** I got to interject something
13 here. This is Jerry Ensminger. I think you are
14 barking up the wrong tree by doing -- by trying to
15 identify where these people lived. Okay? The reason
16 I'm saying that is because there are -- there is no
17 information in Marine service record books to what
18 barracks or where they lived on base.

19 All right, number two, what you need to
20 concentrate on is the command that they were assigned
21 to. Because it doesn't make a damn where he -- you
22 lived. You were at work every day, if you were at
23 Hadnot Point, and you were being exposed every day
24 while you were at work. Not only while you were at
25 work, you had to come in three to four times every

1 week and participate in physical training, PT, for
2 which you didn't get to go home after PT to take a
3 shower and change your clothes. You brought your
4 clothing along and you took the shower in the barracks
5 or at your work place, if showers were there, and then
6 you went to work for the rest of the day.

7 **DR. DAVIS:** And let me add, these National
8 Academy of Sciences report on drinking water and
9 health, volume six, had a modeling study in 1986 that
10 showed that 50 percent of your exposure to volatile
11 organic compounds in drinking water comes from
12 cooking, bathing and showering.

13 **DR. DEARWENT:** Yeah, this is one area we will
14 lean heavily on Frank and Perri and their experience
15 based on the other studies because I know it's
16 something you guys have had to deal with on a pretty
17 constant basis.

18 **MR. ENSMINGER:** Well, I'm just telling you
19 there's no way you're going to find out where these
20 people were barracked, okay; it's not in their service
21 records. You're not going to find that information in
22 any records in St. Louis.

23 **DR. BOVE:** Correct. This is Frank. But what we
24 can do is what we're doing in the mortality study, is
25 getting some sense of where people were barracked,

1 based on the memories of your -- by yourself, for
2 example, and others. And we use that information and
3 see if that affects the analysis. We do a couple of
4 different kinds of analyses here, including just
5 looking at Lejeune versus the other bases, with this
6 in mind, that people get exposed no matter where their
7 residence is, whether it's off base, on base, whether
8 the barracks are at Hadnot Point or somewhere else on
9 base. But we want to use all the information we --

10 **MR. ENSMINGER:** That's fine but what I'm trying
11 to avoid, Frank, is people being prejudiced because
12 they didn't actually live on the base. If a guy was
13 married and was living off base, the way it sounds,
14 from what I just heard, that person would not be
15 included in the study.

16 **DR. BOVE:** No. No. No, no. No. They're
17 included in the study. The question is: How do --
18 what to assign as their exposure. So the first cut is
19 to look at Lejeune versus the other bases, okay? So
20 this person, because they're assigned to Lejeune, no
21 matter whether they lived on or off base or where they
22 lived on base, they are considered exposed for that
23 analysis.

24 And then we try to tease out whether we can use
25 the family housing records and the barrack locations

1 **DR. BOVE:** Okay, okay. Sorry.

2 **DR. AKERS:** Back in the 50s and 60s, they were
3 Marines, they had MOSs, butchers and bakers and meat
4 cutters. They were in the Corps, had gone through
5 training.

6 **MR. ENSMINGER:** That occupational field was the
7 3300 field.

8 **MS. RUCKART:** But you know, there is one group of
9 people who may have to be excluded. I just wanted to
10 mention this because there were some records -- there
11 were some people who were searched for at NPRC who
12 Eddie could not find records for. So we actually gave
13 him 30 names to search for, and a few people were at
14 Quantico, they had served more recently and the
15 records haven't made it over to NPRC and we can look
16 there, but there were still a few who were unaccounted
17 for so some cases may drop out if we just cannot get
18 any information about where they were located.

19 **DR. AKERS:** Let me ask a question, just to make
20 sure I'm perfectly clear. The controls are drawn from
21 people who didn't have the case cancers, per se. They
22 could have been stationed at Lejeune, Pendleton --

23 **DR. DEARWENT:** No.

24 **DR. AKERS:** El Toro -- well, not El Toro, but
25 Quantico, wherever.

1 **DR. DEARWENT:** Correct.

2 **DR. AKERS:** You just couldn't have the cancers
3 they were questioning, regardless of where you were
4 stationed.

5 **DR. DEARWENT:** Right. And just to be clear, that
6 first table that I showed, that had 61 male breast
7 cancers and it was roughly double that of female
8 cancers, that was for all Marines from '95 to 2010; it
9 wasn't Lejeune-specific.

10 And then what we just discussed here is a good
11 example of why that 61 is kind of an estimate and
12 won't be the final number once you get into these
13 exclusionary criteria. Some may be eliminated.

14 **DR. AKERS:** And again, to make sure I'm perfectly
15 clear, the females that are noted, they are female
16 Marines or dependents or just females in general who
17 had the breast cancer?

18 **DR. DEARWENT:** Female Marines. Well, you could
19 catch dependents in the VA cancer registry.

20 **MS. RUCKART:** Those were ^ different code. Those
21 numbers are provided for those people who are coded as
22 Marines. There are other breast cancers, but they
23 were not coded as Marines. So that number that he
24 showed you were the numbers of Marines, female and
25 male.

1 **DR. AKERS:** How about nurses at the naval
2 hospital? Would they be included under Marines?

3 **MS. RUCKART:** Did you search for Navy?

4 **MR. PARTAIN:** Corpsmen.

5 **DR. AKERS:** Corpsmen?

6 **MR. PARTAIN:** There are several Navy corpsmen on
7 my list.

8 **DR. AKERS:** So that group of individuals would be
9 lost then?

10 **MR. PARTAIN:** There are quite a few Navy corpsmen
11 that went through there, both female and male.

12 **MS. BLAKELY:** My father-in-law was a Navy
13 corpsman. He died of the same cancer as my mother, so
14 you're disqualifying people that were in service.

15 **DR. DEARWENT:** The question really goes back to:
16 Would those people have been -- if they had been
17 diagnosed with cancer, would they have been captured
18 by the VA cancer registry. That's the kicker.

19 **DR. BOVE:** They would be. They would be.

20 **DR. DEARWENT:** And if they would be --

21 **DR. BOVE:** We were thinking about this as well.
22 The problem as we see it is that the Navy, the
23 percentage of the Navy at Camp Lejeune is tiny
24 compared to the entire Navy personnel. And so we
25 would get a lot of people, and we'd have to do a lot

1 of work, for one thing, to look at all these cancers,
2 both male and the control series, who would definitely
3 not be exposed because -- on ships or anywhere else.
4 So we thought limiting it to the Marine Corps made
5 sense efficiency-wise 'cause we're going to have to go
6 back and look at hard copy records to do this.

7 This is also why we decided not at this point to
8 look at female breast cancer, okay, strong case could
9 be made that we should be looking at that as well,
10 because of the work involved in trying to do that, and
11 going through all these records, because it's --
12 they're not computerized, okay? And unfortunately
13 they're not computerized because if they were that
14 would change things drastically here, but they aren't.
15 And they probably will never be computerized because
16 of the expense that the Marine Corps says it would
17 take and the number of people hours, and so on and so
18 on. So that's why we're not including Navy.

19 We think we have enough cases -- the key thing
20 here is we think we have enough cases of male breast
21 cancer to do a study and to have sufficient
22 statistical power to see something if there's there.
23 So that's why we're doing it this way.

24 There are all kinds of other approaches and other
25 populations that we can look at for male breast cancer

1 but this seemed to be the best thing to do that could
2 be done in a reasonable amount of time, with the kind
3 of work force we have and the limitations of the data
4 that we're faced with. Okay, so we realize we're
5 missing cases but that doesn't mean that the study's
6 invalid at all. It has nothing to do with the
7 validity of this study.

8 **MS. BLAKELY:** Yeah, but the study will be valid
9 but will it be full-scale enough to capture the male
10 breast cancer cases and obviously show the evidence
11 that there is a problem?

12 **DR. BOVE:** Yes. That's what I'm saying. Because
13 we think that we have enough cases to make -- if it's
14 there, we can make the case that there's an
15 association, a relationship, between this kind of
16 exposure and this disease, yeah. And that's what -- I
17 mean, that's the question we're asked -- that we're
18 trying to answer.

19 **DR. DEARWENT:** So, just --

20 **MR. ENSMINGER:** Boy, you talk about a
21 break-through study. I mean, if you've got -- if that
22 ever happens, holy Christ.

23 **DR. DEARWENT:** So, yeah, earlier in the meeting,
24 we talked about how to -- how we will interpret
25 findings. And just so you guys understand it, and

1 this really applies across all the epi studies here,
2 that we're looking at multiple aspects in terms of our
3 interpretation, or multiple, you know, considerations.
4 One is the strength of the association, so the
5 magnitude of the odds ratio. Another is an exposure
6 response relationship. Those, you know, are we seeing
7 more cases in those that have higher exposure? And
8 another is the consistency of the findings both within
9 the study and when compared to other studies of this
10 nature.

11 And that's the timeline that we've laid out, and
12 you'll see that 2012, Q4, that's basically September,
13 end of September, end of our fiscal year, we're
14 indicated, you know, we should be through -- the
15 protocol should be peer reviewed, we'll hopefully have
16 approval from CDC's IRB at that point, we'll have at
17 least initiated the IRB review at the VA.

18 Once all that's done, which is the, you know,
19 towards the end of the calendar year, we've got all of
20 our approvals and clearances to go, we'll get data
21 back from the VA on the VA cancer registry, actually
22 have the participants' information that we can then go
23 to St. Louis and spend, you know, at a minimum of six
24 months or so doing a lot of this data abstraction,
25 cleaning, what have you.

1 So we're probably a good year and a half out from
2 having this thing, you know, at least ready to go for
3 clearance. And I think that's it.

4 **MR. STALLARD:** Great. Thank you, Steve.

5 **DR. DEARWENT:** Yes, sir.

6 **MR. STALLARD:** All right. Any questions? Yes?

7 **DR. CLAPP:** Frank mentioned power, do you have a
8 slide about power or do you want to say anything about
9 it?

10 **DR. DEARWENT:** Funny you ask 'cause I think we
11 have an extra slide set in here just in case it came
12 up. Supplemental slides. Reading their minds there,
13 Dick. So here's your example. So just everyone,
14 statistical power is the ability to find an -- it's
15 the ability to find an association, should it really
16 exist. So bottom line is do you have enough people
17 with enough exposure such that if there was an
18 exposure-disease relationship, you can find it through
19 an analysis like this.

20 So, you know, what we've done is, you know, we've
21 already identified a 4 to 1 ratio of controls to
22 cases. When you use many more controls than you have
23 cases, that's a way to help increase your statistical
24 power, so we're thinking we're going to have roughly
25 60 cases and 240 controls, so a total of 300 overall

1 participants in this study.

2 And then looking at the assumption of exposure
3 prevalence amongst the controls, bearing that from 10
4 to 40 percent, you get varying odds ratios that are at
5 least, you know, two, if not three times, you know,
6 what you would expect.

7 So what we have -- based on having 60 cases and
8 using 240 controls, we have the ability to see
9 something, should it exist. And that's -- and that is
10 really the kicker on this, that Frank was getting to.
11 I mean, obviously there are concerns about narrowing
12 the scope and eliminating the cases, which you never
13 want to do, but as long as we can have very strong
14 criteria that we adhere to for both case and control
15 inclusion, and can stand by that and still have the
16 ability to see something, should it be there, that's,
17 that's our concern.

18 **DR. DAVIS:** I think it's important to make clear
19 that the power or probability of finding an effect
20 depends on two different things. One is the expected
21 size of the relative risk that you're looking at. So
22 for example if male breast cancer was five or ten
23 times greater in people exposed to solvents than not,
24 you don't need to look at as many people as if it was
25 for example just 50 percent greater, and that's just

1 an unknown at this point, isn't it?

2 **DR. DEARWENT:** It is. But thank you for that
3 clarification.

4 **MR. STALLARD:** Science 101. Any other questions?

5 **MR. PARTAIN:** When you guys do get to -- you --
6 Perri mentioned like you have 30 of the 61 that you're
7 not sure?

8 **DR. DEARWENT:** The 30 number was, Eddie took, you
9 know, the subset of folks that he was going to go to
10 St. Louis and try to abstract records on, Frank and
11 Perri were able to give him 30 Marines that spanned
12 across different times of service and different ranks
13 and what have you. And --

14 **DR. BOVE:** We just took it straight from the DMDC
15 data. We didn't know anything about their health
16 status at all. Just keep that in mind, okay, it was
17 just 30 people. We just wanted to see if we could
18 find information on a random sample of 30.

19 **MR. PARTAIN:** Okay.

20 **MS. RUCKART:** And the way it was done was we had
21 the DMDC data from '75 to '85, so I made six
22 three-year, you know, chunks, so ten people from each
23 of those time periods, so they would be more
24 distributed, and then various ranks.

25 **DR. BOVE:** Right, in the DMDC data has the date

1 when you started military service, although sometimes
2 it's pretty flaky, and you get different dates for the
3 same person, which is part of the problem with this
4 data set. But we can base the sampling that Perri
5 just talked about, based on when that date occurred.
6 So if they start at 60s, 70s and 80s, we took people
7 out.

8 **DR. AKERS:** So the 30 were not officially had
9 cancer (multiple speakers) showed up on your list, 30
10 people.

11 **DR. BOVE:** Just wanted to see how it worked.

12 **MS. RUCKART:** Well, let me add something else,
13 like Frank was saying, we know that the DMDC data is
14 not 100 percent, you know, accurate so another part of
15 this process we wanted to see if the DMDC data shows
16 this person was at Lejeune -- we took 30 random
17 people -- would their personnel records at St. Louis
18 show us that they were at Lejeune? That would make us
19 feel more confident for our other studies 'cause we're
20 basing everything off their unit code from the DMDC.

21 **DR. BOVE:** And then that's why -- this is
22 actually -- this was a discussion that occurred
23 between me and the point of our point of contact in
24 the Marine Corps, which was just how good the DMDC
25 data is and whether the St. Louis data would be useful

1 as a corrective to see how good the DMDC data was.
2 And we thought it was a good idea. Sometimes you get
3 good ideas from all kinds of places. And this idea
4 was instead of relying on the DMDC data for this
5 study, actually to go to St. Louis and get hard copy
6 for all these people, the breast cancer cases and the
7 control cancers as well. And look at that and see,
8 for the people who are in the DMDC data as well, see
9 how the two corresponded. We thought that would be
10 useful as well. So that's why we're going to use the
11 hard copy records as well as the DMDC data and see,
12 and do sort of a quality check.

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

14 **MR. PARTAIN:** So you think that the 61, granted I
15 know they're not going to all be from Lejeune, but do
16 you think that we're going to be able to get enough to
17 have a statistical relevance for everything?

18 **DR. DEARWENT:** Yeah, and that's exactly what that
19 slide addresses.

20 **MR. PARTAIN:** Okay.

21 **DR. BOVE:** We'd like to get below two but we
22 can't generate more cases out of the VA than are
23 there. But this is reasonable. You always want
24 stronger power, you always want to be able to detect
25 the odds ratios below two, if you can. But increasing

1 the number of controls here would not really do much
2 more than this. If you take -- have an eight to one
3 ratio you'd still be roughly in the same territory so
4 this is pretty much what you can do with this data.

5 **DR. DEARWENT:** And how long ago did we get the
6 estimate on the 61? That's been within the last few
7 months, hasn't it?

8 **MS. RUCKART:** Early in the year.

9 **DR. DEARWENT:** Yeah, so I would expect more cases
10 have been added since that time.

11 **MS. RUCKART:** Well, it depends. I mean, it
12 depends if they're using partial year data or if they
13 want to give -- wait to the full year, so we don't
14 know that yet.

15 **DR. DEARWENT:** We'll give you guys the numbers
16 once we get the final, which will be after the VA.

17 **MR. PARTAIN:** And just to visit back, I know we
18 were talking about the corpsmen, Navy corpsmen
19 involved, I mean, is there something that can be --
20 I'm assuming this is computerized and stuff. Is there
21 something the VA can do to produce, maybe Brad, to see
22 how many Navy personnel with male breast cancer have
23 been reported and just to do a quick check to see how
24 many are corpsmen, and look at it. 'Cause the reason
25 I'm bringing it up, there are quite a few corpsmen on

1 the list that have contacted me.

2 **DR. BOVE:** They don't have it broken down that
3 way. It's just simply Navy, Marine Corps -- sort of
4 like the DMDC data. That's all it has is M for
5 Marine, N for Navy, and their unit. If you know what
6 their unit is, then that's fine, but that's the DMDC
7 data. The VA cancer registry will just probably have
8 an indicator variable for -- I mean, that's what we've
9 heard, just simply Marine, Navy, Air Force, so on.
10 That's why.

11 **DR. DEARWENT:** And just so I'm clear, so the Navy
12 corpsmen would be swamped by all other Navy's
13 personnel?

14 **DR. BOVE:** Yeah.

15 **MR. STALLARD:** All right. Well, then I'll get to
16 that. Thank you very much for this presentation.
17 This is an example of the CAP having advanced an idea
18 and its coming into fruition. Frank, you wanted to?

19 **DISCUSSION ON FETAL/INFANT DEATHS**

20 **DR. BOVE:** Yeah. This is another example of the
21 CAP going way beyond what other CAPs probably do, and
22 collecting data for us, and bringing it to our
23 attention. So Mary Blakely did some work going
24 through death certificates for three years from North
25 Carolina. And so the first year she looked at was

1 1979. I hand counted it, so it may not be exactly
2 right, but there are 24 death certificates here. Six
3 of them were fetal death certificates. And the thing
4 I was mentioning to Mary before is one of the things I
5 never could understand is when states decide to call
6 it a fetal death and when they decide to call it an
7 infant death. Some of these infant deaths died within
8 an hour of birth but they're given a death
9 certificate, not a fetal death certificate. So there
10 is some movement there that I have a feeling that some
11 states do it differently than others.

12 But anyway, of the six fetal death certificates,
13 three weren't born while the parent lived on base,
14 according to the death certificate information I saw.
15 But three were born on the base, so half of them were,
16 and two, I know, were in the small for gestational --
17 were not in the small for gestational age ^ but we got
18 the data for two of those three from the state back in
19 the mid-90s when we found that there weren't enough
20 fetal deaths to really study.

21 We saw that there were some 80 fetal deaths for
22 Lejeune, and you would expect it something like three
23 times as many, so we knew we weren't getting all the
24 fetal -- even close to getting all the fetal deaths in
25 Camp Lejeune so we didn't go any further with that

1 information. We also didn't have information for most
2 of them on cause of death.

3 For these fetal death certificates, some did have
4 a cause of death, including there was one anencephaly,
5 which is in our case control study. So most of the
6 diseases I found on the infant deaths were due to
7 preterm birth, for example immature respiratory
8 system, excessive amniotic fluid because the
9 swallowing mechanism for the fetus hadn't been
10 developed. So these are -- a lot of these diseases
11 are diseases that are related to preterm birth.

12 And so even though we're not studying these
13 people in particular, we are studying preterm birth in
14 the small for gestational age study, so we'll capture
15 some of this by looking at preterm birth in that
16 reanalysis.

17 Other conditions included what we called -- what
18 are called pregnancy and delivery complications
19 including cord problems, like being twisted around the
20 neck, ruptured placenta, incompatibility of blood type
21 between the mother and the fetus, and so on. There
22 were a few SIDS cases and one or two septicemia cases.
23 But there were many unknowns, even among the infant
24 deaths and certainly among the fetal deaths. So that
25 was the 1979 package.

1 There are two other years that Mary Xeroxed death
2 certificates from, in 1960 I counted 101, so you
3 really went to work on in 1960 deaths. Again, most of
4 them were due to the same kinds of diseases I
5 mentioned for the '79 group, related to preterm birth
6 or related to pregnancy and delivery complications.

7 In this group there were six with heart disease
8 but it wasn't specified as to what kind. There were a
9 couple of ventricular septal defect and one atrial
10 septal defect in this group, which is a hole in either
11 the upper or lower chambers of the heart. There was a
12 patent ductus arteriosus, PDA, which is often called
13 heart murmur, and there it's basically an abnormal
14 blood flow between the aorta and pulmonary arteries,
15 which can be corrected.

16 All these are corrected by surgery but I guess in
17 cases they do lead to death. There was two
18 hydrocephalies and then there was two mentioned
19 multiple anomalies, it wasn't otherwise specified.

20 So there were some birth defects within this
21 probably so the other causes of death were either
22 unknown or there's a whole list of all kinds of
23 complications, could be due to birth defects that they
24 just haven't been able to identify. They either
25 didn't do an autopsy or whatever. And there were two

1 acute lymphocytic leukemias, one age two and one age
2 four. Now these wouldn't be in the study because this
3 happened in 1960.

4 And then in '58, I counted 97 this time. And
5 there was one what we call conotruncal heart defect, a
6 major heart defect, where the vessels are switched --
7 aortic and pulmonary vessels are switched, and this is
8 a major heart defect which we were hoping to study in
9 the case control study, and we couldn't because we saw
10 that we were totally underestimating the number. We
11 weren't ascertaining the way we should be. Probably
12 we had about a third of what we expected, so we
13 abandoned looking at that because obviously we weren't
14 capturing them.

15 There were two NTDs, neural tube defects in this
16 '58 group. Actually there was more than two -- I'm
17 sorry, there were two encephaloceles, which is a very
18 rare neural tube defect. There were four
19 anencephalies, which I saw, another neural tube defect
20 that's forming out of the brain. There were a couple
21 of hydrocephalies, and again a couple with multiple
22 anomalies not otherwise specified. And somehow there
23 was a melanoma, metastatic melanoma, of a 46-year-old.

24 So anyway no, we really appreciate the work that
25 went into this. This gives us some handle on the

1 deaths that did occur among those who were not
2 considered fetal deaths. And it strengthens our view
3 that to look at preterm birth a lot more seriously
4 this time around.

5 In my own research I haven't seen much with
6 preterm birth except one instance where we looked at
7 preterm birth at Hanford and found an association, but
8 in general, I haven't seen much with preterm birth in
9 these kinds of exposures; however, it hasn't been
10 studied that much and, you know, we'll have better
11 data this time around. So maybe we'll see something
12 this time. We did not see it the last time around,
13 with this -- in this small for gestational age preterm
14 birth study.

15 **DR. AKERS:** Would you like to have the website
16 for Matt Avery, who's head of the Department of
17 Statistics for the State of North Carolina? I mean,
18 I've got his information here and he can, he can tell
19 you what criteria they use for fetal death versus an
20 infant death and that sort of thing. And the data
21 goes back until somewhere in the 40s. They have data
22 on that going all the way back.

23 **DR. BOVE:** Yeah, but as I said for some reason
24 there was a very low number of fetal deaths in this
25 population.

1 **DR. AKERS:** I haven't look at the data, I just
2 know it exists and it does go back to the 40s.

3 **DR. BOVE:** Yeah, yeah, yeah.

4 **DR. AKERS:** Center for Health Statistics in
5 Raleigh has that information.

6 **DR. BOVE:** Yeah, thank you.

7 **MS. BLAKELY:** This is Mary Blakely. I have been
8 back to the register of deeds, and I have collected up
9 through 1984 and I've got 1990. So I have from '50
10 to, except four years, which I'm going to go back and
11 get. And I'm more than willing to share all of them
12 with you.

13 **DR. BOVE:** Sure. Okay, thank you.

14 **MR. ENSMINGER:** I'd like to add that, you know,
15 that Mary's really put a lot of work into this and
16 that it has not gone unnoticed by any of us, so good
17 job, Mary.

18 **WRAP-UP**

19 **MR. STALLARD:** Thank you. All right, we're at
20 the end of the formal agenda a little bit early this
21 time and it calls for wrap-up. Do we have anything in
22 mind about wrap-up? I mean, do we have a date for the
23 next CAP that will be set up? That's one thing we
24 have to take care of. Do you have anything to add?

25 **DR. DEARWENT:** Yeah, I was just going to echo we

1 might as well talk about the next time that we all get
2 together.

3 **MR. STALLARD:** Yeah.

4 **DR. DEARWENT:** I get the feeling that you guys
5 would be much happier if when we had the next meeting,
6 we actually had more substance to share. You know,
7 and then based on our timelines, it looks like, you
8 know, at a minimum, I think by end of this calendar
9 year or very early 2013, the water modeling'll be out,
10 at least two of the epi studies will be out. Are you
11 guys willing to -- us kind of play it by ear for a few
12 months and we see how that timeline progresses and
13 then set a date through, you know, communicating via
14 email down the road? Except for Jeff; he's going to
15 excuse himself.

16 **MR. STALLARD:** Jerry, any thoughts on that?

17 **MR. ENSMINGER:** I didn't pick that up. I
18 couldn't hear.

19 **DR. DEARWENT:** So I was saying that I get the
20 impression that that the CAP meeting would be a little
21 more fulfilling if the next one occurred at such a
22 time that we actually had the water modeling out for,
23 you know, for public release as well as, you know, at
24 least a couple of the epi studies. And so I was
25 suggesting maybe we kind of play it by ear for the

1 next couple months, and as that timeline starts to
2 crystallize a little bit better than it has at this
3 point, we could set a date. And then again --

4 **MR. ENSMINGER:** Well, my only problem with that
5 is that historically every time we get a date, it's
6 never a date certain, and the closer we get to the
7 date, then all of a sudden we find out that, well,
8 it's not going to be released. It's not ready yet.
9 So, but --

10 **DR. DEARWENT:** Well, based on the recent --
11 although I wasn't involved, the recent interactions
12 with congressionals, I think we're fairly committed
13 and locked in, at least by the end of this calendar
14 year to have some of these things out. So.

15 **MS. BRIDGES:** Did you just mention November?

16 **MR. STALLARD:** We didn't. We're talking about
17 that now. Dr. Portier?

18 **DR. PORTIER:** I --

19 **MS. BRIDGES:** I thought he had mentioned
20 November.

21 **DR. PORTIER:** I would bet that the CAP would love
22 to discuss the first study that comes out and not wait
23 for all of them. And what I would suggest we do is,
24 using my best judgment, about a month before I'm
25 pretty sure that report will clear, we start to set up

1 a time for you to get here. That would be close to
2 the clearance date for the report as best we can tell.

3 That pushes my staff to clear the report faster,
4 and I will wait to do that until I'm absolutely
5 certain it's cleared my part of the center and is
6 elsewhere in our process of review. Would that work
7 for the CAP? So you might not get more than about a
8 three-week notice that we'd like to have a meeting.
9 But that would give us probably the most accurate
10 chance of getting you a meeting where we're actually
11 going to present results from one or two of these
12 studies.

13 **MR. ENSMINGER:** Oh, man, and let's not forget,
14 now, you've got Chapter B that's going to be coming
15 out in between here.

16 **MR. STALLARD:** D.

17 **MR. ENSMINGER:** Yeah, Chapter D, I'm sorry.

18 **DR. DEARWENT:** Yeah, the claim right now is to
19 have the drinking water -- the water modeling out
20 before the epi studies, and that's, you know, that has
21 a lot of substance to it. So we just wouldn't want to
22 set an expectation of say a meeting towards the end of
23 this calendar year where it's all done and at this
24 point looks like maybe just the water modeling or one
25 of the epi studies may be done.

1 **MS. RUCKART:** But doesn't it make sense, that,
2 you know, is fine to have a separate meeting dedicated
3 to the water modeling but shouldn't we use that same
4 approach where a few weeks out, when we're very
5 certain when the date is, we have the meeting so
6 people don't come and we're disappointed we can't have
7 approval discussions?

8 **MR. STALLARD:** All right. So someone help me to
9 summarize. What did we just decide?

10 **DR. PORTIER:** Well, we haven't heard from the
11 CAP.

12 **MR. STALLARD:** Well, we heard from Jerry.

13 **MR. PARTAIN:** I would like to have a meeting --
14 you mentioned the water model being done in November.
15 We could spend almost an entire CAP meeting talking
16 about the water model. And I'd like to have -- I
17 would like to have a CAP meeting prior to the release
18 of the water model. You know, you mentioned about
19 getting us a, you know, a copy of the report or
20 whatever before -- at the same time the Marine Corps
21 and the Navy get it. That'd be a good chance for us
22 to get the report, look at it and talk about it before
23 it's released.

24 **MR. ENSMINGER:** You know, I agree with that. I
25 mean, and by that time we'll have Chapter D.

1 **DR. PORTIER:** That we can't do. What -- this
2 meeting's a public meeting and if we start talking
3 about the results of that document at a public
4 meeting, we have in essence released the document.
5 So --

6 **MR. ENSMINGER:** Yeah, yeah.

7 **DR. PORTIER:** Yeah, we'll --

8 **MR. PARTAIN:** Can we coincide the release?

9 **DR. PORTIER:** We can try. We can try to coincide
10 the release with the date that we sit down and talk
11 with you. There's a lot that goes into a release of a
12 document like this with national consequences to the
13 document and national interest in it.

14 So I'll work with my communications staff to see
15 what we can and cannot do around that. It becomes a
16 bit of a zoo when you have too much going on around
17 the release of a big document. But we'll do what we
18 can. But the bottom line is, we can't talk about the
19 results in this meeting prior to releasing a document.

20 **MR. ENSMINGER:** Yeah, that's --

21 **MS. RUCKART:** I have an option. Another option,
22 what about a closed CAP meeting, Dr. Portier? Or CAP
23 members? Is that a possibility?

24 **DR. PORTIER:** I don't know the rules.

25 **MS. BLAKELY:** We could invite the Marine Corps to

1 attention now.

2 **MR. ENSMINGER:** I said I hate to tell you this,
3 Jeff, but you will continue to hear from me.

4 **MR. BYRON:** Actually I'm glad to hear that,
5 Jerry, and I hope to hear from all of you eventually.
6 But if not, I'll see you in the hereafter.

7 **MR. ENSMINGER:** I got a point of interest for
8 everybody. I just got an email from CBS news.
9 They're going to run another story on Camp Lejeune
10 prior to the House vote. So.

11 **MR. STALLARD:** All right. Do I have to remind
12 people to submit vouchers and things?

13 **MS. RUCKART:** Only if they want to get
14 reimbursed.

15 **MR. STALLARD:** Any final notes and comments, Dr.
16 Portier?

17 **DR. PORTIER:** I just want to add my thanks to
18 Jeff and all of you for all the efforts you put into
19 helping us to do this the right way. We really do
20 appreciate it. Thank you very much.

21 **MR. BYRON:** Thank you.

22 **MR. ENSMINGER:** Even me?

23 **MR. STALLARD:** Glenn?

24 **MR. MARKWITH:** Glenn Markwith from Navy Marine
25 Corps Public Health Center with just a quick

1 postscript. One of the issues that was discussed
2 earlier in the day was the civilians claim process and
3 getting information out there. And at lunchtime I was
4 looking through the information that is out there, and
5 it's in the FAQs. It's in the FAQs on Lejeune
6 website.

7 It goes over how to do the VA for the service
8 members and also how to do the claims process for
9 civilians. And even people who don't fall under those
10 categories, if you're not a service member or a
11 civilian, how do you go through the federal torts
12 claim process, and it gives website info numbers. So
13 I just kind of wanted to close with that positive, and
14 that the information is out there.

15 **MR. ENSMINGER:** Well, wait a minute. Now, that
16 isn't for health benefits, though. That is only for
17 federal tort claims. That's for SF-95s.

18 **MR. MARKWITH:** Well, the stuff --

19 **MR. ENSMINGER:** That doesn't have anything to do
20 with the Federal Employees Compensation Act.

21 **MR. MARKWITH:** The stuff for the Department of
22 Labor that's on there has to do with workman's comp
23 claims. If the civilian feels like they --

24 **MR. ENSMINGER:** Oh, it does? Okay, okay, good.

25 **MR. MARKWITH:** Yes, sir.

1 **MR. ENSMINGER:** My apologies.

2 **MR. MARKWITH:** There's no worries. And the
3 second thing I wanted to say, I know there was some
4 concern about the registry website not working
5 correctly. And there's going to be a letter
6 forthcoming to the CAP to explain exactly what
7 happened, but the gist of it was that the servers
8 transitioned from the Navy annex to the Pentagon and
9 then down to Lejeune, and during that process some
10 code was messed up and the static monthly report that
11 showed up didn't change from December 2011 until it
12 was finally updated and they caught the error.

13 The way it was explained to me was the score card
14 kept running, the data kept being recorded but the
15 monthly static report didn't change because it was
16 looking at the old server. And now they've got that
17 corrected and it's been, you know, doing the right
18 thing since the end of March, so another positive note
19 that they've got that corrected. I just wanted to put
20 that out there. Thank you.

21 **MR. STALLARD:** Thank you, Glenn.

22 **MR. ENSMINGER:** Well, I have a question on that
23 point. And you know, it's something that nobody in
24 the Marine Corps or anybody on Capitol Hill can get
25 the Marine Corps to answer, and that is that migration

1 that you keep talking -- that's a nice new word,
2 migration, of the computer down to Camp Lejeune. I'd
3 like to know what mode of transportation you guys used
4 to get that down there because it took three damn
5 months.

6 I mean, that's -- I know you can't answer that
7 but that's just the point I want to make, you know,
8 that the Marine Corps and Department of the Navy's
9 rhetoric is about how concerned they are about our
10 health, safety and welfare, but their actions belie
11 their words, okay?

12 It has been this way ever since this issue's come
13 up and, you know, for them to -- for the leadership of
14 the Department of the Navy and the United States
15 Marine Corps to put you out here in the front, I think
16 is totally unfair and I'm not aiming this at you in
17 any way. But the conduct and the lies and the
18 misinformation and disinformation that have been put
19 out by the Department of the Navy and the Marine Corps
20 leaders is just, it's -- I can't believe it. I just
21 cannot believe it.

22 And if you want a prime example, go look at that
23 damn brochure that they posted on 16 March on the
24 website. That thing is full of omissions, full of
25 obfuscations, full of half-truths, full of total lies.

1 **MR. MARKWITH:** Well --

2 **MR. ENSMINGER:** It's ^.

3 **MR. MARKWITH:** In regards to the migration of the
4 servers that we were talking about earlier, I just
5 want to say that the details are going to be in that
6 letter and I'm hopeful that it will answer some of the
7 questions that you have about the time period there.

8 But I do know in talking with them that there
9 were some errors in the code because it was
10 referencing an old server and the report was not on
11 the old server anymore, and that's the way it was
12 explained to me in terms of why that was in error.
13 But the positive thing I wanted to leave y'all with
14 was that it's now been corrected, and they found out
15 why it was doing that, and it's actually been
16 recording numbers from the registry; it just wasn't
17 showing up on the monthly report card.

18 **MR. STALLARD:** All right. Thank you.

19 **MR. ENSMINGER:** And then I would like to point
20 your attention to the statement that they put up on
21 their website, which basically blamed all these errors
22 on -- or insinuated that the victims were registering,
23 were multi-registering. The victims were. It wasn't
24 a fault with the Marine Corps or the Department of the
25 Navy's program, it was basically the blame was put on

1 the victims, like they were some kind of perpetrators,
2 that they were underhanded, and they were registering
3 multiple times. I took that as a damn insult, okay?

4 **MR. MARKWITH:** I can --

5 **MR. ENSMINGER:** And you can carry that back to
6 your people. You know, I look at that as an insult.

7 **MR. MARKWITH:** Yes, sir. I can tell you that
8 certainly was not the intent. The way it was
9 explained to me was that it was an error in coding and
10 it's since been corrected and the details are coming
11 to the CAP in a letter. And hopefully it'll be here
12 very soon.

13 **MR. ENSMINGER:** Well, why don't they put that
14 stuff in their statement on their public site? 'Cause
15 that's where everybody sees that thing.

16 **MR. PARTAIN:** Yeah, the public site made it very
17 clear that the errors were due to multiple
18 registrations, duplicate registrations so that is, you
19 know, insinuating that the victims are going on there,
20 here, count me; here, count me again.

21 And if that's true in case it's what you said,
22 what they described, they need to make sure the
23 actions follow up with words and that the public
24 disclaimer that's available for Congress, for media,
25 for people to see, acknowledges that there was an

1 error on the part of the Marine Corps and the Navy,
2 and that the victims and the families had nothing to
3 do with it. Right now that doesn't read that way.

4 **MR. MARKWITH:** Understood. That was certainly
5 not the intent.

6 **MR. ENSMINGER:** And the other -- the explanation
7 I got through the congressional offices on this matter
8 was that if people went back into the program they had
9 already registered, but if they went back in to update
10 their information, such as their contact information
11 or they may have moved and may have gone in to put in
12 a new address, the system was counting them again.
13 The program was counting them over again. So I mean,
14 but you get my point. Well, you understand what Mike
15 just said. You know, saying that it was a glitch with
16 the program and, you know, let's stop this finger
17 pointing. I mean, the Department of the Navy and
18 Marine Corps have never accepted any kind of
19 responsibility or blame for this issue, never.

20 **MR. MARKWITH:** Well, what I wanted to do was
21 report that they did find the source of the error and
22 they're going to detail that to the CAP in a letter
23 and that it is actually up and running. And that's
24 the positive part I wanted to report to the CAP today.

25 **MR. PARTAIN:** One thing, Glenn, if you would,

1 when they provide us with that letter, I would ask
2 they provide us with a breakdown and count to date as
3 conveyed in the letter, by state and by total count.

4 **MR. STALLARD:** All right. I think that wraps it
5 up. And I think I'd like to thank Glenn for being
6 here and joining the CAP as a new member, and we look
7 forward to your participation in the future.

8 **MR. MARKWITH:** Thank y'all for letting me be
9 here. Appreciate it.

10 **MR. STALLARD:** Absolutely. So safe journey home
11 on the roads today, be careful, and we'll be in touch
12 about the next meeting. Thank you very much. Signing
13 out, Jerry, bye.

14 (Whereupon, the meeting was adjourned, 2:23 p.m.)
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I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of July 26, 2012; 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 August, 2012.

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