THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY

convenes the

THIRTY-FIRST MEETING

CAMP LEJEUNE COMMUNITY ASSISTANCE PANEL (CAP) MEETING

May 13, 2015

The verbatim transcript of the Meeting of the Camp Lejeune Community Assistance Panel held at the Embassy Suites, Greensboro, North Carolina, on May 13, 2015.

STEVEN RAY GREEN AND ASSOCIATES

NATIONALLY CERTIFIED COURT REPORTING

404/733-6070

C O N T E N T S

May 13, 2015

WELCOME, INTRODUCTIONS AND ANNOUNCEMENTS 5
SHEILA STEVENS, DR. PATRICK BREYSSE

SUMMARY OF THE MAY 12TH PUBLIC MEETING 10
DR. PATRICK BREYSSE

ACTION ITEMS FROM PREVIOUS CAP MEETING 26
DR. ANGELA RAGIN

UPDATE ON SOIL VAPOR INTRUSION AND DRINKING WATER EXPOSURE EVALUATIONS 47
RICK GILLIG

UPDATES ON HEALTH STUDIES 55
PERRI RUCKART, FRANK BOVE

VETERANS AFFAIRS UPDATES 68
BRAD FLOHR, DEBORAH HEANEY, BRADY WHITE, LOREN ERICKSON, DANNY DEVINE

CAP UPDATES AND CONCERNS 186
CAP MEMBERS

WRAP-UP/ADJOURN 205
DR. PATRICK BREYSSE, SHEILA STEVENS

COURT REPORTER'S CERTIFICATE 208

TRANSCRIPT LEGEND

The following transcript contains quoted material. Such material is reproduced as read or spoken.

In the following transcript: a dash (--) indicates an unintentional or purposeful interruption of a sentence. An ellipsis (. . .) indicates halting speech or an unfinished sentence in dialogue or omission(s) of word(s) when reading written material.

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

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

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

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

-- “^” represents unintelligible or unintelligible speech or speaker failure, usually failure to use a microphone or multiple speakers speaking simultaneously; also telephonic failure.

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

(alphabetically)

BOVE, DR. FRANK, ATSDR
BREYSSE, DR. PATRICK, NCEH/ATSDR
CANTOR, DR. KEN, CAP TECHNICAL ADVISOR
CLAPP, DR. RICHARD, CAP MEMBER
CORAZZA, DANIELLE, CAP MEMBER
DEVINE, DANNY, VHA
ENSMINGER, JERRY, CAP MEMBER
ERICKSON, LOREN, VA
FLOHR, BRAD, VA
FORREST, MELISSA, NAVY/MARINE CORPS
FRESHWATER, LORI, CAP MEMBER
GILLIG, RICHARD, ATSDR
HODORE, BERNARD, NEW CAP MEMBER
MASLIA, MORRIS, NCEH/ATSDR
ORRIS, CHRISTOPHER, CAP MEMBER
PARTAIN, MIKE, COMMUNITY MEMBER
RAGIN, DR. ANGELA, ATSDR
RUCKART, PERRI, ATSDR
SMITH, GAVIN, CAP MEMBER
STEVENS, SHEILA, ATSDR, CAP LIAISON
TEMPLETON, TIM, CAP MEMBER
WHITE, BRADY, VA
WILKINS, KEVIN, CAP MEMBER

1

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

2 (9:11 a.m.)

3 **WELCOME, INTRODUCTIONS, ANNOUNCEMENTS**

4 **MS. SHEILA STEVENS:** Okay. Good morning.
5 Welcome back. A lot of you, I see, were here last
6 night at our public meeting. First of all, I want
7 to go through -- my name is Sheila Stevens; I'm with
8 the Agency for Toxic Substances and Disease
9 Registry. From now on we'll just call it ATSDR, and
10 I'll try to stick to that.

11 Quickly, a couple logistics things. If you
12 have cell phones, please turn those off at this
13 time. If you -- there are bathrooms in the back of
14 the room. We'll have a break around 10:30, if we go
15 by schedule. So there's a men's and a women's
16 bathroom in the back. We have coffee. We have some
17 snacks back there, so please help yourself to those.

18 I want to welcome all the veterans again, and
19 their families that are here. Let me see a raised
20 hand of all the folks I have that are veterans and
21 their families. Thank you. I have a couple people
22 in the audience. I have Mike Fenley with Senator
23 Burr's office. Mike?

24 **MR. NICK WILKINSON:** He just stepped out but
25 he's here.

1 **MS. STEVENS:** Thank you. And I have Nick
2 Wilkinson from Senator Tillis's office.
3 **MR. WILKINSON:** I'm the guy who just yelled at
4 you.
5 **MS. STEVENS:** Oh, thank you. And if I have any
6 other members from the Senate or Congress, if you're
7 in the room right now, would you please stand so I
8 can recognize you?
9 Okay. So here's what I'm going to do. I'm
10 going to start with having each of our members here
11 in the CAP and on the ATSDR staff and the VA, that
12 are here sitting at the table, they're going to go
13 around the room and introduce themselves. And a
14 reminder to you guys sitting at the table, you have
15 to push the button or it's not going to go out live.
16 So start with Dr. Breysse. You want to go
17 ahead and -- you can use your microphone.
18 **DR. BREYSSE:** So good morning everybody and
19 welcome. My name is Patrick Breysse. I'm the
20 Director of the ATSDR, and this is my second CAP
21 meeting. And I'm happy to be here.
22 **DR. RAGIN:** Good morning, everyone. My name is
23 Angela Ragin-Wilson. I'm Chief of the Environmental
24 Epidemiology Branch, and I do a lot of work with
25 Frank and Perri. Thank you for being here.

1 **MR. GILLIG:** Good morning. My name is Rick
2 Gillig, and I'm the Branch Chief of the Central
3 Branch within the Division of Community Health
4 Investigations. That's the branch that's redoing
5 the health assessment on the drinking water
6 exposures. And we're also doing the project on
7 vapor intrusion.
8 **MS. FORREST:** Hello, I'm Melissa Forrest. I'm
9 here on behalf of the Navy/Marine Corps to listen to
10 your questions and your concerns, and take back
11 action items to the Marine Corps so that we can
12 provide information to the CAP.
13 **DR. CLAPP:** Richard Clapp. I'm a member of the
14 CAP. I'm a retired professor from Boston
15 University.
16 **MR. HODORE:** Good morning, my name is Bernard
17 Hodore, first time on the CAP.
18 **MR. ORRIS:** Good morning, I'm Christopher
19 Orris; I'm a member of the CAP.
20 **MR. MASLIA:** Good morning. My name is Morris
21 Maslia. I'm with the Division of Community Health
22 Investigations, and my team did the water modeling
23 that is used for the epidemiological studies and the
24 vapor intrusion studies and to look at the public
25 health assessment.

1 **MR. WHITE:** I'm Brady White. I'm with the VA,
2 and I'm the Program Manager over the Veteran and the
3 Family Member Health Reimbursement.
4 **MS. RUCKART:** Hi, I'm Perri Ruckart, ATSDR. I
5 work on the health studies.
6 **DR. BOVE:** Good morning, I'm Frank Bove. I
7 work on the health studies at ATSDR.
8 **DR. CANTOR:** Good morning, I'm Ken Cantor, a
9 member of the CAP. I'm a retired epidemiologist
10 from the National Cancer Institute.
11 **MR. ERICKSON:** Good morning, I'm Loren
12 Erickson. I served 32 years active duty in the
13 Army. Now I'm -- have joined the VA. I'm the
14 incoming Acting Chief Consultant for Post-deployment
15 Health. Somewhat new to Camp Lejeune issues but
16 learning a lot. Thank you.
17 **MR. DEVINE:** Danny Devine with VHA.
18 **MR. FLOHR:** Brad Flohr, Veterans' Benefits
19 Administration.
20 **MR. TEMPLETON:** Tim Templeton, a Marine
21 survivor of Camp Lejeune contamination.
22 **MR. WILKINS:** Kevin Wilkins, CAP member.
23 **MR. SMITH:** Gavin Smith, CAP member.
24 **MR. PARTAIN:** Mike Partain, dependent, CAP
25 member.

1 **MS. FRESHWATER:** Lori Freshwater, dependent. I
2 lost my mother to two types of leukemia, and two
3 siblings to neural tube defects. CAP member.
4 **MS. CORAZZA:** Danielle Corazza, Camp Lejeune
5 family member, CAP member.
6 **MR. ENSMINGER:** I'm Jerry Ensminger. I'm on
7 the -- a member of the Camp Lejeune CAP.
8 **MS. STEVENS:** Okay, thank you. Just one thing,
9 after the meeting -- towards the end of the
10 meeting -- this is a little different meeting than
11 what we had last night. So in the public meeting,
12 we had people -- we had kind of a Q&A session with
13 the people who were in the audience. At the end of
14 this meeting, when we get towards the end, we will
15 have a microphone for people who have questions,
16 okay? So that's how this meeting works. It's a
17 little different.
18 So with that, I'm going to turn the meeting
19 over to Dr. Breysse.
20 **DR. BREYSSE:** Before we start, I'm going to, on
21 the record, officially recognize the, the team at
22 ATSDR that did the water modeling work, and Morris
23 Maslia was the PI in that. And many of us know that
24 it received the 2015 Excellence in Environmental
25 Engineering and Science Award. And that award was

1 given by the American Academy of Environmental
2 Engineers and Scientists. So congratulations,
3 Morris.
4 [Applause]
5 **MR. MASLIA:** Thank you.
6 **SUMMARY OF THE MAY 12TH PUBLIC MEETING**
7 **DR. BREYSSE:** So I'd like to just -- I'd like
8 to briefly review last night's public meeting. So
9 we've had a number of public meetings in the past.
10 As many of you know, I'm new to ATSDR. I've been at
11 ATSDR now for five months.
12 This is my second CAP meeting. It's one of the
13 most enjoyable and one of the most challenging
14 activities that I've taken on as, as head of the
15 National Center for Environmental Health and ATSDR.
16 But I thought last night was just a wonderful
17 session, and I'd like to just reflect on it for a
18 few minutes.
19 So I think it's important that people in our
20 position at ATSDR, scientists, people at the VA,
21 take some time to listen. And last night was an
22 opportunity to listen. And I think we heard lots of
23 different things. We heard from a broad spectrum of
24 people about a broad spectrum of concerns that deal
25 with healthcare provisions, about compensation. We

1 heard a lot of outrage. We heard a lot of concern
2 about responsibility and owning up for what was done
3 and who's responsible for, for, for the situation at
4 Camp Lejeune.
5 There are lots of questions about what ATSDR's
6 doing and how our science is informing the Veterans
7 Administration decisions. And these are ongoing
8 discussions, discussions that have been happening
9 for a long time and will continue to happen.
10 I'd like to reiterate ATSDR's commitment to
11 understanding the public health impact of what
12 happened at Camp Lejeune and providing the
13 information to as broad spectrum of stakeholders as
14 possible, to make sure that the best decisions are
15 made to account for that impact and to appropriately
16 take care of people who are damaged and hurt and
17 suffering because of the pollution at Camp Lejeune.
18 So I'd like to just spend a few minutes and
19 open the floor up to -- if there's anybody else who
20 would just kind of share a thought or two about what
21 they took away from the CAP meeting last night. As
22 we go around the room, a number of us were here at
23 the table. I'd like to just think here for a minute
24 about what people took from the CAP meeting last
25 night. Jerry?

1 **MR. ENSMINGER:** Well, there were a lot of
2 people that vented. It was a good release for some
3 people. The only problem was that a lot of them
4 were venting their anger at the wrong either entity
5 or the wrong individual in that entity.
6 It still disturbs me greatly that the
7 Department of the Navy and the Marine Corps does not
8 send people here who can answer questions. I know
9 they send Melissa over here as a note-taker. But,
10 you know, we don't need a messenger service; we need
11 people from -- representing the Department of the
12 Navy/Marine Corps sitting at these meetings, that
13 can be responsive to the community.
14 **DR. BREYSSE:** So I think, if I could echo that,
15 that there's lots of players in this, this tragedy.
16 **MR. ENSMINGER:** Absolutely.
17 **DR. BREYSSE:** And it's going to work best for
18 everybody impacted if all those players would work
19 together and are committed to addressing what
20 happened at Camp Lejeune. I think that speaks to
21 the Navy, the Marine Corps, to the public health
22 agencies, like the one I head, to the Veterans
23 Administration, as well as other service-related
24 organizations. So I think you're right. I think we
25 have to find a way to work together better, and that

1 was a message I took from last night.
2 Anybody else? Well, to make this efficient, if
3 you want to say something, why don't you -- I hate
4 to be disorganized, but if you flip your name card
5 standing upright so that we can see that you want to
6 say something. That way, it would... Richard, you
7 wanted to say something really quick?
8 **DR. CLAPP:** Yeah, well, it could be quick --
9 well, I will be quick. I agree with Pat, last
10 night, that there was powerful emotions in the room
11 and powerful issues raised by people who were
12 affected, and the agency needs to hear that and the
13 public needs -- you know, the general public needs
14 to hear that. So that happened last night. It was,
15 I think, a very successful meeting in that regard.
16 Also I think there are some updates that
17 happened last night, and you presented the -- and
18 Dr. Bove and Dr. Ruckart -- sorry, I gave you a
19 promotion, Dr. Ruckart -- Presented some of the
20 research that had been done since the NRC report in
21 2009. And we're in a new day now, and I think those
22 who were responsible for compensating veterans have
23 to address that, and have to realize that time has
24 moved on, and that 2009 report, as we referred to it
25 last night, is hopelessly out of date. So that came

1 through loud and clear. I’ll stop with that.
2 **DR. BREYSSE:** Great. Anyone else?
3 **MS. CORAZZA:** I think that there's a lot of
4 room for more communication about how the VA works.
5 I happen to have it because I'm a family member and
6 also a service-disabled veteran who has used the VA
7 for many things. And I really realized last night,
8 listening to people's questions and concerns, that
9 they have very little understanding of the different
10 stove pipes more or less within which VA operates.
11 I do want to give credit to Brady for standing
12 up and taking some of the fire. And I think very
13 few people realize how limited his particular scope
14 is. So he took a lot of, I think, fire that -- it
15 wasn't deserved. So I'd like to see more
16 clarification from the VA. I would have loved to
17 see the VA give ten minutes on, this is the
18 difference between healthcare part of the VA, and
19 the disability and compensation part, because it
20 isn't clear, if you've not used the system. And I
21 think it does create a lot of unnecessary angst
22 amongst family members, who are, you know, very
23 uninitiated into this side of government.
24 **DR. BREYSSE:** And I think that was clear also.
25 We'll have an opportunity today, on today's agenda,

1 for the VA to maybe help clarify that. But to the
2 extent that I can understand it as well, I'm
3 committed to working with the VA to make sure I
4 understand it, because it is a complex system. And
5 there are different silos and different stove pipes,
6 and trying to understand that is a challenge for me.
7 But I'm, I'm new to the government. But at least if
8 I can understand it, I can help everybody else
9 understand it as well. Lori?
10 **MS. FRESHWATER:** Well, just to echo what
11 Danielle was saying, it's hard enough for veterans
12 to navigate the system. So now that we're
13 introducing family members, who have never done it,
14 it's incredibly difficult. They are -- they're lost
15 and they're frustrated and they're -- and by the
16 time they're there they're already ill, and, and
17 having to try and figure all of this out.
18 So I would agree that I would like to see the
19 Veterans Administration come in and everybody take a
20 step back from -- and have a less adversarial role,
21 and have the VA come in as an educational -- an
22 opportunity to educate.
23 And we could help; that's what we're here for.
24 We're the Community Assistance Panel. We're not
25 here to work for any entity; we're here to foster

1 communication among everyone and make sure everybody
2 gets heard. So we could actually be a help to the
3 VA, if we could work together to help people
4 understand what's going on.
5 And I just want to say thank you for your
6 leadership, because it has made a big difference in
7 the work I do and, and the feeling as though I'm
8 walking forward instead of on a treadmill that's
9 going nowhere. And it's not a criticism of anything
10 else. It's just been really wonderful, and I
11 appreciate your openness. And I want to say a
12 special thank you to the scientists while I have a
13 chance, because they really are amazing, and, and
14 it's very hard for me to communicate people who are
15 angry and sick, that I deal with on social media and
16 most type places, that the scientists are moving as
17 fast as they can. They're doing it as fast as they
18 can. Science is slow. We all want it to go faster.
19 But without the science we have nothing, nothing.
20 So I want to say thank you to the scientists who
21 work very hard every day, and I feel very grateful
22 that we are as far as we are, because a lot of
23 contaminated sites don't have what we even have at
24 this point.
25 **DR. BREYSSE:** Thank you for your kind words.

1 Mike?

2 **MR. PARTAIN:** Well, big eye-opener last night
3 was the extent of which the community still does not
4 understand the issues, the frustration that is out
5 there. Late in the meeting I asked you, and brought
6 concerns to the forefront of the question about your
7 agency's position on whether there was a hazard in
8 the drinking water at Camp Lejeune, and you
9 responded in the affirmative. The -- it's a
10 beginning step, to have a government agency
11 acknowledging that we have been affected by what
12 happened at Camp Lejeune, and that there was a
13 hazard in, in consuming the water and being exposed
14 to the contaminants of the base.

15 It's kind of akin to like the fire department
16 coming out and saying your house is on fire. No one
17 wants to believe it until the fire department makes
18 an announcement. And, and over the past year and a
19 half that announcement's been made.

20 Now the next step is to get the other
21 government agencies talking to ATSDR that can help
22 the veterans and their families, mainly the VA. I
23 did see a lot of dysfunction last night with the VA.
24 The representative up there last night did a great
25 job with the limited -- did a great job of trying to

1 field questions, but frankly he was the wrong person
2 there. He was the right person for the families,
3 and that's what he was supposed to be there for, but
4 there was no one up there answering questions from
5 the VA to the veterans. And I sat there -- despite
6 the fact that there were several people here. And I
7 sat there and I scratched my head wandering why
8 aren't these people up there talking. Why doesn't
9 the VA, who knew this thing was going to happen, who
10 knew we had a community meeting, and nobody was here
11 to field questions or talk about what these veterans
12 need. You know, the VA’s, they're first responders.
13 They're the ones who are going to come in here and
14 help clean up the mess and make what of it, take the
15 wrong that has happened to the veterans and their
16 families, and make it right.
17 And I would encourage more open dialogue and
18 more discussions between the VA and ATSDR with the
19 science that has been accomplished here. This isn't
20 junk science. I mean, Morris received an award for
21 what he did, and recognized by his professional
22 society. Okay? If it was junk science, he wouldn't
23 be sitting there with a trophy that weighs more than
24 he does.
25 **DR. BREYSSE:** To be fair, Morris doesn't weigh

1 that much.

2 **MR. ENSMINGER:** Can't even carry it on his

3 bike.

4 **MR. PARTAIN:** And, you know, the next step of

5 ATSDR is our public health assessment, and when that

6 is released. Hopefully that will be sooner than

7 later.

8 **DR. BREYSSE:** And we'll get updates on that as

9 we move forward.

10 **MR. PARTAIN:** But, you know, going forward,

11 though, people want to believe and want to trust in

12 our government. This is an opportunity for our

13 government to come and do the right thing.

14 It is a tragedy, it is -- affected a million

15 people, by estimates and everything, a million

16 Marines and their families are affected from 1953 to

17 1987.

18 You know, accidents happen. Who was at fault?

19 That's not the important thing right now. What's

20 important is taking care of these families. I'm

21 dealing with a dying Marine in Florida right now.

22 He's covered by the healthcare. He has kidney

23 cancer, the calling card cancer for Camp Lejeune

24 exposure to these chemicals. TCE was placed as a

25 human carcinogen in 2011 by the EPA because of its

1 links to kidney cancer. IARC followed suit. Yet
2 this man has been denied from the VA for kidney
3 cancer 'cause he smoked. But yet he has a letter
4 from the doctor explaining that his kidney cancer
5 isn't derived from that, but he's still denied.
6 The only thing he wants -- he's dying, he's
7 metastatic; he's actually in the hospital right now.
8 And the only thing he wants is to die in peace and
9 to know his wife is going to be taken care of. Is
10 that too hard for the VA to do? Is that too hard
11 for our government to step in and take care of these
12 veterans, who volunteered to serve and protect our
13 country?
14 And going back to my point with last night,
15 what I saw was dysfunction. What needs to happen is
16 our agencies need to get together. They need to
17 meet. If there's differences of opinion, they need
18 to be resolved. There needs to be disclosure. How
19 does the VA determine who gets benefits, who does
20 not? A clear understandable method.
21 **MR. ENSMINGER:** They don't know.
22 **DR. BREYSSE:** Thank -- thank you, Mike. I
23 think those are, those are all things that I'm
24 committed to help work with the VA on, and I
25 think --

1 **MR. PARTAIN:** One, one last point, and I don't
2 want to blow the VA too much but, but prior to last
3 year, the VA had consistency or consistently awarded
4 around 25 percent of the VA claims being presented
5 for Camp Lejeune. Over the past year, we've had
6 four scientific studies of the water model come out
7 that have shown connections. And the body of
8 science has gone in one direction, away from what
9 the VA's decision has been, yet the VA's award rate
10 has dropped from 25 percent to around 5 percent.
11 It's counterintuitive to science, and they -- and it
12 cannot be explained.
13 **DR. BREYSSE:** Thanks, Mike. We'll come back to
14 some of these issues later on, but I want to make
15 sure we get around the room before we move on to the
16 agenda.
17 **MR. SMITH:** Real quickly, just to follow on
18 everything that's already said, I just wanted to
19 point out the observation I had last night of the
20 courage of people in the room that stood up and
21 shared their stories. There were a couple in
22 particular that... I think you -- when we get
23 involved in some of this, as I deal with families
24 and -- from the civilian side, and I remember my
25 father from years ago, it's a reminder to me. It

1 was a very visceral reminder to me of what we're
2 doing here, and the courage it takes to step forward
3 and share. I know someone mentioned that,
4 especially for the Marines, that usually we're
5 taught to suck it up and deal with it, and not to
6 admit it. So to come here, to speak out, to show
7 that courage, to find other people and to connect
8 with them and to get them involved and to make sure
9 that everyone is taken care of and working together
10 and be involved, I think, is a real testament to the
11 strength of the Marine Corps from Camp Lejeune and
12 all the people involved. So thank you for that.
13 **DR. BREYSSE:** Tim?
14 **MR. TEMPLETON:** Being the last guy, I think
15 everybody pretty much covered it. But one thing
16 that I would like to say is, from last night, it was
17 great to hear everyone get the opportunity to air
18 their concerns. A lot of those concerns, again, and
19 I know this is going to sound like I'm beating a
20 dead horse, but a lot of those concerns did have to
21 do with the VA. I'm really encouraged that we have
22 several VA representatives here today. I'm looking
23 forward to some cooperation and partnership moving
24 forward.
25 **DR. BREYSSE:** Okay. Brad?

1 **MR. FLOHR:** Yeah, I'd just like to say that
2 I've been coming to these CAP meetings since the
3 first one in 2011, I believe. And I've been the
4 only VA person here for a lot of that time, and I've
5 only missed, I think, one CAP meeting in that time.
6 And the very first one I came to, I gave a
7 presentation on the disability claims process, what
8 we need, the evidence we look at in the decisions
9 that we make. I know there's a lot of new CAP
10 members here. I would have been glad to have done
11 that last night, had I been asked but I was not. I
12 would be glad to do it in a future CAP meeting, for
13 those that, that are new and want to know about the
14 claims process. Like I said, I'd be glad to do it.
15 **MS. FRESHWATER:** I think we want initiative
16 from the VA. I don't -- we're dealing -- we
17 understand you're busy but we're dealing with an
18 awful lot. So I think what we would like is for the
19 VA to step up and say, hmm, there are a lot of
20 people out there that are -- the whole new program
21 with the family members. There's a whole lot of
22 people filing now. I bet it would be helpful to go
23 through the system. You know what I mean? I
24 appreciate what you're saying but, I, I think we're
25 looking for the VA to come forward and be active

1 and -- that's what I meant by as opposed to an
2 adversarial role. We need the VA to be not passive,
3 here to defend; we need the VA to be here to help
4 actively.
5 **DR. BREYSSE:** More proactive?
6 **MS. FRESHWATER:** Yes.
7 **DR. BREYSSE:** Any other senses from the CAP
8 meeting -- or from the public meeting last night?
9 Richard?
10 **DR. CLAPP:** This is very brief. This is my
11 brief thing. I mentioned a website last night to
12 you and it was a com, and it's not -- the Clinics
13 for Occupational Environmental Medicine website is
14 aoec.org. So I'll just correct that on the record.
15 **DR. BREYSSE:** So that's the Association for
16 Occupational Environmental Medicine Clinics; is that
17 what AOEC stands for?
18 **DR. CLAPP:** It is. There's no medicine in the
19 website, aoem -- or aoec.
20 **DR. BREYSSE:** So a number of people came up to
21 me afterwards and said, you know, my doctor -- I
22 have all these complaints about injuries and
23 concerns about screening for chemicals that I may
24 have been exposed to or was exposed to, and my
25 doctors don't know anything about this, and what

1 resources that may help me. And so this is the
2 resource that's been set up and for exactly this
3 purpose.
4 These clinics aren't necessarily going to be
5 able to examine everybody but they can provide
6 resources to your doctors to help understand about
7 what should be done. If you're worried about your
8 exposures, this is something you need to talk to
9 your doctor about. These are things your doctor can
10 do in terms of screening and examinations that can
11 be done to minimize your risk. And these are
12 resources to help your doctor understand, you know,
13 what would be appropriate medical tests and
14 diagnosis and screening opportunities be.
15 Any other feedback on the CAP meeting? I mean,
16 I'm sorry, I mean the public meeting. So like I
17 said, I began saying that listening is important,
18 and we're going to try and schedule other public
19 meetings over the next year or so across the
20 country, recognizing that Marines are not just in
21 North Carolina anymore; they're all over the
22 country. And I think there's a story to be told and
23 there's people who need to be heard. And we're
24 committed to provide an opportunity to tell those
25 stories and, and a venue to listen.

1 So moving on with the agenda, the next item on
2 the agenda is action items from the previous CAP
3 meeting. And Dr. Angela Ragin, can you review those
4 with us?

5 **ACTION ITEMS FROM THE PREVIOUS CAP MEETING**

6 **DR. RAGIN:** Sure, good morning again. We have
7 quite a few action items to go over from the last
8 CAP meeting that was held January 15, 2014 (sic) in
9 Atlanta. Before I begin, I would like to recognize
10 the two new CAP members, Danielle Corazza and
11 Bernard Hodore.

12 The first set of action items is for the
13 Department of Navy. I will read the action items
14 and ask Melissa Forrest to respond. The first
15 action item: The CAP would like the Department of
16 Navy to provide rationale For Official Use Only
17 status of source documents that is currently being
18 used by the ATSDR.

19 **MS. FORREST:** For Official Use Only is used to
20 identify documents that may contain information or
21 material which, although unclassified, may not be
22 appropriate for public release. DON, Department of
23 the Navy, expedites delivery of requested documents
24 to ATSDR for their work without the documents
25 undergoing a formal review. These documents are

1 labeled FOUO because they must be returned to the
2 DON, Department of Navy, for formal review and
3 compliance with the Freedom of Information Act prior
4 to any requested release to the public.
5 **MR. ENSMINGER:** Now FOUO, is that an official
6 classification under the Freedom of Information Act
7 now? No, it's not.
8 **MS. FORREST:** I, I can't answer that question.
9 **MR. ENSMINGER:** FOUO is crap, okay?
10 **DR. BREYSSE:** So other than that colorful
11 description, can you help explain to me what FOUO
12 stands for again, and what's the significance of
13 that with respect to -- the issue here is that
14 ATSDR, we need as much information as available
15 about what might be known about the chemical
16 contamination at Camp Lejeune. And much of that
17 information needs to come from the Navy. And so in
18 that context, what does FOUO mean?
19 **MS. FORREST:** Well, what we're saying is, you
20 know, when you ask us for large amounts of
21 documents, we're trying to get the information to
22 you as quickly as possible. If it's something that
23 you want to be able to release to the public, it has
24 to go through an official review. So to try and
25 expedite you getting the information you need, we

1 are just marking it all FOUO so that it can go over
2 to you and you can --
3 **DR. BREYSSE:** So we have access to it.
4 **MS. FORREST:** Yes. If we want to release it to
5 the public, the whole group or any one particular
6 document, then we have to do a review of it. We
7 can't just send over mass amounts of information and
8 say it's okay to give it out; we have to do a
9 review. So we're sending it in lumps like that with
10 that classification to try and expedite your
11 scientific process. So I don't know if there's
12 something that we can work on, you know, to...
13 **DR. BREYSSE:** So, so it's clear from our
14 perspective that we need it for our scientific
15 process, but the community will also benefit from
16 seeing these documents as well. So if there's a
17 process through which we could expedite that
18 assessment, once we had our look at the data,
19 obviously it is a priority to extract the
20 information we need for our studies, I think that
21 would be -- you know, it would be helpful.
22 **MR. ENSMINGER:** Well, also, to make your
23 science valid, you've got to be able to reveal the
24 sources and make the sources of your information or
25 your studies available to the public and available

1 to anybody that wants to try to replicate it.

2 **DR. BREYSSE:** Absolutely.

3 **MR. ENSMINGER:** If they can't replicate it and
4 they don't have the documents -- well, if they don't
5 have the documentation, they can't replicate it. So
6 it's, it's not scientifically sound.

7 **MS. FRESHWATER:** Can I ask you a question,
8 Melissa?

9 **MS. FORREST:** Yes.

10 **MS. FRESHWATER:** And, and help me understand,
11 if it's not classified, why is it just not
12 classified? I mean, if documents are not meant to
13 be seen by the public eye, why -- they're,
14 they're -- do you see what I'm saying? Like it's
15 either classified or not.

16 **MS. FORREST:** I am not an expert on classified
17 and unclassified documents. I mean, I can take that
18 particular question back. What I'm hearing is that
19 we need to work on some sort of process to both give
20 you the information as quickly as possible and
21 identify which information CAP members would like to
22 review or you would see beneficial for the public to
23 have access to, so that at the same time as you're
24 starting to use the documents, we do whatever review
25 we have to so it can be released. Is that what I'm

1 hearing?
2 **MS. FRESHWATER:** I, I want a better explanation
3 as to why documents that are not classified, that
4 are nowhere near classified, that have never been in
5 a classified universe, are not open to the public.
6 Because it feels like it's just CYA, and it feels
7 like if we go and -- through a process to file a
8 Freedom of Information Act, you know, it's just
9 slowing everything down.
10 And the public, the Marines and their families,
11 who drank water that have made them sick, should be
12 able to see documents that are not classified. I
13 mean, these are old documents. There's not -- one
14 example that was so absurd was not wanting the
15 location of the water towers to be known. The water
16 towers are red and white checkerboard. They're,
17 they're famous. You know, you can see them from
18 like South Carolina. So that is just an example,
19 and I am not taking it out on you, and I don't think
20 you're, Jerry, just a note-taker, Melissa. I've
21 found you very -- I've, I've enjoyed working with
22 you, and I know there's only so much you can do.
23 But I want you to find a very direct way to --
24 I want a very clear answer as to why, if documents
25 aren't classified, the public cannot see them.

1 Because I don't buy that they have to look at them
2 before the public can see them. I mean, these,
3 these people are public. They work for the
4 government but they're not -- they don't have -- do
5 you guys have any clearance? Do you have any --
6 have you been up and been cleared for, you know,
7 classified documents?
8 **MS. FORREST:** I, I think that --
9 **MS. FRESHWATER:** Do you see what I'm saying?
10 **MS. FORREST:** I do. I think the review process
11 that we're doing is to ensure that we aren't
12 releasing anything we shouldn't.
13 **MS. FRESHWATER:** But why -- what would be in
14 there that shouldn't be seen? Give me one example.
15 **MS. FORREST:** I, I don't know. I'm just saying
16 there's a process we have to follow. And I, I hear
17 what you're saying, and I think that we can work on
18 something that ensures that you get the information
19 you need quickly, and we can still do this review,
20 and you can still have access to it.
21 **DR. BREYSSE:** So Melissa, let's just put that
22 down; we'll do that today. What Jerry said is
23 absolutely right, though. For us to use the data at
24 the end of the day, the public needs to see what
25 data we're using. People who don't agree with us

1 and want to double-check, who do our peer reviews,
2 need to see that data, so everybody can check our
3 science. So the science is not defensible unless
4 all the sources, all the resources, that go into
5 that are publically available. So it's crucial for
6 us to defend what we do at the end of the day. We
7 can do our work while we sort this out, but we have
8 to make sure what we use is more broadly available.
9 And we have to stand up to the scrutiny of public
10 inspection of what we do, of scientific inspection
11 of what we do, and all that is based on making this
12 information widely available.
13 **MS. FORREST:** So I'm, I'm hearing two things to
14 work on, which is the process to make sure you are
15 able to release the information you need to release,
16 and you want a clear explanation, Lori, of why --
17 **MS. FRESHWATER:** Like a list.
18 **MS. FORREST:** -- if you could just help me
19 formulate your question so I make sure I take back
20 the correct question.
21 **MS. FRESHWATER:** I would like a list of
22 reasons, you know, like Danielle just mentioned,
23 personal information, okay? So that's one of the
24 reasons that they're going to say. I would like a
25 full list of the reasons that we cannot see every

1 single document. As people who are working on this
2 and trying to help Marines and their families, I, I
3 would like to know exactly every reason that
4 they're -- that these documents that are not
5 classified, that we can't have them.
6 **MS. FORREST:** And I don't know that I'm
7 explaining it well enough, and if I want to take it
8 back and get an accurate answer. I think what --
9 the answer to that is you can see things that are
10 not classified. We just have to ensure that the
11 information that we're sharing with you does not
12 have anything in it that does need classifying or
13 sensitive nature. And I --
14 **MR. PARTAIN:** Melissa, can I cut to the chase
15 with this? Those lists have been provided by the
16 Marine Corps in the form of FOIA exemptions, things
17 like attorney/client privileges, where the JAG
18 attorney was advising them on press releases on what
19 to say or not say to the public of Camp Lejeune, you
20 know, personal information or what have you, or just
21 whatever, you know, FOIA exemption they stick on
22 there, and they provided that list to us when they
23 released the Navy portal.
24 Interesting enough, a lot of this document
25 discussion at issue really became a problem after

1 2008, when we released our first timeline that was
2 taken with the initial batch of documents that were
3 dumped on ATSDR by the Marine Corps. In fairness to
4 ATSDR and the work, the things that we were finding
5 were not scientific in nature, quantities, things
6 like that; they were historical information of what
7 happened on the base, for example, the fuel issues
8 with benzene in the water.
9 And as it became apparent that we were taking
10 this information and making it useful and coming out
11 and writing ATSDR with other avenues to look into,
12 the Navy and Marine Corps began clamping down on
13 what they released, how they released it, and
14 redacting the information.
15 But as far as the reasoning that Lori is asking
16 for, that has been provided in the form of FOIA
17 exemptions and also the use of FOUO, which is not,
18 as Jerry mentioned, not a legitimate redactable
19 excuse. So I didn't mean to jump in but then I
20 guess that some of this has already been answered.
21 **MS. FRESHWATER:** I would like to review that
22 again now, you know, now that we've moved further
23 down the road.
24 **DR. BREYSSE:** Okay. I think that -- we have a
25 number of action items so I think we, unless there's

1 something new to add to this, I think that we, if we
2 have time, we need to --
3 **MR. ORRIS:** Well, I do have something new to
4 add to this, because I happen to have one of those
5 documents that's (inaudible) dated from July 24,
6 2013.
7 **DR. BREYSSE:** Can you speak into the
8 microphone?
9 **MR. ORRIS:** Oh, I'm sorry. I happen to have
10 one of these documents that the Department of Navy
11 doesn't want to hand to us, and it's dated July 24
12 of 2013. And it's a technical memorandum, final,
13 issued by CH2M Hill, regarding Building 133. Now,
14 it came as quite a shock to me when reading this
15 document, and I saw that there's PCE concentrations
16 that more than double exceeded generic ^ for Camp
17 Lejeune. However, since there's only that one VOC
18 that was detected above the screening level, you
19 decided that it was not necessary to account for
20 cumulative non-cancer risks. Those non-cancer risks
21 are only things as birth defects in women of
22 child-bearing age, liver and kidney damage. And
23 it's, it's quite shocking to see that there is vapor
24 intrusion potential in the training room at Camp
25 Lejeune in July of 2013.

1 Now, you know, this is just one document out of
2 the many documents that are out there, but it's,
3 it's -- I can understand why you don't want to give
4 those documents to us, because we keep finding
5 documents that show that there's ongoing problems at
6 the base. And I would really like to know whether
7 you have notified the people who work in Building
8 133 of the potential vapor intrusion. I won't hold
9 my breath waiting for your response, 'cause I know
10 you have to go back to your bosses, but if I worked
11 at that building, I'd hold my breath every time I
12 went in there.
13 **DR. BREYSSE:** That's a sudden different issue,
14 but we'll make sure we capture it. But I think it's
15 clear that there's a barrier that we need to
16 understand and we need to either break down or
17 figure out a way to work around it.
18 **MS. FRESHWATER:** Chris, were they notified at
19 all? Not just about vapor intrusion but was anyone
20 in the driving school notified that there was
21 contaminated soil in 2012?
22 **MR. ORRIS:** I wouldn't have that. I can't
23 answer that question. That's going to be from the
24 Department of the Navy whether they're notifying
25 their personnel of ongoing exposures in this.

1 **MS. FRESHWATER:** It's a good question, isn't
2 it?
3 **DR. BREYSSE:** Yeah. Great question. Angela?
4 **DR. RAGIN:** The next action item for the
5 Department of the Navy. This is in reference to
6 notification of women who may have been exposed to
7 TCE vapor intrusion at Camp Lejeune. The CAP would
8 like to know how and when were the women notified,
9 and was this notification timely?
10 **MS. FORREST:** As explained in a response to a
11 September 2014 action item, comprehensive vapor
12 intrusion studies are ongoing in several locations
13 on Camp Lejeune for multiple ground water
14 contaminants, including TCE.
15 In recent years, multiple fact sheets and other
16 forms of information have been provided to workers
17 to notify them of plans and findings throughout the
18 vapor intrusion investigation process. The term
19 timely was used in our response to the
20 September 2014 action item to explain our plans for
21 notification that may be needed in the future,
22 because each site is different and issue is
23 different and would require a different timeline for
24 response.
25 For future TCE vapor intrusion issues, as with

1 other such issues that may arise, our goal is to
2 provide appropriate, accurate and timely
3 notification to our workers.
4 **MR. ORRIS:** Melissa?
5 **MS. FORREST:** Yes.
6 **MR. ORRIS:** It only takes one instance of
7 exposure for a baby in utero to be given a life-
8 threatening birth defect. What exactly does the
9 Department of the Navy consider timely, given the
10 extreme severity of TCE vapor intrusion?
11 **MS. FORREST:** I can't respond other than what
12 was in the response, that, you know, it depends.
13 It's a site-specific issue. We don't -- there's not
14 an answer for timely for each situation.
15 **MR. ORRIS:** I don't think that that answer is
16 good enough for women of child-bearing age on the
17 base who might be exposing their children in utero
18 today. I don't think that that's good enough, and I
19 think it's a disservice to every man and woman in
20 the armed services who put their lives on the line.
21 They don't need to expose their children because of
22 their job. And I don't think that we're providing a
23 timely notification. But I'm looking at this study,
24 and I know you're not.
25 **DR. BREYSSE:** So can we ask the Navy/Marines to

1 be more specific about what timely means and --
2 **MR. ORRIS:** Well, the EPA considers it such an
3 important issue that they are going through their
4 Superfund sites and shutting down any locations
5 where there is TCE vapor intrusion because of the
6 risk of cardiac defects. And I'd like to know why
7 the Department of the Navy is not following suit.
8 **MS. FRESHWATER:** And I think that maybe we
9 should do a better job of getting out to the
10 national media and getting more information out that
11 there is risk on base, on Camp Lejeune, today. And
12 then maybe they, the people that are on base, the
13 Marines there now, could demand a definition of
14 timely. 'Cause that's really what I want. I want a
15 definition of timely. I want, what does that mean?
16 **DR. BREYSSE:** Okay. Angela?
17 **DR. RAGIN:** The next action item for Melissa:
18 The CAP would like for the Department of the Navy to
19 provide the model number for the GCMS and
20 information for when it was first purchased.
21 **MS. FORREST:** The Marine Corps would like to
22 provide clarification on this action item. We are
23 not asking for the GCMS model number to prepare a
24 response. The initial action item referenced a
25 document which can provide us with context and

1 background information for our research so that we
2 look into the appropriate records. We will be more
3 than happy to continue to look into this; however,
4 as we indicated previously, we need the reference
5 document, originally promised by the CAP.
6 **DR. BREYSSE:** So there's some feedback --
7 **MR. PARTAIN:** It was, that document was sent at
8 the last CAP meeting. I just resent it this
9 morning.
10 **MS. STEVENS:** You sent it. We got it. Okay,
11 we don't need it. We got it. Melissa, we'll send
12 that to you.
13 **DR. BREYSSE:** It didn't get to the main --
14 **MS. STEVENS:** We just got it. Just got it.
15 Well, we got it for the second time but we'll send
16 it to you.
17 **MS. FORREST:** And I will take that back for us
18 to begin our research.
19 **MR. ENSMINGER:** And the GCMS did not come from
20 the Marine Corps; it came from the Navy
21 Environmental Health Center in Norfolk.
22 **MS. FORREST:** This is why we need the
23 documents, so we make sure we are looking into the
24 right instance, the right equipment, answering your
25 question appropriately.

1 **DR. BREYSSE:** Angela?
2 **DR. RAGIN:** The next set of action items for
3 the ATSDR. ATSDR leaderships and experts will
4 discuss a request from the Department of the Navy a
5 database with all information of environmental data
6 related to Camp Lejeune that is functional and easy
7 to use for review by scientists and CAP members.
8 And Rick Gillig will respond to that action item.
9 **MR. GILLIG:** We had a discussion about this
10 database in the context to the soil vapor intrusion
11 project. We do have the files for the soil vapor
12 intrusion project. We're using various computer
13 programs to search those files. So rather than a
14 relational database, we can use keyword searches to
15 find the information of interest to us and pull out
16 that information.
17 **DR. BREYSSE:** Next?
18 **DR. RAGIN:** The next action item: ATSDR and
19 the CAP will review VA's Camp Lejeune research and
20 studies, web page, and provide recommended updates
21 and corrections to Brad Flohr. Brad will keep the
22 CAP informed of any updates that are made to the
23 website. I will turn over to Frank Bove.
24 **DR. BOVE:** I actually don't have that in front
25 of me. There were -- there are still some issues on

1 the VA website, under the compensation part of the
2 website, where there -- a statement about the fact
3 that we still don't know the extent of the
4 contamination at the base, and also a statement that
5 was equivocal about kidney cancer and
6 trichloroethylene, so those are still there as far
7 as I know. But I checked a couple days ago.
8 **DR. BREYSSE:** All right. Brad, these are the
9 two things we mentioned -- I mentioned to you last
10 week. So we can get those exact URLs to you guys as
11 well. Any other concerns about the VA website?
12 **MR. ORRIS:** Yeah, I, I brought this up at the
13 last CAP meeting as well, for the family benefits
14 section. You're still -- have that form up, that
15 for authorization of medical release. That form
16 that you have up is a VA-to-VA form that is in
17 reference to HIV and alcohol abuse, which, I think,
18 is highly inappropriate for family members to fill
19 out.
20 And I also still think that you should not be
21 asking for comorbidities and risk factors from
22 family members' physicians, when they apply for
23 benefits. That should be something that is
24 completed by your team in your investigation and not
25 provided up front from a doctor. No doctor's going

1 to, you know, put that information anyway. And it
2 just seems to me a tactic to limit applications. So
3 again, please address those issues.
4 **DR. BREYSSE:** Chris, can we -- so we're clear,
5 can you put that in writing, so the VA can have
6 something concrete to respond to?
7 **MR. ORRIS:** Absolutely.
8 **DR. BREYSSE:** Thank you. Angela.
9 **MS. STEVENS:** Chris, just send that to me when
10 you get it, and I'll make sure it gets to Brad.
11 **DR. RAGIN:** The next action item for ATSDR: It
12 was a request that ATSDR update their tox fact sheet
13 on TCE. And I have copies here of the tox facts
14 sheet. It was updated, and some additional language
15 was added to the fact sheet, and I'll just read the
16 language for you. But I do have some copies here.
17 The language that was added to the fact sheet: The
18 International Agency for Research on Cancer and the
19 EPA determined that there is convincing evidence
20 that trichloroethylene, or TCE, exposure can cause
21 kidney cancer. The National Toxicology Program is
22 recommending a change in cancer classification to
23 known human carcinogen, and we have a website here
24 where that information can be found. And if anybody
25 wants a copy of the fact sheet, they can see me, but

1 it can be found on our website.

2 **MR. ENSMINGER:** When was that made? 'Cause I

3 looked at it over the weekend.

4 **DR. RAGIN:** The update was made --

5 **MR. ENSMINGER:** Yesterday.

6 **MS. STEVENS:** Yesterday.

7 **MR. ENSMINGER:** Gee, only took three years, you

8 know.

9 **DR. BREYSSE:** Angela?

10 **DR. RAGIN:** The next action item: ATSDR will

11 review and consider adding or incorporating details

12 for Mike Partain's timeline on our website. The

13 action item was addressed to Mike. Mike, do you

14 want to clarify or respond?

15 **DR. BREYSSE:** So the discussion was -- I

16 remember the discussion.

17 **MR. PARTAIN:** Yeah, getting my timeline over to

18 you, which I will.

19 **DR. BREYSSE:** Yeah. And it turns out we had a

20 timeline on our web page. At the time it wasn't

21 clear that we did have a timeline, so I think,

22 rather than put yours on, I think we decided to just

23 stay with the timeline that we have, which is

24 consistent with what you have.

25 **MR. PARTAIN:** Okay, 'cause I don't recall

1 seeing that timeline. Is it the annotated documents
2 and things or?
3 **DR. BREYSSE:** I don't believe it's annotated
4 like that.
5 **MR. PARTAIN:** Okay, 'cause I think that would
6 be -- well, I'll take a look at the timeline.
7 **MR. ENSMINGER:** I'll guarantee you it's not --
8 **MS. FRESHWATER:** Yeah, the -- his timeline, the
9 importance is the documents, because people can go
10 through and look at every single document that backs
11 up exactly what we're saying. So if -- and I
12 understand if you don't even want to put the whole
13 timeline but a link. Let Christian put, you know,
14 or email, that type thing. At least people have
15 access to Mike Partain's timeline 'cause it should
16 be famous. It's amazing.
17 **DR. BREYSSE:** We'll take that under further
18 consideration.
19 **DR. RAGIN:** The next action item for the ATSDR.
20 The CAP requested ATSDR invite a Department of Labor
21 claims representative relevant to civilian employees
22 at Camp Lejeune to attend the CAP meeting. And we
23 are waiting for some information from the CAP.
24 **MR. SMITH:** Right. I'm actually working on
25 collating some questions from the civilian community

1 now, and I'll get those in. I want to try to get
2 those in so that we can at least get their presence
3 for the next meeting.
4 **DR. RAGIN:** ATSDR was asked to provide the
5 revised CAP guidance document to the CAP for review,
6 and comment. And I think that was accomplished, and
7 the guidance document has been posted on ATSDR's
8 Camp Lejeune website.
9 And we have quite a few action items for the
10 VA. Would you like to hold those at that session or
11 continue?
12 **MR. ENSMINGER:** Well, I think there was an
13 action item for ATSDR about the public health
14 assessment too, the reissuance of the public health
15 assessment and where that's at in the review
16 process.
17 **DR. BREYSSE:** Well, we'll cover that when we do
18 update of our studies.
19 **MR. ENSMINGER:** Okay.
20 **DR. BREYSSE:** So we're at a point right now
21 where we should be transitioning to the soil vapor
22 intrusion work. Why don't we hold off the action
23 items for the VA until we have a session about VA
24 input into the process. Anybody have a problem with
25 that?

1 So Rick, you want to give an update on the soil
2 vapor intrusion and drinking water exposure
3 evaluations?
4 **UPDATE ON SOIL VAPOR INTRUSION AND DRINKING WATER**
5 **EXPOSURE EVALUATIONS**
6 **MR. GILLIG:** Sure. Jerry, to address the issue
7 you just raised about the status of the health
8 assessment on the drinking water exposures, that
9 document is in clearance. That document, we look at
10 exposures to drinking water, both through drinking
11 water, we also look at exposures that are related to
12 using the water for showering, for bathing, for
13 swimming pool recreational use, Marines in training
14 in the swimming pool or the pool facility. We're
15 also looking at exposures to workers in dining
16 facilities, both workers working the serving lines
17 as well as those washing pots and pans and dishes.
18 We're also looking at exposures to workers in the
19 laundry facilities.
20 So we're covering a broad range of exposure
21 scenarios with that document. Again, that's going
22 through clearance at this point. We hope to have
23 that document out for peer review this coming
24 summer. The CAP members will receive that as one of
25 the peer reviewers.

1 **MR. ORRIS:** Rick, I have a question for you.
2 Are you using the detection screening methods
3 provided by EPA or are you using the values provided
4 by the Department of the Navy? 'Cause I noticed
5 that the Department of the Navy is still, even to
6 this day, using the industrial indoor air screening
7 level for their vapor intrusion models. And I know
8 that that is a different valuation than what the EPA
9 recommends.
10 **MR. GILLIG:** You know, the health comparison
11 value and the health endpoint we're using we're
12 basing on the studies done by the EPA.
13 **MR. ORRIS:** Okay. Thank you.
14 **DR. CANTOR:** Rick, I have a question as well.
15 This is Ken Cantor. So in your comments yesterday
16 you mentioned inhalation several times, but also
17 there's an issue about dermal exposure and
18 transdermal conveyance of TCE and other ^ molecules
19 such as this. So I wondered to what extent is
20 dermal exposures included in your evaluation?
21 **MR. GILLIG:** We did evaluate dermal exposures.
22 As far as the extent, I couldn't tell you. I know
23 it's covered in the document. I know that was a
24 concern that Jerry had also raised about health
25 program -- healthcare workers with frequent hand

1 washing. So that, again, that is addressed in that
2 document.
3 **MR. ENSMINGER:** And food service.
4 **MR. GILLIG:** And we -- I did talk about food
5 service, yeah, both the line workers as well as
6 people washing dishes, pots and pans.
7 **MR. TEMPLETON:** This is Tim Templeton. Real
8 quick question. And I know we've had just a short
9 discussion over email about MEK, one of the
10 stabilizers that may have been used in TCE. There's
11 an effect with -- currently with dioxane and/or MEK
12 has on TCE's ability to people -- to do damage to
13 bodies. Is that accounted for? Is the MEK
14 accounted for in any way?
15 **MR. GILLIG:** Our document focuses on the VOCs,
16 the VOCs that were at the highest levels. Again,
17 our document is based on the modeling that Morris
18 Maslia and his team conducted.
19 **DR. BREYSSE:** So does that mean MEK was not
20 part of the assessment?
21 **MR. GILLIG:** What I've seen of the MEK levels,
22 they were very low, so it was not part of the
23 assessment.
24 **DR. BREYSSE:** Morris?
25 **MR. MASLIA:** Just to reemphasize and clarify,

1 the water modeling looked at the VOC chain and
2 degradation from PCE to TCE, DCE to various
3 conjoiners; DCE, vinyl chloride, and then of course
4 benzene in the industrial area. We've not separated
5 out components of TCE or things of that nature.
6 **DR. BREYSSE:** Any other updates, Rick, on the
7 soil vapor or the --
8 **MR. GILLIG:** Yes, for the soil vapor intrusion
9 project, I had quite a few updates at the last CAP
10 meeting. We've completed the index of approximately
11 23,000 electronic files. Those are documents we've
12 obtained from EPA, from the Navy, from the State,
13 the North Carolina Department of Environment and
14 Natural Resources, also documents we obtained from
15 the CAP.
16 We've loaded these files into a SQL database.
17 That SQL database allows us to rapidly do keyword
18 searches. We'll also be using Adobe Acrobat to do
19 keyword searching. That program identifies the page
20 number from the various documents that we want to
21 look at those page numbers that indicates what
22 keywords and what page numbers those are on. We
23 want to review those to make sure the SQL Server
24 keyword search is as robust as the Acrobat keyword
25 search. So it's kind of doing double duty on it.

1 We've completed our review and removed
2 duplicates, and created an index, and put these
3 documents on the FTP site. So we put the CAP-
4 provided files on the FTP site, those provided by
5 the North Carolina Department of Environment and
6 Natural Resources. We had some files from the data
7 mining, ATSDR's data mining, technical work group.
8 And we also had underground storage tank documents
9 provided by the Navy, and some of those are
10 available on the FTP site.
11 I want to let you know that we have received
12 funding from the Department of the Navy to hire the
13 contractor. We're in the process of selecting a
14 contractor, and this contractor will assist us with
15 reviewing the electronic files to identify those
16 with information of interest. And then we'll be
17 pulling out that information and using that as a
18 basis for our soil vapor intrusion project. Any
19 questions?
20 **MR. TEMPLETON:** Are you assigning keywords to
21 the PDFs that are all raster paper-scanned --
22 scanned documents in there? They don't -- they're
23 not paper documents?
24 **MR. GILLIG:** I'm not sure I understand your
25 question, but we'll be searching all of the files

1 using keywords.

2 **MR. TEMPLETON:** I noticed that there were

3 several of the PDFs that were -- that are scanned

4 documents, and so they'd use optical character

5 recognition, OCR --

6 **MR. GILLIG:** Correct.

7 **MR. TEMPLETON:** -- on them. So there's a way

8 to add the keywords to a PDF document that are

9 pulled out. I don't know, other than OCR, how you

10 would do that, unless you just reviewed the document

11 visually and said, okay, this one says Building

12 1101, and then you made that one of the keywords

13 that was part of the PDF file itself.

14 **MR. GILLIG:** We've had people whose computer

15 skills are so far above mine, and they've provided

16 great -- a great resource. They told us how --

17 exactly how to do it.

18 **MR. TEMPLETON:** Perfect. Thank you.

19 **MR. PARTAIN:** And Rick, throw something out

20 there, of course with Dr. Breysse's permission, but

21 as you're going through these documents, understand

22 that we're not dealing with just a small amount of

23 documents. You're dealing with thousands upon

24 thousands upon thousands of pages. So, you know,

25 the keyword searches and identifying these things,

1 even with the keyword search, you're still dealing
2 with thousands of pages of documents.
3 I, for one, on the CAP, and anyone else who
4 would like to be lumped in here, would be more than
5 glad to do -- to assist you guys and do some close
6 reading of the documents, because even though a
7 keyword search may turn up things, just like when we
8 did the timeline back in 2008, a closer reading of
9 the documents that frankly, I know you guys are
10 pressed for time and resources, would it be
11 something that you're not -- it's a resource that
12 you don't have necessarily available to you. But as
13 a CAP, we would be glad, if you come across
14 something that you think may be important or a
15 document that needs a closer reading and historical
16 interpretation, that may point you in a direction
17 somewhere else; for example, what happened with the
18 benzene issue in 2009, we would be glad to do that.
19 Just, you need to let us know what document or
20 documents that you want us to look at or
21 interpretation. I would encourage, if that's
22 possible, to get that feedback back to us.
23 I know it occurs with the Marine Corps, when
24 you guys have questions on their source documents
25 and things, and I would encourage you to engage the

1 community as well, 'cause we would be more than
2 happy to do that. I know I will.
3 **MR. GILLIG:** Okay. I'd like to put that down
4 as a follow-up item. And we'll discuss that with
5 Dr. Breysse.
6 **MS. FRESHWATER:** Yeah, I think the diversity of
7 the CAP would help in that instance, you know, being
8 able to see different contexts and connections.
9 **DR. BREYSSE:** So that's a great suggestion.
10 We'll take it into consideration at a minimum with
11 the document uploads. We're happy to have the CAP,
12 the VA, Navy, anybody looking over our shoulders,
13 going through the same documents, making sure that
14 we didn't miss anything. So whether we invite you
15 to help out early in the process or it comes, you
16 know, after the documents become publicly available,
17 that input's going to be valuable one way or the
18 other.
19 **MR. ORRIS:** Rick, I have a question regarding
20 the dates that you were looking at. What data
21 period are you looking at for the vapor intrusion
22 study?
23 **MR. GILLIG:** We made the request for documents
24 back in 2013 so we're looking 2013 backwards. But I
25 believe our -- the documents that we have, we have

1 2014 documents as well. So I can't tell you the
2 exact date, the most recent document, but the
3 document that you referenced earlier is one that was
4 placed on our website, or the FTP site rather. So
5 we know we have documents well into 2013, and I
6 assume we also have some from 2014.
7 **MR. ORRIS:** So when you update your public
8 health assessment, you're also going to update
9 whether or not there is any current vapor intrusion
10 occurring at the base?
11 **MR. GILLIG:** Yes.
12 **MR. ORRIS:** Thank you.
13 **DR. BREYSSE:** Anything else, Rick?
14 **MR. GILLIG:** That's all.
15 **DR. BREYSSE:** Any more questions for Rick?
16 So why don't we switch now to the updates on
17 the health studies, and then we'll take a break, and
18 after break we'll come back and discuss with the VA.
19 So Perri and Frank?
20 **UPDATES ON HEALTH STUDIES**
21 **MS. RUCKART:** I just have a couple of updates
22 where we are with the studies that are in progress
23 that we mentioned last night. The male breast
24 cancer study, it's completed in terms of the agency
25 review. It was submitted to the journal

1 *Environmental Health* on April 20th. That's the same
2 journal where the other four health studies were
3 published. It'll be a minimum of six weeks until we
4 get a response from the journal, so we're still
5 within that six-week time frame here. And then if
6 it's accepted, we need to respond to their peer
7 reviewers' comments. So just to let you know, we
8 still have a little bit of time here before it's
9 actually published.
10 **DR. BREYSSE:** If all goes well, it could be a
11 couple months from now, but it's --
12 **MS. RUCKART:** Right. I'm estimating late
13 summer would be a best-case scenario, but it could
14 be beyond that.
15 The health survey, we're continuing to analyze
16 the data, and we expect to have a draft report
17 available to start the agency clearance by the end
18 of the summer. That's just a really massive effort
19 with upwards of 60 outcomes and the five chemicals,
20 so quite a bit of work there.
21 The cancer incidence study, the protocol is
22 undergoing agency review, and the next steps are
23 submitting for institutional review board approval.
24 That's when the subjects just get into, that you are
25 properly working within the subjects, and working

1 with our procurements and grants office to award a
2 contract. Any questions?
3 **MR. ENSMINGER:** Yeah, where -- the cancer
4 incidence study protocol?
5 **MS. RUCKART:** Right. That was the one I said
6 is currently undergoing review by the agency, and
7 the next steps are the human subjects.
8 **MR. ENSMINGER:** Yeah, but we could never get an
9 explanation about the agency's review process, and
10 who is included in that black hole, I like to refer
11 to it as, because nobody can ever tell me what kind
12 of procedures do you have in place for your internal
13 review process? How long is somebody given to allow
14 this thing to languish in their in-box or on their
15 desk or until the NCAA basketball season's over
16 with, and they can finally put their attention to
17 it.
18 You know, this is crap. I mean, this is why we
19 talk about bureaucracies. This is very important.
20 And, you know, when I was in the Marine Corps, as a
21 senior staff NCO, when I got an action item, I was
22 given a limited amount of time, and it was put right
23 on there when I received it, on the cover letter,
24 how long I had to review that thing and get my
25 comments back in.

1 **DR. BREYSSE:** Jerry, I'm with you a hundred
2 percent. So -- remember, I'm new, but let me tell
3 you what I think -- what we started to do. So for
4 the male breast cancer study, this worked really
5 well. There was a linear process that we had where
6 we sent it to one person to review it and approve
7 it, sent to another person to review it, and then
8 another person, go up the chain. And in talking to
9 Frank and Perri, it turns out there was -- every
10 level had the same sort of comments, so they were
11 addressing the same comments multiple times, all the
12 way up the chain.
13 So what we did was, we sent it to everybody in
14 the chain at once. We said, send your comments to
15 Perri and Frank, and have them address them, and
16 we'll all meet as a group and we'll talk about the
17 comments. Because sometimes I would suggest
18 something that would be different than what they
19 already changed, because somebody else had suggested
20 it when it got to my place. So it was a very
21 inefficient unacceptable process.
22 So we did it that way for the male breast
23 cancer study, we short-circuited a lot of the
24 review, and it was approved a lot quicker, and we're
25 doing the exact same thing for this study.

1 So right now, the cancer incidence protocol is
2 on the desks of five or six people. We were given
3 'til -- we're given a date, I can't remember the
4 exact date, this Friday or next Friday, send
5 comments in. Once the comments come in, we're going
6 to ask the investigators to digest them, summarize
7 them, and we'll have a meeting where everybody who
8 commented will sit down, and we'll hash that out as
9 a group, and then it'll be done. So we're going to
10 have the process take a couple of weeks rather than
11 six months.
12 **MR. ENSMINGER:** Thank you.
13 **DR. BREYSSE:** Any other updates on the health
14 studies?
15 Once the cancer incidence study gets going,
16 it'll be -- it'll probably be more informative to
17 fill you in where things are, but at this stage of
18 the study, unfortunately, we have to let the review
19 take its toll. So if there's no other questions,
20 we'll take a break.
21 **MR. ENSMINGER:** Weren't we going to cover the
22 revised public health assessment in this portion?
23 **DR. BREYSSE:** Jerry, you got a phone call right
24 when Rick did that -- and he'll do it again. You
25 stepped out.

1 **MR. ENSMINGER:** Oh, is that right? I'm sorry.
2 **MR. GILLIG:** I think you had that planned.
3 **DR. BREYSSE:** Real quick.
4 **MR. GILLIG:** So Jerry, the document is going
5 through clearance.
6 **MR. ENSMINGER:** Yeah, here we go again.
7 **MR. GILLIG:** Expect to release it for peer
8 review this summer. Members of the CAP will be one
9 of the peer reviewers.
10 **DR. BREYSSE:** So Rick, this is not one that's
11 come to my attention about doing the kind of a
12 short-circuit review process. Can you make sure
13 that we talk about a way to expedite the review
14 process, like we did for these other documents?
15 **MR. GILLIG:** Yes, yes.
16 **DR. BREYSSE:** I think we can do that.
17 **MR. ENSMINGER:** You know, but Mike, in his
18 opening remarks, brought up about, you know, science
19 is slow. I mean, most people don't understand that.
20 I didn't understand that until I got involved in the
21 Camp Lejeune issue, and I finally saw how long it
22 takes to actually do good science. It takes a long
23 time. But the water part of the public health
24 assessment, I mean, the water models have been
25 completed for a long time, and -- over three years -

1 - and we still don't have the revised public health
2 assessment. I mean, three years? Really? I mean,
3 the science is done. It took over three years to
4 write this revised public health assessment? Just,
5 just on the water.
6 **DR. BREYSSE:** I understand, Jerry.
7 **MR. ENSMINGER:** That's not science; that's
8 bureaucracy at work.
9 **DR. BREYSSE:** You're absolutely right. We can
10 do better and we will do better. It shouldn't take
11 that long.
12 **MR. PARTAIN:** Dr. Breysse, revisiting the
13 timeline, I finally got my computer to get on the
14 internet. The timeline that y'all have posted is
15 from '89 to the present, with ATSDR's activity, and
16 what we were looking for is more of an historical
17 timeline of the contamination event at Camp Lejeune,
18 which is what we -- you know, what we did the
19 research on.
20 And that's what -- you know, basically our
21 timeline goes from 1942, with the inception of the
22 base, to 1989, when it's listed as a Superfund site,
23 and has everything annotated and linked to a
24 document. That's what we were asking to get
25 published onto the site.

1 **DR. BREYSSE:** Yeah. We'll take a -- we'll look
2 at that again.
3 **MS. FRESHWATER:** And I think that goes back to
4 the importance of having more eyes on the documents,
5 because the more Marines and families we have seeing
6 these documents, the more they might connect and
7 say, well, what about this or what about that?
8 And so you -- and I have one really quick
9 question for Rick. I found an old photo in an
10 officers' wives cookbook of Paradise Point Sitter
11 Service, from 1968. And I had never heard of
12 Paradise Point Sitter Service, so I'm wondering does
13 anyone know where that was? Like as far as -- you
14 know, we've talked about where the current Tarawa
15 Terrace School is and whether that's on the same
16 ground as the one that was torn down.
17 And I'm just wondering -- I want to put that
18 out there. I'd love to know where this -- I have
19 pictures of these kids, and I have no idea where
20 they are. It's another sitter service.
21 **MR. GILLIG:** Lori, honestly, I've never heard
22 of that.
23 **MS. FRESHWATER:** Do you mind if I let her help
24 me?
25 **DR. BREYSSE:** Yes, please. Can you step up

1 here? Introduce yourself, please.
2 **MS. GRESS:** I'm Bonni Gress. I'm a Marine's
3 wife. Paradise Point Sitter Service was behind --
4 there was a BOQ across from the club, from the
5 officers' club.
6 **MS. FRESHWATER:** Right.
7 **MS. GRESS:** And behind the BOQ was a building,
8 and that was the sitter service.
9 **MS. FRESHWATER:** Okay. Okay, great. Thank
10 you.
11 **MS. GRESS:** Kind of in the area where the golf
12 course --
13 **MR. ENSMINGER:** Yeah.
14 **MS. GRESS:** -- and back behind BOQ was the
15 sitter service.
16 **MS. FRESHWATER:** Okay, 'cause the golf course
17 is one of the sites that we look at, so that's
18 really great information to have. Thank you so
19 much.
20 **DR. BREYSSE:** And so Lori, what we can do is we
21 can add that to the keyword search to documents to
22 see if that's referenced in any of these documents.
23 **MS. FRESHWATER:** I'll send you the photograph
24 with the notation, and they just -- it says,
25 children learn to play together, share their toys

1 and eat together at the Paradise Point Sitter
2 Service.
3 **DR. BREYSSE:** And where'd you find that
4 picture?
5 **MS. FRESHWATER:** An officers' wives cookbook.
6 I was going through my mother's things, and they
7 have some old photos. And I haven't finished going
8 through it yet, but I hope to find more. And I'd
9 never -- I knew about the base sitter service but I
10 never knew there was one at Paradise Point.
11 **MR. GILLIG:** If you come across the building
12 number, I would love to get that.
13 **MS. FRESHWATER:** Okay, I think -- from what
14 she's telling us, I think we can probably figure it
15 out.
16 **MR. GILLIG:** Okay. Thanks.
17 **DR. BREYSSE:** Any other questions for Rick or
18 Perri or --
19 **MR. TEMPLETON:** Rick, I just -- one more, real
20 quick. I noticed that in some of the documents that
21 we've had opportunity to review, that there were
22 fuel tanks that were in Paradise Point, Midway Park
23 and Tarawa Terrace. There were several, in fact.
24 And I think it was in Midway Park, there may have
25 been 44 of them, command and underground storage

1 tanks that were in there for heating oil and so
2 forth. So those are considered in the vapor
3 intrusion piece? Great. Thank you.
4 **MR. GILLIG:** Yeah, we have found oil storage
5 tanks, heating oil, in many areas of the base.
6 **MR. ORRIS:** Rick, I have one final question for
7 you also. In your opinion, in your scientific
8 opinion, would you agree or disagree with the
9 Department of the Navy's assertion that
10 contamination on the base ended in 1989, based on
11 the work you have done with the vapor intrusion?
12 **MR. GILLIG:** Chris, I'm not sure of the context
13 of that statement, but the contamination did not end
14 in 1989.
15 **MR. ORRIS:** Thank you, Rick.
16 **DR. BREYSSE:** Any last questions or concerns
17 for the ATSDR scientists' studies?
18 It's 10:30. Why don't we take a break. When
19 we come back we'll spend some time in discussion
20 with the VA.
21 (Whereupon, morning break ensued, 10:26 till
22 10:50 a.m.)
23 **DR. BREYSSE:** All right. Are we assembled? So
24 we talked about clearance and security a few minutes
25 ago, and I just want to tell a story as people are

1 assembling. So in my previous life as a university
2 professor, I wrote a report for the Department of
3 Energy on some worker exposures at the Los Alamos
4 National Laboratory, using only publicly available
5 documents. And I wrote the report and we sent it to
6 Los Alamos.
7 And a week after we sent the report, some DOE
8 security people came to my office and said, we're
9 confiscating your computer, and we need to know
10 every computer that has a copy; we have to collect
11 all those computer systems. And I said what do you
12 mean? Because my personal computer at home and my
13 laptop had it, and there was five other people who
14 were writing this thing, and we had no idea how
15 many...
16 So it turns out that we had taken two pieces of
17 information that were not secure, but we put them
18 together in a way that they'd never been put
19 together, when somebody at the Department of Energy
20 decided that the combination of this information was
21 something, a whole story that they didn't want the
22 world to know, and they couldn't tell me what it
23 was, but they said your report's got, you know,
24 secure information in it, and you're in trouble.
25 So we got the university attorneys involved,

1 and they agreed not to take our computers. They
2 wanted to do a quick security clearance, and so at
3 the end of the day, they reviewed it, and they
4 decided to clear the information that we had in our
5 report, and not tell us what it was. So that got us
6 off the hook.
7 And so there was a week where I was calling all
8 my colleagues and saying, somebody may come take
9 your computer, and I just signed an agreement that
10 says nobody -- you're not to leave anything in that
11 computer for the next week while this determination
12 is made. So I'm very careful about secure documents
13 and things, and we'll take that seriously as we work
14 with the Navy to make sure that stuff is releasable
15 when we can.
16 **MR. PARTAIN:** I say, Dr. Breysse, that's
17 actually a good segue to it, I need to ask the
18 Marine Corps.
19 **DR. BREYSSE:** Go ahead, Mike.
20 **MR. PARTAIN:** A few days ago I noted the Marine
21 Corps has revamped their website for Camp Lejeune,
22 in the bottom right-hand corner of the front page of
23 Camp Lejeune historical water.
24 When you go -- and this is a problem that came
25 up several years back, and it actually took Congress

1 hanging the Marine Corps to fix it. It has
2 resurfaced. When a -- a family member just pointed
3 out to me, and she asked -- she went to register for
4 the Marine Corps -- on the Marine Corps' web page
5 for the Camp Lejeune registry, and there is a page,
6 when you go to register, or go onto the site, it
7 pops up and says, the certificate for this page is
8 invalid. It's not -- you know, do not proceed. We
9 don't recommend you proceed.
10 **MR. ENSMINGER:** The security.
11 **MR. PARTAIN:** Yeah, the security certificate,
12 which is very disturbing, especially for someone who
13 has no idea what they're looking at. And it gives
14 you two options: One, to abandon the page and
15 leave, and the other is to, you know, ignore the
16 advice and go forward.
17 I sent an email to the Camp Lejeune water email
18 address last week. I've yet to get a response. But
19 being that this problem is something that has been
20 in the past, I'd like to see if the Marine Corps can
21 get it fixed sooner than later.
22 **MS. FORREST:** I will definitely take that back.
23 **VETERANS AFFAIRS UPDATES**
24 **DR. BREYSSE:** All right, so we'd like to spend
25 some time now with the update from the Veterans'

1 Affairs, the VA. And before we get in -- and we
2 opened the telephone line. Is there anybody on the
3 telephone line?
4 **DR. HEANEY:** Yes.
5 **DR. BREYSSE:** Could you introduce yourself,
6 please?
7 **DR. HEANEY:** Yes, I'm Dr. Debbie Heaney, and I
8 am one of the subject matter experts.
9 **DR. BREYSSE:** Thank you. All right, so Brad,
10 any updates from the VA?
11 **MR. FLOHR:** Yeah, Angela, you want to go down
12 our action items?
13 **DR. RAGIN:** Sure. The first action item for
14 the VA: The CAP asked that the VA share ATSDR's
15 updates and recommendations on the VA Camp Lejeune
16 research and studies web page with the Veterans'
17 Health Administration.
18 **MR. FLOHR:** Yes, and at the last CAP meeting, I
19 went back and I talked with Dr. Erickson and others
20 in public health, and they looked at their website,
21 and they did make some changes.
22 **DR. ERICKSON:** This is Loren Erickson. Let me
23 just mention that we have hot links, which I just
24 checked yesterday, to the ATSDR websites, a couple
25 different hot links, that go directly to those

1 valuable studies.
2 **DR. RAGIN:** The next action item: The CAP
3 requests a representative from the Veterans Health
4 Administration to attend the CAP meetings in-person.
5 **MR. FLOHR:** We have three of them.
6 **DR. RAGIN:** Okay.
7 **DR. BREYSSE:** Well, it says three. They get
8 credit for three meetings then.
9 **MR. FLOHR:** We can skip the next one then.
10 **DR. RAGIN:** The next action item: The CAP
11 asked if the Veterans Administration accepts ATSDR's
12 work and findings on Camp Lejeune.
13 **MR. FLOHR:** For me personally, yes.
14 **MR. ENSMINGER:** What's that mean?
15 **MR. PARTAIN:** We appreciate that, Brad, but
16 what about the agency?
17 **MR. FLOHR:** I think the agency does, yes, as
18 far as I know. I have no reason to believe that
19 they don't.
20 **DR. ERICKSON:** Let me make a comment. It's
21 probably a good time to talk about what we were
22 talking about. I mentioned that I'm somewhat new to
23 the Camp Lejeune issues, and I'm currently the
24 incoming acting chief consultant for post-deployment
25 health. We very much value the interactions that

1 we've had with our ATSDR colleagues, and we've had a
2 number of meetings.
3 I've mentioned to some members of the CAP
4 already that there is activity that's occurring
5 outside the CAP between these two federal agencies
6 that isn't always apparent. In many cases we're
7 discussing the very studies that have been presented
8 today. We've got some of the plans that are in
9 place for these new studies, finalizing such,
10 discussing what these studies mean. And in fact
11 even this morning Dr. Breysse and I were having
12 breakfast together. And we want the same thing. We
13 want to do right by the Camp Lejeune veterans and
14 family members. We want to have a solid and
15 scientific evidence base that we can work from and
16 have actually good policy.
17 And Ms. Freshwater, I think your comment
18 earlier was right on the money in that we want to
19 have understandable policy, policy that is clearly
20 communicated. And we want to have a very
21 cooperative non-adversarial relationship. And I'm
22 very hopeful. Hopefully I'm not naive in this
23 regard.
24 I'm very hopeful and I'm encouraged by the
25 types of things that we've worked on. In fact even

1 this morning, when Dr. Breysse and I were talking
2 about a way forward being able to review the
3 existing 15 conditions that are in the Camp Lejeune
4 legislation, and then matching that up with the most
5 recent studies, to have a discussion about what are
6 those gaps? What is the new information since the
7 legislation came out? What would be recommendations
8 that we would make?
9 And just as an aside, it was asked last night
10 why is VA, why is ATSDR not lobbying Congress? And
11 of course by law, we cannot lobby, and maybe the
12 individual didn't mean that word. So we can't
13 formally lobby but we can certainly interact with
14 our representatives, with their staffers. We do
15 that not on an infrequent basis, and in fact we're
16 looking forward to opportunities to actually come
17 forward in a united front, the ATSDR and the VA
18 together, to talk about, you know, where are those
19 gaps and where might be some suggested legislative
20 changes for the Camp Lejeune law.
21 Dr. Breysse, I don't know if you wanted to add
22 to that.
23 **MR. ENSMINGER:** I have a question about that.
24 **DR. BREYSSE:** Can I interrupt real quick?
25 **MR. ENSMINGER:** Yeah.

1 **DR. BREYSSE:** Can I just have a second? I
2 think, Jerry, before you jump in, there are things
3 that we agree on, that we can move forward. There
4 are things that we might not agree on, that we need
5 to discuss about that. But what we are able to
6 agree on, I think, it's in everybody's interest that
7 it's our moral imperative to identify those and
8 start moving things forward along those lines. And
9 I think that's what we agreed to this morning.
10 **MR. ENSMINGER:** Okay. You talk about new
11 science that has come out since the law was passed
12 and signed into law -- when the bill was passed and
13 then signed into law. You just had a report come
14 out in March that was commissioned by the VA on Camp
15 Lejeune with the Institutes of Medicine, the IOM for
16 short. Yeah, I mean, and they came up with all
17 kinds of recommendations, I mean, where are you at
18 with that?
19 **DR. ERICKSON:** Sir, I'm glad you asked, and
20 that's why I have the report in front of me. Just
21 for everyone's sake, this is also available on the
22 Institute of Medicine website. This is entitled:
23 *Review of VA Clinical Guidance for the Health*
24 *Conditions Identified by the Camp Lejeune*
25 *Legislation*.

1 You already have heard from Mr. Brady White
2 concerning the program; it seems he's actually
3 managing that program. I am really delighted to
4 tell you that we have had a work group that has been
5 looking at this intently, to write clinical guidance
6 policy, to respond to what the IOM has said. And
7 what's important here is not for you to appreciate
8 that we have a bureaucracy like ATSDR and things
9 take time, but rather to understand that to deal
10 with the recommendations, the intricacies that the
11 IOM has brought forward, and there are a lot of
12 recommendations that were in there, is going to take
13 some time because it involves translating their
14 recommendations into our document and our way of
15 doing business, so that then we have a clear way
16 forward.
17 And, you know, in fact even just this week, I
18 was sent a copy to review of the draft of new
19 guidance. And, you know, we are making progress on
20 that. I don't have a date for completion, 'cause
21 that might be your next question. But I will tell
22 you that we very much appreciated the work of the
23 Institute of Medicine, and that they are an
24 independent body that is, I don't think, unduly
25 influenced by outside forces. They agree with us in

1 some areas of our existing clinical guidance, and
2 said, you're right on track, and some other areas
3 they said, you need to be looking more broadly.
4 Chris and I were talking about this this
5 morning. I think some of the changes that are
6 coming, though it's pre-decisional, I think people
7 will find to be encouraging. I don't want to usurp,
8 you know, the authority of leaders that are over me
9 to state exactly what those might be at this time,
10 because it is in process. But I think we're on the
11 right track.
12 And again, the goal here is for us to put proof
13 to the fact that VA wants to be a learning
14 organization, that we realize that publishing the
15 first set of clinical guidelines was good and was
16 appropriate and got the program running, but that we
17 want to continue to learn and bring new information
18 to bear such that these are updated. And sometimes,
19 because we don't necessarily have the full array of
20 experts that we need, we call upon places like the
21 Institute of Medicine to bring in experts from
22 around the country, to then actually provide us with
23 additional guidance. And so I'm actually very
24 encouraged, and I thank you for your question.
25 **MR. ENSMINGER:** Well, you were discussing this

1 work group that you formed. How many
2 representatives from the community do you have on
3 your work group?
4 **DR. ERICKSON:** Brady, you're on the work group.
5 Can you answer that?
6 **MR. WHITE:** That dealt primarily with the three
7 clinicians that we have, with the four related
8 illness and injury study set. And then I was there
9 kind of representing the process and the program.
10 **MR. ENSMINGER:** I'm asking you how many people
11 from -- representatives from the community, if any?
12 You have nobody -- nobody represents the community
13 on this work group. I mean, that's the problem with
14 the VA, is the transparency, okay? There is none.
15 I mean, your own Secretary gave a speech on the
16 24th of April to the Association of Healthcare
17 Journalists, and they questioned him about VA
18 policies, including the agency's notorious
19 opaqueness with the public. And McDonald readily
20 acknowledged that the VA has had what he called a
21 Kremlinesque mentality, and told a room full of
22 journalists that he was trying to change it. And he
23 said, he's trying to promote a culture of openness.
24 I mean, if you're going to have a culture of
25 openness, you have an Institute of Medicine report,

1 you form a working group, and yet you don't have any
2 experts or any members of the community on your work
3 group.
4 **DR. BREYSSE:** Danielle, do you have something
5 to add to this?
6 **MR. ENSMINGER:** Now, I don't know if I can
7 volunteer Dr. Clapp or Dr. Cantor to that work
8 group; I wish I could.
9 **DR. BREYSSE:** Danielle?
10 **MR. ENSMINGER:** And I'd love to sit on it.
11 **MS. CORAZZA:** I wasn't going to ask for quite
12 such a big ask. My question was, can we, as family
13 members and/or chronically ill patients, submit
14 recommendations? And specific, the IOM report
15 recommended that, unless somebody has been formally
16 diagnosed, it's not being treated or covered. The
17 ongoing monitoring of some diseases, like
18 scleroderma, which I happen to have markers and/or
19 some symptoms of, is very expensive. So something
20 as simple as, as long as it's acknowledged you have
21 the blood work that shows it and we need to monitor
22 it. Or another example, my mom had breast cancer.
23 She was a Camp Lejeune active duty service member at
24 36. So I have to have ongoing mammograms. And
25 again, these are very costly tests that are doctor

1 ordered and approved. But somewhere where we could
2 submit feedback along those lines or, hey, I live in
3 DC; I'm happy to come and sit silently and quietly
4 in the corner of a meeting, would be helpful,
5 because these are feedback -- this is feedback
6 that's viable and valid, especially for the family
7 members, who are not veterans and who are not
8 receiving regular healthcare from the VA.
9 **DR. BREYSSE:** So is the VA open to considering
10 some external participation in the working group?
11 I'm not saying any of you are, but are you open to
12 considering it?
13 **MR. WHITE:** For the clinical guidelines group,
14 if both the agencies is willing to look at that, I
15 wouldn't have an issue with that obviously.
16 So but getting back to your question about the
17 prescreening, right now, for family members, and
18 I'll be going over this in a little bit more detail
19 later, to qualify for the program you have to have
20 administrative eligibility clinically. So once you
21 meet that administrative eligibility side, you have
22 to have one of the 15 conditions, and then we can
23 reimburse you. Now once that happens, if you save
24 your bills, we can reimburse you back to two years
25 from when you received treatment.

1 **DR. BREYSSE:** But that's something that might
2 be considered. Has anyone considered that or --
3 we're hearing that there's a big burden of screening
4 associated with being at-risk but short of having
5 the disease, that the --
6 **MS. FRESHWATER:** Well, what it comes down to,
7 and I think, Brady, you've maybe run into this in
8 the past, is the legal interpretation of the
9 wording. So if you say diagnosis, and my doctor
10 says you've got all the markers and life's really
11 going to hurt after 40, we need to continue to
12 screen you because you have this active blood work
13 and some of the symptoms. Depends on who you ask
14 and how it's interpreted.
15 So my feedback would be, if you're going to
16 apply it and the VA's open to it, maybe we need to
17 change the wording to, if you have diagnostic
18 markers that indicate the disease is coming, or
19 something along those lines, if that makes sense.
20 So my question -- I'm worried about the
21 interpretation and how that's going to kind of come
22 down the pike. And so my feedback would be let’s
23 maybe make that clearer so that the clinicians
24 and/or the, you know, program managers, can say yes
25 or no without having to go back case by case, and

1 fight the battle.
2 **DR. ERICKSON:** Yeah, your point's really well
3 taken. I'm taking lots of notes for many different
4 things that you guys have shown us, but for that
5 particular -- if you've not been to the IOM website,
6 you can just Google IOM, you know, VA clinical
7 guidelines, and you'll find this. It's free, you
8 know, you can go right to the pages.
9 But if you see the section on scleroderma, you
10 saw that the IOM made some very direct comments that
11 we are responding to. I want to encourage you in
12 that regard.
13 **MR. PARTAIN:** I'd like to take a moment to step
14 back from when we got started here, we were talking
15 about the studies at the ATSDR, y'all mentioned the
16 word accept. Can we define that? Because, you
17 know, I understand that you've accepted the reports
18 but what does that mean? Is the VA in agreement
19 with the findings from ATSDR? Are you disputing the
20 findings of ATSDR? Where does the VA stand with
21 that work?
22 **DR. ERICKSON:** You know, maybe you can help us
23 understand the wording stuff. But I can speak to,
24 you know, the way I look at this, and I shared this
25 with our scientific colleagues here from ATSDR.

1 There's no question that the work that they've done
2 is incredible in that it took a tremendous amount of
3 effort from initial conception of the plans through
4 execution, through analysis, et cetera.
5 The studies are in the peer-reviewed
6 literature. It is an important part of a broad body
7 of knowledge about these chemicals, about the
8 exposures, about the health effects, about this
9 particular population, all of which is important in
10 total.
11 When you say accept, I don't know -- I'm not
12 sure which direction you're going. I value the work
13 that they've done. I recognize the value with -- of
14 the work that they've done. There may be some
15 differences in some of the details here and there
16 and the interpretation. And the reason why I say
17 this is, you know, there's jokes about
18 epidemiologists, you know, that you get a bunch
19 of -- Frank's already smiling; he probably knows
20 this one -- whatever, scientists or epidemiologists,
21 you get them in a room, and we're at a large
22 conference, and one is presenting their work,
23 there's always discussion about the interpretation.
24 And how deep that interpretation goes, how strong
25 can be the recommendations or the discussion that

1 follows those results.

2 And we've had some of those discussions. I'm
3 not prepared at this point, and I don't want to take
4 up the time to talk about, you know, these areas,
5 but this is part of that ongoing collaboration. And
6 Dr. Breysse, just a few moments ago, said that there
7 are areas where we clearly agree and we're going to
8 move forward to. There's areas where we're going to
9 continue to discuss. There are areas that we are
10 locking arms to move forward on this. And that
11 means that -- I hope that means that we accept, in
12 the terms that you've phrased the question.

13 **MR. PARTAIN:** Well, the word accept came from
14 y'all. So it's not a -- to clarify anything that I
15 might have -- I want to understand what does -- I
16 mean y'all said accept. You accepted the report.
17 What does accept mean? Do you agree with the
18 findings in the reports or not?

19 **DR. ERICKSON:** I think the word accept -- I
20 mean, I'm new to this so I don't know the providence
21 of the word accept in these discussions. But it was
22 one of the do-outs? Is that what that was? There
23 was a phrase, the do-out, does the VA accept --

24 **DR. RAGIN:** Yes.

25 **DR. ERICKSON:** So I don't know where that word

1 came from.

2 **DR. RAGIN:** It was raised at the last CAP

3 meeting.

4 **MR. PARTAIN:** No, I asked you. I asked you to

5 report, and the word that you guys responded back

6 was, we accept the report. I'm asking you what does

7 that mean? I mean, you can accept a report and not

8 agree with it; you can accept the report and agree

9 with it. Because part of the reason why I'm asking

10 this is, as I said earlier this morning, there is a

11 body of evidence with science, post-NRC report, that

12 is showing connections between exposure,

13 occupationally and so forth, with TCE and adverse

14 health effects. And the VA's approval rates are

15 counterintuitive to what science is saying.

16 Their approval rates have dropped from

17 25 percent from a couple years ago down to five

18 percent, with the last information that my senators

19 supplied -- or provided me. So going back to the

20 word accept, what does the VA -- how does the VA see

21 ATSDR's work? Are you accepting it as legitimate

22 science? Are you accepting the conclusions of the

23 reports and the findings of the reports? Are you in

24 dispute of that? Are you disagreeing with ATSDR's

25 work? This needs some solid ground to make the

1 Jello a little bit harder so we can stand on it
2 here.
3 **MS. FRESHWATER:** Why aren't the veterans
4 getting the benefit of the doubt if you are
5 accepting the science? Why are we trying to find
6 ways to deny it instead of ways to support and...
7 **MR. FLOHR:** As Dr. Erickson said, yes, we
8 accept and value all the work that went into these
9 reports. They're very valuable. We use them in
10 making determinations on claims.
11 **MR. PARTAIN:** I understand that. What do you
12 accept about the reports and what do you value about
13 the reports? I'm asking for something more concrete
14 than a generalized statement. Does the VA accept
15 the findings of the reports or do they not? Yes,
16 they accept the finding of the reports.
17 **MR. FLOHR:** Absolutely.
18 **MR. PARTAIN:** Okay. And --
19 **MR. FLOHR:** Why would we not?
20 **MR. PARTAIN:** Well, I mean, that's what I'm --
21 **MR. FLOHR:** Scientific studies.
22 **MR. PARTAIN:** -- trying to get to. Okay.
23 **MR. FLOHR:** There's a lot of scientific
24 studies.
25 **MR. PARTAIN:** I understand that. And the --

1 but that's what I'm trying to get at. What do y'all
2 mean by accept? That you're saying that you accept
3 the conclusions of ATSDR's work?
4 **MR. FLOHR:** Yes.
5 **MR. PARTAIN:** VA does.
6 **MR. FLOHR:** Sure.
7 **MR. ENSMINGER:** Dr. Erickson and I had a brief
8 discussion during the break. And there is a -- we
9 have to get past stuff that's been committed by
10 representatives of the VA in the near past, that
11 have been committed against the Camp Lejeune
12 community. And one of those was a training
13 PowerPoint that was created by Dr. Walters that was
14 used to train clinicians who were going to be
15 examining Camp Lejeune veterans and family members.
16 That training PowerPoint was a road map for denying
17 people, number one.
18 Number two, the description of the typical --
19 of her view of the typical Camp Lejeune veteran's
20 spouse, in that training PowerPoint, was obscene,
21 demeaning. She described her view of the typical
22 Camp Lejeune veteran spouse as fat, toothless,
23 diabetic, had a history of, family history of breast
24 cancer, homeless, car-less, --
25 **MS. FRESHWATER:** On public assistance.

1 **MR. ENSMINGER:** -- Medicaid, which means
2 they're on welfare. I mean, that, that was a slap
3 in the face.
4 And ever since Kevin got his hands on that
5 training PowerPoint, we have not seen Dr. Walters
6 since. She would not show her face. She got on the
7 phone a few times, and then claimed that she was
8 having technical difficulties with the phone and
9 hung up. And then she, she absolutely just refused
10 to discuss her training PowerPoint. I mean, just
11 outright refused to discuss it. And this was what
12 was used to train clinicians. Brad was at the
13 training.
14 **DR. BREYSSE:** So Jerry, you want to ask a
15 question about --
16 **MR. ENSMINGER:** Yeah, I mean, you know, we've
17 got amend this distrust. I mean, you've got to fix
18 this.
19 And you're not doing a very good job because
20 now, you went and hired these -- well, I don't know
21 if you hired them by contract -- these SMEs, that
22 you call them, that are make -- giving their
23 opinions which you're basing your denials on.
24 **DR. BREYSSE:** But Jerry, can you ask a
25 question, just to be fair to the VA and me?

1 **MR. ENSMINGER:** Yeah, I mean, what are you
2 going to do to repair this damage that you've done
3 to this community with that, that PowerPoint?
4 **MR. DEVINE:** I think the PowerPoint that you're
5 talking about was used in support of the healthcare
6 law versus what SMEs use to adjudicate the claims.
7 So I think there is a little bit of a difference.
8 **MR. ENSMINGER:** This was in training of your
9 clinicians. Brad, you were in it in Salt Lake City.
10 **DR. BREYSSE:** Can we focus on going forward
11 with the question how do we repair the damage rather
12 than debate this --
13 **MR. ENSMINGER:** Well, I want to get it
14 clarified what it was used for.
15 **MR. FLOHR:** And that -- actually I was at Salt
16 Lake City, and New York also, Albany training
17 session, I was not there at any time when
18 Dr. Walters was there. She was there earlier, then
19 headed back to DC.
20 I was there just to talk about the claims
21 process and how we use medical opinions and how
22 important it was for us to get good medical
23 opinions, to consider all the science and make a
24 good reasoning for their determination. But I
25 wasn't actually there when -- this was not just Camp

1 Lejeune; it was for all types of occupational
2 exposures. It was for commissions that provide
3 occupational health.
4 **MR. ENSMINGER:** But it was mainly --
5 **MR. FLOHR:** No, it wasn't actually. She was
6 only there for a very short period of time, maybe an
7 hour.
8 **MR. ENSMINGER:** I'm not -- but that whole damn
9 PowerPoint was almost all Camp Lejeune. It had a
10 couple pages at the end about what this would mean
11 for other DOD sites, yeah.
12 **MR. FLOHR:** What I'm saying is there was a lot
13 more in the sessions than just that PowerPoint.
14 **MR. ENSMINGER:** And it mentioned the C-123 air
15 craft, Agent Orange, at the end, but that was it.
16 The rest of the -- the body of the thing, 20-some
17 pages, was about Camp Lejeune.
18 **MR. DEVINE:** But again, it's the difference
19 between what is in support of the healthcare law or
20 what the SMEs use in reviewing veterans' claims.
21 **MR. ENSMINGER:** Yeah?
22 **MR. DEVINE:** There's a world of difference.
23 **MR. ENSMINGER:** But, but they were training the
24 clinicians that were going to be screening these
25 people coming into the program. And it was -- she

1 was prejudicing people right, right from the get-go.
2 **MR. DEVINE:** So let me -- let's go back to the
3 beginning, and it goes to what I think you were
4 talking about: How do we clear this up? And I've
5 been talking to Danielle a little bit about what is
6 the process and what's the difference between doing
7 the healthcare law and taking care of veterans and
8 dealing with those kinds of issues. They're two
9 different worlds. And what we tend to do, because
10 it can be confusing, is to intermingle all of this.
11 So what I would like to commit to, and mind
12 you, I just volunteered to do this ten days ago, so
13 I'm relatively new to this, but I think what we
14 should do, each and every single one of these
15 meetings, I don't care how many times or how many
16 times you have seen or heard the presentations,
17 Brad's stuff and that VHA stuff should be put up on
18 the screen, whether it's five minutes, ten minutes,
19 whatever it happens to be. So we have an
20 understanding that there's two, two worlds here in
21 dealing with claims and how those folks were trained
22 and dealing with the healthcare law.
23 Frankly the healthcare law, I think, is very
24 important. Getting you folks into treatment,
25 getting you guys taken care of is going to lead to

1 us finding the answers on many of these things. So
2 I'm really in support of the healthcare side of it
3 and anything that we can do to broaden that scope, I
4 think, is great.
5 **MR. ENSMINGER:** So what's your position?
6 **MR. DEVINE:** I'm with DMA. I'm one of the
7 senior folks with DMA. I'm neither a doc nor a
8 scientist.
9 **MR. ENSMINGER:** What's DMA?
10 **MR. DEVINE:** Sorry about that. Disability
11 management assessment.
12 **MR. ENSMINGER:** Oh.
13 **MR. DEVINE:** We're the folks responsible for
14 taking care of claims inside the healthcare side.
15 So I apologize for that. It was a good question.
16 I'm one of those that got to come down because
17 of your request for a VHA in-person representative.
18 So I volunteered to do it. And so I came on down to
19 listen to the stories and things that I heard, and
20 there's some very simple things that I think we
21 should be doing. And we are not doing it as a
22 community. And I would point to the VSOs.
23 One of the gentlemen last night was talking
24 about, I think he was with the Marine Corps, I am
25 very surprised at how little the VSOs know, or the

1 MSOs for that matter. The veteran service
2 organizations, the military service organizations.
3 You folks, any of your people, should be able to go
4 to one of these people and say, I'm a Lejeune guy,
5 I'm a Lejeune family member, and they should go
6 ding, ding, ding. Maybe they don't have all the
7 expertise but they should know where to go and not
8 leave you with a struggle.
9 I want to take that on as a responsibility, and
10 I've already hired Brad on to help me do this. We
11 want to talk to these folks, but not the executive
12 directors of DC, because you love bureaucracy so
13 much --
14 **MR. ENSMINGER:** I do?
15 **MR. DEVINE:** There was sarcasm. But the
16 executive directors, while they're, you know,
17 obviously good guys, they deal with legislation
18 mostly inside the Washington offices. We need to
19 get to the service officer training corps. And
20 those are the folks that I want to focus on, so that
21 when your folks go out there, no matter where they
22 are in the country, there's a decent understanding
23 of what to do.
24 **MR. ENSMINGER:** Okay, in the current law, as it
25 stands, has 15 ailments on it. And the IOM has

1 recognized that there was a shortfall of it because
2 of the science that's been done. And ATSDR also
3 agrees that there are other ailments that need to be
4 included in that law, so for the Congressional
5 delegation back there, especially Senator Tillis's
6 office and Senator Burr, who originated this law,
7 and Senator Tillis is now on the Veterans' Affairs
8 Committee, we need to amend that law and include
9 these scientifically proven health effects to that
10 law. We need to expand that list.
11 **MR. DEVINE:** The beauty of what you've done is
12 you've formed the baseline. Science continues to
13 march on building on everything else that we already
14 have established. Great.
15 We begin to see -- just like almost any other
16 law that's out there, that's a first thing you do is
17 you go back, take a look and say, we missed certain
18 issues, new science, new things come up. We can
19 amend to make it better. And I think that's the
20 position that we're in.
21 And the things that you guys have brought up,
22 I've read the transcripts, the things that you guys
23 brought up are absolutely essential. I mean, I can
24 bet that's why these two are back there, but you can
25 bet that the folks in DC, who actually have to do

1 the amendments, have an understanding. I think
2 you've heard the doctor here talk about it's
3 probably a good idea. It's time to start doing
4 that. And it's going to be an evolving process,
5 because you guys are doing that groundwork finding
6 new things. That's why the healthcare side is
7 important, and that's going to find all kinds of
8 other issues as well.
9 **MR. ENSMINGER:** Well, it's ended. Senator
10 Burr's staff, Brooks Tucker, has an encyclopedic
11 knowledge of this issue. I mean, I've worked with
12 Brooks now for five years. I mean, and the man
13 knows this issue inside and out. He is a wealth of
14 information. You got to tap it.
15 **MR. DEVINE:** Well, let me suggest one thing
16 that Dr. Erickson was talking about. We have lots
17 of conversation with folks. We have lots of
18 telephone calls with --
19 **MR. ENSMINGER:** I know.
20 **MR. DEVINE:** But let me also suggest something
21 else, and while you tend to demean or degrade our
22 SMEs, those are the other folks that you have to
23 consider to be on your side as well, and here's the
24 reason why. They're the ones, more than Brooks,
25 more than those two back there, more than me, that

1 do this every single day. They're the ones who help
2 inform people up here, folks up front. Those people
3 are exceptionally important to the entire process.
4 **MR. ENSMINGER:** But --
5 **MR. DEVINE:** No, no, no.
6 **MR. ENSMINGER:** No, no wait a minute, wait a
7 minute.
8 **MR. DEVINE:** Wait a minute.
9 **MR. ENSMINGER:** When I look at it --
10 **MR. DEVINE:** I'm asking --
11 **MR. ENSMINGER:** When I look at a denial --
12 **MR. DEVINE:** Wait a minute.
13 **MR. ENSMINGER:** Wait a minute. When I look at
14 a denial for kidney cancer from one of your subject
15 matter experts that wrote that opinion on that
16 thing, and they said they looked at two decades
17 worth of scientific studies, and meta-analysis, and
18 could find nothing that linked TCE to cancer --
19 **MR. DEVINE:** Jerry, wasn't that --
20 **MR. ENSMINGER:** -- I said, really?
21 **MR. DEVINE:** Wasn't that also the one where we
22 said that that has been changed. You've got to get
23 passed that.
24 **MR. ENSMINGER:** Yes.
25 **MR. DEVINE:** Wait a minute. This is why --

1 **DR. BREYSSE:** Jerry, let him finish.
2 **MR. DEVINE:** This is why this is so important.
3 You've got to quit demeaning these folks because
4 what they do is learn from it. They are experts in
5 the field. So that when you guys bring up these
6 things, it is a terrific learning experience, and we
7 can move on and get these things done correctly.
8 We've already -- we've already worked on, I believe,
9 the case that you're referring to.
10 **MR. ENSMINGER:** Yeah, and you changed it and
11 dropped off all the -- dropped out all the
12 incorrect --
13 **MR. DEVINE:** Jerry, we are going to move
14 forward. These are the kinds of things I'm
15 suggesting that we need to do. We found, we found
16 what happened; it got changed. The rest of the SMEs
17 were notified or talked to about what was found, and
18 we're moving on. This is why this is an evolving
19 process and why this is so important. And instead
20 of us berating each other or criticizing what they
21 do, there's no way in hell that I can sit here and
22 accept that these folks want to deny stuff on
23 purpose. There's no way in hell.
24 **MR. PARTAIN:** Okay, but --
25 **MR. ENSMINGER:** Well, well, now wait a minute.

1 You said they corrected it. What they did, they
2 took all the incorrect stuff that they put in their
3 opinion off of it, and still denied the guy his
4 benefits for kidney cancer.
5 **MR. PARTAIN:** Okay. Quick, Jerry, let me jump
6 in here, please.
7 **MR. ENSMINGER:** Go ahead.
8 **MR. PARTAIN:** Okay. You're talking about,
9 first of all, when you mention demeaning people,
10 this is not demeaning people, okay? We're looking
11 at the process. And the first step in the process
12 is transparency.
13 Now I understand that there's guidelines,
14 there's guidance and things that are given to the
15 SMEs. The criteria that you're evaluating these
16 claims, I think, should be public. There should be
17 some transparency in that. We should know what you
18 guys are looking at when we're dealing with these
19 claims for Camp Lejeune. It's not a matter of being
20 a personal bias or anything against one particular
21 individual.
22 Now, when we find inconsistencies and there's a
23 name attached to it, yes, we're going to bring that
24 individual up but that doesn't mean we're demeaning
25 that individual. Now, this is a -- this is

1 something that came from the VA just last month, and
2 I will quote, and this is why I was going about the
3 accept and trying to pin down the accept and you --
4 Dr. Erickson made a comment about, I think it was
5 something about along the lines that unbiased
6 studies or studies with -- from outside influences.
7 This is a quote from the VA that went back to
8 Congress. Quote: Although there is a conflicting
9 scientific evidence regarding long-term health
10 effects of potential exposure, there is limited or
11 suggested evidence of an associated -- association
12 between certain diseases, particularly kidney cancer
13 diseases, cancer of leukemia and lymphomas, and the
14 chemical compounds found at Camp Lejeune during the
15 period of contamination. VA considers disability
16 compensation claims based on exposure to the
17 contaminated water at Camp Lejeune on a case-by-case
18 basis with difference in medical opinions provided
19 by experts in environmental medicine. Okay?
20 If you want to get back to a degree of trust, a
21 dialogue, let's start with transparency. What
22 directions are you giving to these SMEs? How are
23 these claims being evaluated? What criteria are you
24 weighting your evidence on? Which studies are you
25 using? Let's, let's get this out into the public.

1 And that's where the dialogue's going to begin.
2 Otherwise we're just going to be bantering back and
3 forth and, and going nowhere.
4 **DR. RAGIN:** Let me just mention something here,
5 to Mike and Jerry's point. This is an action item
6 that has been going on since the September 11th CAP
7 meeting. The CAP requested a copy of the training
8 materials that are given to the examiners, or the
9 SMEs, that are used to evaluate claims. And they
10 made that request in September, so I just wanted to
11 make everyone aware of that.
12 **MR. ENSMINGER:** That was a year ago in
13 September.
14 **MR. DEVINE:** The -- there was a FOIA request,
15 and I believe it came from a CAP member, and it was
16 -- the materials were provided through that FOIA
17 process previously.
18 **DR. BREYSSE:** I can second what Mike says. I
19 agree. I also have similar concerns about what
20 weight of evidence is given to the decision-making
21 process for deciding when a disease is
22 service-related or Camp Lejeune-related. I know
23 it's a complex medical decision but that
24 decision-making framework has to be clear. How do
25 you weight other risk factors, like obesity, versus

1 TCE exposures, and when, when a letter comes back
2 saying we've denied the claim because we don't think
3 it's service-related, it does nobody good if it's
4 not clear how that decision was made.
5 And I understand that's a complex medical
6 decision but I think there can be, I think,
7 guidelines that are provided to help the service
8 members and scientists like myself understand how
9 those decisions are made.
10 **MR. DEVINE:** So in the conversations that have
11 been had between our two organizations, that hasn't
12 come up yet or we've been dancing around it.
13 **DR. BREYSSE:** It's come up but I've not
14 received any clear --
15 **MR. DEVINE:** So it's still being danced around.
16 **DR. BREYSSE:** Yes.
17 **MR. PARTAIN:** And these SMEs need to be public
18 knowledge. Who -- the SMEs themselves -- the
19 veterans, a lot of times, unless it's by accident,
20 their names or organizations or where they're from
21 or who they are, that are making these life and
22 death decisions, are not known to the veteran. I
23 mean, it goes against our country's due process. If
24 someone's going to be making a decision on my
25 health, and granted, I would not be putting a VA

1 claim in as a veteran for Camp Lejeune, because I
2 was a dependent, but if my -- if my benefits of my
3 future and the future of my family was being decided
4 upon somebody, and they said that I am not
5 service-connected, especially if it's a disease that
6 science seems to be indicating that's tied to these
7 chemicals, I want to know who that person is. I
8 want to know their background; I want to know their
9 qualifications.
10 Because in the past, and part of the reason our
11 angst that you're seeing here today, is we find
12 somebody's name, and then we go out and find that
13 you have a general practitioner contradicting an
14 oncologist. And how does that -- I mean, where's,
15 where's the reasoning in that? An oncologist is a
16 specialist in the field of, of cancer. And you have
17 somebody who's a general practitioner saying no, and
18 their weight is being -- is overriding an
19 oncologist. And that's where you're seeing the
20 frustrations from the community.
21 Now, granted, we don't get all the denials from
22 these veterans, because a lot of these veterans
23 don't know we exist, don't know we're out there,
24 and, you know, 17 years with Jerry, seven for me,
25 we're still trying to get in touch with them. And

1 that's another thing that needs to happen is we need
2 to get together and outreach to these people, and
3 include the community, like Jerry was saying,
4 because we have been treated like the red-headed
5 stepchild for -- since the beginning of this issue.
6 **MR. ENSMINGER:** Well, I have a question.
7 **DR. BOVE:** Can I say something? One of the
8 things that might help the trust is if the VA would
9 acknowledge what's been done by other agencies. For
10 example, the agencies that are mandated to evaluate
11 the carcinogenicity of a compound. I mentioned this
12 last night. We have EPA, we have IARC, and now we
13 have NTP all saying the same thing, that kidney
14 cancer -- TCE causes kidney cancer.
15 It would be helpful if the VA would at least
16 acknowledge those three agencies' inclusions in
17 their statements, in their opinions, in their -- on
18 their website. So they -- I don't think they even
19 talk about ATSDR's work. There are three agencies
20 whose mandate it is to examine this issue. The NRC
21 report is not an agency that is supposed to assess
22 this; EPA, IARC and NTP are, and that's what needs
23 to be stated in these -- in these statements that
24 the VA's making.
25 Then you can say, well, give -- even though

1 these agencies have said this, we'll deny or we'll
2 do this action because of something else, maybe the
3 person wasn't there long enough, whatever opinion
4 you have. But at least start off by saying that you
5 acknowledge that these agencies have, have
6 concurred. Okay?
7 **DR. BREYSSE:** And I would take it one step
8 further. Also include in the training or
9 instructions for SMEs, that you should -- as part of
10 these medical records reviews, you shouldn't be
11 second-guessing the carcinogenicity of these
12 compounds. There should be just this given as a
13 known fact that TCE causes kidney cancer. And there
14 should be no ambiguity about that in these medical
15 record assessments, especially when they come back,
16 you know, as a reason for denial, because in part
17 we're not sure whether TCE causes kidney cancer.
18 And I've seen some denials that have been sent
19 through CAP members, earlier this year, that they're
20 still claiming, in their written correspondence
21 back, that TCE -- it's not clear whether TCE causes
22 kidney cancer.
23 **MR. ENSMINGER:** I mean, when you told me that
24 you had these experts that write these opinions, and
25 these people are experts --

1 **DR. HEANEY:** Can you hear me?
2 **MR. ENSMINGER:** -- then --
3 **MR. FLOHR:** Is that Dr. Heaney?
4 **MR. ENSMINGER:** Yeah, well, wait a minute.
5 **DR. BREYSSE:** Dr. Heaney, hold on one second.
6 **DR. HEANEY:** No problem.
7 **MR. ENSMINGER:** -- that these people are
8 experts. If they're experts, then they would know
9 what the EPA classified TCE in September of 2012,
10 reclassified it. They would know that IARC has
11 reclassified it. They would -- if they did a
12 thorough review, an exhaustive review, I believe the
13 wording was, of all the studies that have been --
14 decades of studies that have been done, and the
15 meta-analysis of those studies, then they would know
16 that TCE causes kidney cancer.
17 But that one claim that I -- denial that I was
18 referring to, this person went as far as to say they
19 had looked at all this stuff, and there was no
20 evidence that TCE causes cancer at all.
21 **DR. BREYSSE:** Okay. Dr. Heaney? You have the
22 floor.
23 **DR. HEANEY:** Yes, I'm here. Well, there are a
24 few things I can talk to. First of all, we do know
25 that TCE is a carcinogen, and that it can cause

1 kidney cancer. We know that. But that's not the
2 same thing as saying, in these specific situations,
3 with the length of time of exposure, with the route
4 of exposure, and with the other factors involved,
5 that it causes kidney cancer in those situations.
6 So recognizing that something is a hazard doesn't
7 mean it's causation in a specific case.
8 **MS. FRESHWATER:** What about the law?
9 **MR. ENSMINGER:** Wait a minute. I got a
10 question, Dr. Heaney.
11 **DR. HEANEY:** Sure.
12 **MR. ENSMINGER:** Number one, are you a -- are
13 you a VA employee or are you a contractor?
14 **DR. HEANEY:** I'm a VA employee.
15 **MR. ENSMINGER:** So you're on the VA's payroll.
16 **DR. HEANEY:** I am.
17 **MR. ENSMINGER:** Okay. So you're not contracted
18 at all?
19 **DR. HEANEY:** No, I'm a VA employee.
20 **MR. ENSMINGER:** Okay. Now, what crystal ball
21 do you have, when you look at these things, that
22 tells you exactly at what levels and how long a
23 person had to be exposed to this stuff to make your,
24 make your determinations?
25 **DR. HEANEY:** Well, we don't have crystal balls,

1 obviously, but we try to compare the risk factors to
2 see which is most likely -- to see if the exposures
3 at Camp Lejeune reach a less likely -- I'm sorry, at
4 least as likely as not threshold.
5 So even if we are to go by the mortality study
6 of -- that was done by ATSDR, they list the ratio of
7 increased risk of kidney cancer as 1.9-something,
8 1.98. So then we look at the specific case, and we
9 look at the risk factor: obesity, hypertension,
10 family history, smoking, et cetera, and we look at
11 the increased risk caused by those factors, and
12 certainly it becomes additive with the different
13 factor. And then we can weigh the evidence to give
14 us a picture of the likely causation in the case.
15 **MR. ENSMINGER:** Okay. And out of all the Camp
16 Lejeune cases that you've reviewed thus far, since
17 you've been doing this, how many have you
18 recommended approval of for service-connected
19 benefits?
20 **DR. HEANEY:** Well, I don't recommend approval
21 or denial. VBA does that. We just give our opinion
22 of causation. But I haven't kept a list so I cannot
23 answer that question.
24 **MR. ENSMINGER:** Well, I'd be interested to see
25 the ones that have been approved, to see what kind

1 of science and what the threshold is for approval.
2 **DR. HEANEY:** Well, it's not a threshold.
3 **MR. ENSMINGER:** Evidently there is.
4 **MR. PARTAIN:** Dr. Heaney.
5 **DR. HEANEY:** Based on -- uh-huh?
6 **MR. PARTAIN:** Just out of curiosity, 'cause
7 I've never met you, and I've just seen your name in
8 passing, but --
9 **DR. BREYSSE:** Could you introduce yourself
10 since she can't see you, when you started speaking.
11 **MR. PARTAIN:** This is Mike Partain, I'm a
12 member of the CAP.
13 **DR. HEANEY:** Okay.
14 **MR. PARTAIN:** I'm just curious and interested
15 in your background. We were talking about this
16 earlier, with transparency. If you don't mind, what
17 is your background and your degree and specialty?
18 You mentioned -- I understand you're a VA employee,
19 but just out of curiosity.
20 **DR. HEANEY:** Certainly. I received my
21 undergraduate degree and my medical school degree at
22 Emory University in Atlanta. I did my residency in
23 occupational medicine at the University of Michigan,
24 and as part of that, received my master's in public
25 health. I am board-certified in occupational

1 medicine. I am a fellow of the American College of
2 Occupational and Environmental Medicine, and the
3 past president of the Michigan Occupational and
4 Environmental Medical Association.
5 **MR. PARTAIN:** Now, besides the VA, do you do
6 any other employment or have a business of your own?
7 **DR. HEANEY:** I do some private consulting,
8 separate from the VA.
9 **MR. PARTAIN:** And what is the nature of that
10 private consulting?
11 **DR. HEANEY:** That's not related to my work at
12 the VA; it's not relevant.
13 **MR. ENSMINGER:** Oh, really?
14 **MR. PARTAIN:** Is it health consulting or is
15 it -- I'm, I'm just curious. I mean, like I said,
16 we're looking at transparency.
17 **DR. HEANEY:** Transparency from the VA. I don't
18 think that means transparency as part of people's
19 personal lives and work outside of the VA.
20 **MR. PARTAIN:** And my final question, in your
21 opinion, is there a difference between an
22 occupational exposure to VOCs, such as TCE and PCE,
23 and a lifestyle exposure, where you're immersed in
24 it 24 hours a day, seven days a week, 365 days a
25 year?

1 **DR. HEANEY:** Well, I don't -- if you're talking
2 about occupational versus environmental, yes, I
3 think there's a difference. I don't think that --
4 if you're talking about Camp Lejeune, for example, I
5 don't think people are immersed in an exposure 24
6 hours a day. But typically the levels of exposure
7 in occupational studies are greater than the levels
8 in environmental studies, and also the length of
9 time working in an occupation is higher -- is
10 greater than the cases that we've seen, or most of
11 the cases we've seen as far as time at Camp Lejeune.
12 **MR. PARTAIN:** Well, the -- you know, on the --
13 the lifestyle was what I referred to as --
14 **DR. HEANEY:** Yeah, I don't know what that
15 means.
16 **MR. PARTAIN:** Well, what I mean by that is very
17 clear in the fact that, you know, we lived on the
18 base 24/7. I was conceived and carried onbase and
19 born at the base hospital, all of which were
20 contaminated, including the water bottle my mother
21 used to make my formula with. These Marines and
22 service members who were at the base, the vast
23 majority of them lived on base, whether it be the
24 barracks or married housing, so they were exposed in
25 the showers; they were exposed in the mess hall,

1 which used steam to cook; they were exposed in their
2 occupational settings; and on top of all that, they
3 were drinking the water on the base as well.
4 So there is -- I, I feel there's a difference,
5 and that's what I was getting at, between an
6 occupational exposure and what I would deem as a
7 environmental or slash lifestyle, because, you know,
8 like in my case, I was made in these chemicals.
9 And, you know, I underwent the unfortunate
10 experience of developing male breast cancer at the
11 age of 39. And, you know, I hear and I see these
12 denials, obesity and smoking and things like that
13 being thrown out there like -- almost like playing
14 cards. In the case of male breast cancer, I've seen
15 several denials where obesity was cited as a factor.
16 One veteran was called obese, and I mean, the guy's
17 a bean pole. And if obesity was such a great
18 risk -- risk factor for male breast cancer, I would
19 think that a good portion of our society should be
20 getting tested or mammograms on a regular basis,
21 because, you know, there is quite a bit of obesity
22 out there.
23 But anyway, that's what I have.
24 **DR. BREYSSE:** So, so Mike, let me -- if I can
25 add to that. Dr. Heaney, I think the gist of the

1 question is, how do you weigh, when you said that
2 you look for the weight of evidence and decide
3 whether it's at least as likely or not, how --
4 what -- how do you weigh those? How do you decide
5 whether this TCE exposure, which has been
6 characterized, but is perhaps underestimated or
7 uncertainty about the estimation, we have disease
8 risk factors that have point estimates that may be
9 0.9, but if you look at the upper boundary of the
10 point estimate, it might be much higher. How do you
11 weigh the uncertainty of that point estimate, given
12 the uncertainty of the personal risk factors to come
13 up with a weight of evidence to suggest it's less
14 likely than not? That's not clear to me. This is
15 Pat Breysse, speaking, from ATSDR.
16 **DR. HEANEY:** Thank you. You know, each case is
17 different. And it's not yes, someone was exposed or
18 no, someone wasn't exposed. It's not they're obese
19 or not obese. We look at the specifics of the case.
20 Certainly how long they were at Camp Lejeune. We
21 look at what their occupation was at Camp Lejeune.
22 As far as other risk factors: How long they smoked,
23 when they stopped smoking, if they smoked, what kind
24 of thing they smoked, cigars or cigarettes. We look
25 at the length of time of obesity. We look at so

1 many different things. And we put it all together,
2 and we do our best in weighing the evidence and
3 seeing what it shows.
4 So a lot of these studies that show -- some
5 show an increased risk; some don't, but in the ones
6 that do, a lot of them are occupational studies
7 where the person has been exposed for five, ten, 15,
8 20 years. And we do get some cases where people
9 were at Camp Lejeune for only a few weeks, and
10 that's a different case from someone who was at Camp
11 Lejeune for five years.
12 So each case is different. I can't say that
13 it's a situation where a risk factor is always a
14 risk factor is the same risk factor. It depends on
15 the case.
16 **DR. BREYSSE:** Dr. Cantor from the CAP would
17 like to ask you a question.
18 **DR. HEANEY:** Certainly.
19 **DR. CANTOR:** Hi, Dr. Heaney. I'm a retired
20 epidemiologist from the National Cancer Institute in
21 the environmental -- occupational environmental
22 group there. Have you considered interactive
23 effects in your assessment? And what I mean by that
24 is, and not additive but multiplicative effects,
25 which are quite common in cancer epidemiology. I'll

1 give you an example. It doesn't have to do with
2 TCE, but it's something that we saw in a study of
3 kidney cancer which did not involve chemical
4 exposures; it involved obesity and hypertension.
5 And for each of those alone, the relative risk is
6 maybe 2 or 2.5, but for a person with obesity and
7 hypertension, the relative risks were in the order
8 of 8 or 10.
9 So therefore if a person was TCE exposed, even
10 for a maybe relatively brief period, and they are
11 smokers or they have hypertension or they are obese,
12 there might well be interactive effects that would
13 put them over the edge of having the cancer or not.
14 So I wonder if you have considered these interactive
15 effects, and if so, how you've done so.
16 **DR. HEANEY:** Yes, I'm familiar with the
17 hypertension and obesity studies. In fact that's
18 something that I cite in my report. I'm not -- I
19 don't know of any specific solvent studies with the
20 other conditions but would love to review them if
21 you have them.
22 **MS. FRESHWATER:** That's not his question. Can
23 you clarify, Dr. Cantor?
24 **DR. CANTOR:** Yeah. That wasn't my question.
25 It's, it's --

1 **DR. HEANEY:** No, I understand --
2 **DR. CANTOR:** It's simply the possibility, and
3 we know for example asbestos and cigarette smoking.
4 There are lots of examples in the literature. We
5 don't have examples, as far as I know, of solvent
6 exposure and these other risk factors. But it is
7 probable that it is, it's happening. And so that is
8 the basic question: Have you considered the
9 possibility in your evaluation that this is going
10 on?
11 **DR. HEANEY:** Yes. I understood the question.
12 I haven't considered that possibility. But even
13 with situations such as asbestos and smoking,
14 certainly they're multiplicative; we know that. And
15 certainly asbestos could perhaps tip the scale, and
16 I suppose that's what you're talking about with
17 solvents. But what we're being tasked to do is not
18 say, is any part of the development of this cancer
19 due to solvents. We're being asked to say is there
20 a 50/50 threshold. And I don't think that's the
21 same as, is there part of it that contributed to it.
22 And I don't have any numbers to go by as far as the
23 multiplicative effect.
24 **MS. FRESHWATER:** Can I ask a non-scientific,
25 layman question?

1 **DR. BREYSSE:** Could you introduce yourself?
2 **MS. FRESHWATER:** I'm Lori Freshwater, and I'm a
3 dependent, on the CAP. How do you know which thing
4 tipped it? So if it's --
5 **DR. HEANEY:** You don't.
6 **MS. FRESHWATER:** Okay. So if you don't know
7 which thing tipped it, then how can you deny that it
8 was the chemical that tipped it?
9 **DR. HEANEY:** Because it's not -- we're not
10 looking for the chemical that tipped it. We're
11 looking for --
12 **MR. ENSMINGER:** What?
13 **DR. HEANEY:** -- were solvents at least as
14 likely as not the cause. So which tipped it, we're
15 not being asked that question. Which was the final
16 straw? There's no way to answer that.
17 **MS. FRESHWATER:** Well, if there's no way to
18 answer that, how do you -- how can you tell a
19 veteran that it wasn't exposure to a chemical that
20 made them sick?
21 **DR. HEANEY:** We're looking at a 50/50
22 threshold. And that's the way that we do it. We
23 can't say if a -- if we recommend -- or if we say
24 that it's less likely as not, that's not the same as
25 saying the solvents didn't in any way contribute to

1 it. That's not what we're saying. We are saying
2 it's not a 50/50 situation of causation, that we
3 think it's a 50 percent likelihood that the solvents
4 were a cause.
5 **MS. FRESHWATER:** Okay, so when you're doing
6 this 50/50 threshold, like you yourself, do you know
7 how many -- what the average amount of water that a
8 Marine in training, in August, in North Carolina,
9 drank?
10 **DR. HEANEY:** Well, we have estimates but I
11 don't know exactly.
12 **MS. FRESHWATER:** So you are factoring that in
13 in your 50/50 though? You're factoring in that a
14 Marine would drink more water by large amounts than
15 a typical person.
16 **DR. HEANEY:** Absolutely.
17 **DR. BOVE:** Let me ask a couple of questions.
18 **DR. BREYSSE:** This is Frank Bove.
19 **DR. BOVE:** This is Frank Bove from ATSDR.
20 **DR. HEANEY:** Yes.
21 **DR. BOVE:** First of all, I've gone through the
22 literature, and there's no minimum amount of
23 exposure that's known that causes kidney cancer.
24 The Scandinavian studies have relatively low level
25 of exposure, the occupational Scandinavian studies,

1 had a relatively low level of exposure to TCE.
2 And in our paper on the mortality study of
3 Marines, we estimated that the exposures on a daily
4 basis to Marines, combining both residential and
5 training exposures to the drinking water, were
6 probably equivalent to what was going on in the
7 Scandinavian countries. So we don't -- you know,
8 again, it's not clear to me what the minimum level
9 that you're thinking about when you're wondering
10 whether it's 50 -- above 50 or below 50.
11 Also there's no information on the duration of
12 exposure necessary for causation. So I don't,
13 again, wouldn't understand how you're going to make
14 that decision.
15 The first thing is, when you mentioned smoking,
16 just so you know, if you don't, there was a meta-
17 analysis done by IARC researchers back in 2008,
18 looking at smoking and kidney cancer and other
19 cancers. And for kidney cancer the meta-analysis
20 indicated that the actual overall relative risks
21 were very similar to kidney -- TCE and kidney cancer
22 that were found in all the meta-analysis, done by
23 NCI and the EPA and so on. And so -- and in fact
24 TCE might be a tiny bit stronger risk factor than
25 smoking, for kidney cancer. Are you taking that

1 into account as well?

2 **DR. HEANEY:** We look at everything. I mean, we
3 consider all of the literature that we can find. We
4 factor them all into our decision. But again, it is
5 on a case-by-case basis. And we're considering
6 everything.

7 **MR. PARTAIN:** Dr. Heaney, when you mentioned
8 looking at literature, are you guys using the NRC
9 report of 2009 as your source for literature?

10 **DR. HEANEY:** Well, some of the citations in
11 there are relevant studies that we can go to, but
12 there's many, many, many studies since that time.
13 Those are, I think, only up to about 2008.

14 **MR. ENSMINGER:** Well, I saw one of your -- one
15 of your -- one of your opinions referenced a
16 Canadian study, done by a Christianson?

17 **DR. HEANEY:** Yes.

18 **MR. ENSMINGER:** That study was thrown out of
19 consideration by the NTP when they were reviewing
20 all the studies to use for their reanalysis and
21 reclassification of TCE, as it was -- it wasn't even
22 a factor.

23 **DR. HEANEY:** Well, in the National Toxicology
24 Program profile, they listed the article as low to
25 moderate utility. And then they described that. So

1 there wasn't --

2 **MR. ENSMINGER:** And they discarded it.

3 **DR. HEANEY:** -- no utility.

4 **DR. BOVE:** Well, it said it was limited utility
5 for assessing carcinogenicity because there were
6 only two exposed cases. So it was a study that had
7 less cases exposed than even our worker study at
8 Camp Lejeune. So it really is not a useful study to
9 cite in this regard.

10 I also can't understand why you would use the
11 NRC report when, as I said, there are thorough meta-
12 analyses and reviews of the literature done since
13 then by agencies mandated to do that: IARC, NTP and
14 EPA.

15 **MR. PARTAIN:** And Dr. Heaney, this is Mike
16 Partain again here. Going back to what Jerry was
17 saying with the Montreal study, and I want to
18 preface something, too, before I read something from
19 a denial here. When you're reviewing these, are we
20 dealing with just -- are you looking at one
21 chemical, TCE or just PCE or just benzene, or is
22 there a consideration and weight given to the fact
23 that these veterans were exposed to a toxic cocktail
24 of a mixture of all these chemicals and the effects
25 of all these chemicals compounding upon one other?

1 **DR. BREYSSE:** So Mike, let's let Dr. Heaney
2 answer the previous question --
3 **MR. PARTAIN:** Sure.
4 **DR. BREYSSE:** -- before we consider. The
5 previous question was talking about the Canadian
6 study and that evidence versus just relying on the
7 EPA, IARC and other reviews.
8 **DR. HEANEY:** About using -- why is the NRC
9 report used? Is that?
10 **MR. ENSMINGER:** Yeah, why is it even --
11 **DR. BREYSSE:** Yes, yes.
12 **DR. HEANEY:** Okay. I guess I'm confused why
13 there's an issue with it when if it is used for the
14 conditions in the healthcare law; it is used for the
15 conditions that the veterans who apply for claims
16 use as thinking that there should be compensation
17 because of those conditions. So I guess I'm
18 confused how there's a problem with us citing it,
19 yet the information on it is being utilized.
20 **MR. PARTAIN:** Have you read the NRC report from
21 cover to cover?
22 **DR. HEANEY:** Cover-to-cover, no.
23 **MR. PARTAIN:** You might want to do that. That
24 would answer your question.
25 **DR. BREYSSE:** No, I think the concern is that

1 it's outdated. Its conclusions are no longer
2 relevant given the IARC and the EPA and the NTP
3 review of now, respective to the weight of evidence
4 in TCE and kidney cancer, for example.
5 **MS. FRESHWATER:** And it was on the PowerPoint
6 as well, that's training people.
7 **DR. HEANEY:** That PowerPoint has nothing to do
8 with the subject matter experts and the claims.
9 I've never even seen it. That was, from my
10 understanding is that was related to healthcare.
11 And the clinicians who were showed that, and I don't
12 know who was shown it, but I presume those were
13 primary care physicians who were going to be
14 treating the veterans. It had nothing to do with
15 the clinicians who are doing the compensation
16 claims.
17 **MR. ENSMINGER:** And to answer your question
18 about the health -- the health outcomes that
19 showed -- ended up in that law, that bill was
20 constructed in 2010, okay? And that's why they used
21 the NRC report to construct that bill, which finally
22 became the law for the health outcomes. So since
23 that time, in 2012, in 2013, the EPA and IARC have
24 reclassified TCE. There's been all kinds of new
25 information come out on TCE. So that's why you

1 should not be using the NRC report. And
2 furthermore --
3 **DR. HEANEY:** But it doesn't make sense with the
4 healthcare law.
5 **MR. ENSMINGER:** And furthermore, you want to
6 talk about a biased study, or it wasn't even a
7 study; it was a review. I know all about the NRC
8 report 'cause it was my fault that the damn thing
9 got done in the first place. But I had trust and
10 confidence in somebody who initiated that and put it
11 in an amendment, and that was Senator Dole. And I
12 was told that, not only would the Department of the
13 Navy fund, they -- the only thing that the
14 Department of the Navy would have involved in that
15 would be the funding. And Congress was going to
16 write the charge. Well, the Department of the Navy
17 funded it and they wrote the charge to the NRC. So
18 that thing was biased from the get-go.
19 **DR. HEANEY:** Okay. That's good information.
20 **MR. PARTAIN:** Not to mention the peer review
21 coordinator for the NRC report was a former
22 executive from -- was it Honeywell?
23 **MR. ENSMINGER:** Yep.
24 **DR. BREYSSE:** Okay. Brad Flohr would like to
25 jump in, Dr. Heaney.

1 **MR. FLOHR:** Yeah. You know, this has been a
2 very good discussion. I think it really points to
3 the complexity of the issue. There's a lot of
4 different studies, a lot of different reports, and a
5 lot of people looking at them. The SMEs, like Dr.
6 Heaney, provide medical opinions. They do not make
7 decisions on claims. Those are made by the claims
8 processors in our Louisville regional office. It is
9 a piece of evidence.
10 We have granted claims when we've had a
11 negative VHA opinion, when we've had a really good
12 private opinion which raised it to the level of
13 reasonable doubt. And once we get to that level, we
14 grant the claim. Best thing that a veteran can do
15 is, and I know they can't all do that, is really get
16 a good medical opinion to submit with their claim.
17 Sometimes we wouldn't even ask me -- or ask for a
18 VHA opinion, if we have a really good medical
19 opinion.
20 **MS. FRESHWATER:** I just want to say real quick,
21 very quickly, when you say the complexity of all the
22 studies and there's so many studies out there, I
23 feel like that's muddying something that we're
24 trying to clarify, because what we're talking about
25 is using the latest science instead of old science

1 that's outdated. So I just wanted to say it's not
2 that there's so many studies that contradict, it's
3 that the VA is using studies that have been proven
4 wrong and that are outdated.
5 **MR. FLOHR:** What I mean by that is there's a
6 lot of studies on other risk factors besides TCE
7 that can cause kidney cancer. There's a lot of
8 them. They're not outdated. They're still good.
9 **MS. FRESHWATER:** I understand; I just wanted to
10 make that clear.
11 **MR. PARTAIN:** Brad, the people making
12 decisions, when they get a report back from --
13 **MR. FLOHR:** They don't make decisions; they
14 provide opinions.
15 **MR. PARTAIN:** The people who make the
16 decisions, when they receive the reports back from
17 the SMEs, when you get a statement like this, and
18 this is a report -- this is from an SME, actually
19 this is from Dr. Heaney, and I do want to go back to
20 my question that I asked that we had to come back
21 to, but anyways: There is no clear increased risk
22 in the development of renal cell carcinoma from
23 solvents even with occupational exposures of five
24 years or more. With a statement like that, I mean,
25 it's -- that's dumb.

1 How -- what person would award a benefit or a
2 consideration for a veteran after reading that
3 sentence? And by the way, they go on -- Dr. Heaney
4 goes on to reference the report that Jerry was
5 talking about, which is: Risk of selected cancers
6 due to occupational exposure to chlorinated
7 solvents, in a case control study Montreal, Chris
8 Christianson, MBA, blah-blah-blah. And there's no
9 counterpoints.
10 And that goes back to the transparency question
11 that I began earlier with this conversation. There
12 needs to be transparency from the VA on what you
13 guys are looking at, when a decision's made, they
14 need -- the person making decisions needs to break
15 down the pro and con reports that went into the
16 basis for those decisions, so that there's no rabbit
17 coming out of the hat. We need to understand how
18 that rabbit got there and what basis that rabbit got
19 there -- I mean, how do you determine, what basis,
20 what reports.
21 And going back -- I'd like to go back to
22 address my question about mixed solvents.
23 **DR. BREYSSE:** Well, what was that dated?
24 **MR. PARTAIN:** That was -- by the way, this
25 denial was dated February of 2015 and the report was

1 February of 2013, was when the -- the report that
2 she cited as the basis for denial. But going back
3 to it, I'll read it again for emphasis. There is no
4 clear increased risk in the development of renal
5 cell carcinoma from solvents, even with occupational
6 exposures of five years or more. Okay?
7 Going back to my question. We have mixed
8 solvents, we have people who are living on the base
9 24/7 and working on the base. What weight is given
10 to that versus someone that goes to work in a dry
11 cleaner for eight hours a day for five days a week?
12 I mean, is there -- and the question I'll follow up
13 with Dr. Heaney here, is there -- when you're
14 dealing with a carcinogen, are you looking like a
15 low dose load? I don't know the scientific term for
16 it, but are you looking at it -- you get exposed to
17 a certain amount of chemicals over time, and then
18 that may give cancer, or is there a risk at every
19 exposure, from day one? I drink a glass of
20 TCE-laced water; am I at risk from drinking that
21 glass? Can you say professionally that I can drink
22 that glass and I'm not going to be at risk, but it's
23 going to take me 15 glasses of TCE water over two
24 years to be at risk? Help me understand where that
25 threshold is.

1 **DR. HEANEY:** Yeah, no, I'm not saying that
2 there's no risk, or none of us is saying that
3 there's no risk. The question is, is the risk great
4 enough to rise to the level of 50/50 causation?
5 **MR. PARTAIN:** What about the mixed solvents
6 question?
7 **DR. HEANEY:** A lot of the studies actually were
8 done on mixed solvents rather than simply on TCE
9 alone or PCE alone. So we're looking at research
10 that shows the risk of those.
11 **MR. ENSMINGER:** Dr. Heaney, this is Jerry
12 Ensminger. What's your affiliation with the Heaney
13 Group?
14 **DR. HEANEY:** That's a private consulting.
15 **MR. ENSMINGER:** And who do you consult?
16 **DR. HEANEY:** Again, that is unrelated to my
17 work for the VA.
18 **MR. ENSMINGER:** Well, I mean, do you -- you
19 consult --
20 **MR. DEVINE:** I think you need to take this --
21 **MR. ENSMINGER:** No, you consult industry.
22 **MR. DEVINE:** You asked the question who does
23 she work for. She gave you her credentials, her
24 bona fides. That's the answer to the question.
25 **MR. ENSMINGER:** Yeah, but she's an industry

1 consultant.

2 **MS. FRESHWATER:** I'm a journalist so I'm --

3 **DR. BREYSSE:** Jerry, she's, she's not going

4 to --

5 **MS. FRESHWATER:** -- I'll just put it online.

6 **DR. BREYSSE:** She's not, she's not, she's not

7 going to answer that question.

8 **MS. FRESHWATER:** I know. Well, I'll just put

9 it online then.

10 **DR. BREYSSE:** Okay. So Tim?

11 **MR. TEMPLETON:** Thank you. Been waiting for a

12 while. I got a quick question for Mr. Erickson.

13 The working group you were talking about; is that by

14 chance the Camp Lejeune task force?

15 **MR. WHITE:** The working group that I believe

16 Dr. Erickson was referring to earlier was the

17 clinicians that we have at the VA who make the

18 determination on the healthcare side. We've had a

19 working group a few weeks ago in DC, where they went

20 over the IOM report, and looked at the clinical

21 guidance that had been developed at that point, to

22 see where it could be adjusted.

23 **MR. TEMPLETON:** So if you don't mind me asking,

24 just asking for a yes or no, is the working group

25 the Camp Lejeune task force, the VA Camp Lejeune

1 task force?

2 **MR. WHITE:** I don't think so. I think the task

3 force was originally set up that encompassed a

4 number of agencies within the VA, that were -- it

5 was kind of implemented to start this program.

6 **MR. TEMPLETON:** That's, that's one. Did you

7 have something -- not -- okay. A couple other quick

8 things; I'll try not to take too much time here.

9 There's been some new science obviously since some

10 of the claims were decided, and we want to move

11 forward, and I understand that, but there have been

12 some claims that have been denied in the meantime.

13 Are we going to do anything to go back and look at

14 those claims that were denied through the new lens

15 of the new science?

16 **MR. FLOHR:** Once a claim is denied, it can be

17 reopened. We can re-look at it. What an individual

18 would need to do is send letters based on new

19 science and we'll take a look at it.

20 **MR. TEMPLETON:** Is there a way you can do that

21 without the person who -- the claimant having to do

22 anything where we can review those in light of the

23 new science?

24 **MR. FLOHR:** I don't know. I'll take that back.

25 **MR. TEMPLETON:** I really would like to see

1 that, especially since this issue has evolved as
2 much as it has over a period -- a short period of
3 time that we've had, so I'd really like to see that.
4 Okay, one other quick, quick question, and then
5 I'll make a point. I've read the law several times,
6 and I'm not an attorney. I'm a professional but I'm
7 not an attorney, but I have read several contracts
8 over a fair period of my time in engineering, and I
9 don't understand why, with the way that it's worded,
10 it says that the VA is supposed to provide care,
11 notwithstanding, that's the keyword, notwithstanding
12 that the health conditions cannot be proved to be
13 tied to the contamination -- okay. Notwithstanding
14 means despite the fact that we cannot prove that
15 those health conditions were caused by those
16 chemicals, be able to provide care.
17 So given that, and if you disagree with me
18 there, you know, you'll have an opportunity to punch
19 me, why aren't the 15 health issues, why is that not
20 presumptive? To me that would seem presumptive. It
21 seems to me like you -- the law in itself is saying
22 right there, you will provide care despite the
23 fact -- for these conditions, despite the fact that
24 we don't know whether the chemicals caused those
25 conditions. So to me that seems presumptive, and

1 I'd really like to -- and I'll give you a chance to
2 answer that one, 'cause that's the one that I really
3 want the answer on.
4 The other, real quick is, there's been cases of
5 some really strange health conditions by Marines,
6 sailors, people who worked at Camp Lejeune, going
7 back to 50s, while they were working. And so there
8 is, there is an occupational health record there.
9 Has anybody gone back and taken a look at any of
10 those, to see whether there is a story that jumps
11 out at us because of those exposures? I have
12 someone who was a wife of someone who worked at Camp
13 Lejeune, who was aware that this -- and this was in
14 the late 50s, that they had a rare cancer, and that
15 the people on base knew about it and were treating
16 this person, and there's likely several other cases
17 that are similar to that. I don't -- I can't think
18 that they would not be particularly numerous. So
19 why aren't the 15 presumptive, and could we go back
20 and take a look at the -- at folks that have become
21 sick with certain illnesses at Camp Lejeune back in
22 the 50s?
23 **DR. ERICKSON:** Yeah, this is Loren Erickson. I
24 think the second question may apply more to ATSDR,
25 given that you're doing all the studies.

1 Your first question is a really good one. And
2 I would ask Senator Burr's office, because at the
3 time that they were drafting legislation, I wasn't
4 there but I'm going to bet that that was part of the
5 discussion as to, you know, exactly, you know, which
6 way do we go? Do we make these presumptives for the
7 veterans, as Congress has done in the case of Agent
8 Orange legislation, or do we do something else? And
9 there was a decision to write the law the way it is,
10 and from my standpoint, I don't know why they did
11 it, but I'd like to know the answer.
12 **MR. TEMPLETON:** Yeah, but I guess my question
13 more goes to, given the language is what it is, how
14 could it not be interpreted that that's presumptive?
15 I'd like an answer to that, because I -- I've heard
16 the VA attorneys, your counsel, seems to feel like
17 that it's not presumptive, and that's what's gone
18 out there. But the language on itself, and
19 especially if you take the legal, legal definition
20 of the term notwithstanding, it says that the --
21 that basically those 15 conditions are presumptive,
22 that you'll provide care even if you don't know that
23 they were caused. So why are we going through the
24 song and dance of trying to determine whether, you
25 know, whether somebody was exposed and how they were

1 exposed and their lifestyle and all this other
2 stuff, when it says in the law, notwithstanding. It
3 says we don't know whether those caused that or not,
4 but gosh darn it, we're going to treat them. They
5 have to be treated.
6 **MR. FLOHR:** The law says that, yes, even though
7 it's not known for sure that they were caused by
8 that, VA will provide healthcare. It specifically
9 excludes confiscation.
10 **MR. PARTAIN:** Well, one thing, I'd like to jump
11 in here, Tim, if you don't mind, when we were
12 talking about the IOM and you got the report there;
13 last year, and I'm not picking on you Brad, but this
14 was out of our transcripts here.
15 **MR. FLOHR:** You can always pick on me.
16 **MR. PARTAIN:** Huh?
17 **MR. FLOHR:** You're always picking on me.
18 **MR. PARTAIN:** Oh, yeah, you just step out in
19 front of the bus sometimes, but anyways, of
20 interest, and this is a quote from Brad, of interest
21 about ALS, several years ago, about three or four
22 years ago, the Institute of Medicine issued a very
23 small report on ALS that found that there's a
24 greater incidence of ALS in the veterans as compared
25 to the general population, and based on that actual

1 VA took the steps to make presumptive any veteran
2 who gets ALS is presumed to have caused through
3 their service, and that was a report that came out
4 through the IOM. I'd like to see the same
5 consideration given to the IOM report for Camp
6 Lejeune.
7 And one last thing, going on what Brad was
8 talking about, with the doctors writing --
9 physician. Two points with that. One, same denial
10 letter that I read from earlier. In response to the
11 denial you submitted a statement from
12 Dr. blah-blah-blah, a VA physician. The doctor
13 noted that it's possible that the current cancer
14 could be due to living at Camp Lejeune for a few
15 months. The letter did not include any rationale or
16 support to the statement nor did it list any
17 specific studies to discuss your risk factors. Stop
18 there.
19 **DR. BREYSSE:** What did you just read from?
20 **MR. PARTAIN:** That was a denial letter for
21 kidney cancer from a veteran that was reviewed by
22 the Heaney -- Dr. Heaney. Going back to this, yes,
23 and Dr. -- I mean, not Dr. Walters, Jim Waters, who
24 testified with me back in 2010 to Congress about
25 Camp Lejeune. He was a kidney cancer patient, had

1 been denied, and unfortunately he's no longer with
2 us. He died from kidney cancer. He got his
3 review -- he got his service connection partly only
4 because he worked for a school of medicine in Texas.
5 And in his testimony, he asked the question that I'm
6 going to pose right now. These veterans do not have
7 resources to hire an independent physician and pay
8 them thousands of dollars to get a medical opinion.
9 Now, I understand that you use people like Dr.
10 Heaney and other SMEs, those are resources available
11 to ATSDR -- I mean, ATSDR, to the VA, to do what you
12 need to do. But you're hiring that person and you
13 are paying that person. A veteran doesn't have
14 that. It's an unlevel playing field, okay? And
15 I've seen over and over again in these reports where
16 the VA is coming back to the doctors who are writing
17 nexus letters and saying, provide us a -- basically
18 a signed -- a, a scientific study or whatever, and
19 back this up. No doctor in his right mind is going
20 to do that. Number one, they're not getting paid.
21 They're doing this service for a veteran because
22 they do feel something's there. And now they're
23 being challenged. And you're asking the veteran to
24 come up with the money to pay to get an independent
25 expert to do that. That's unfair, and it goes back

1 to the transparency that I'm talking about.
2 Let's make this whole process transparent.
3 What's -- you know, a veteran might not be able to
4 spend $3,000 for their own subject matter expert but
5 if I know what your subject matter expert is denying
6 my claim based upon, and the studies and the
7 rationale behind that, then I can conduct my own
8 research. And the internet's a great tool for doing
9 that, and that's how we have been successful in
10 getting some of these veterans their claims and
11 their benefits, is because they come to Jerry and I
12 and say, here's our denial. What does this mean?
13 They don't understand this crap. And it usually
14 takes us -- it takes Jerry and I, seeing about three
15 or five denials and seeing the commonalities, and
16 then we start to realize where it's coming from, and
17 then we put it together, and then we help them
18 challenge it. But that comes at my own time or
19 Jerry's own time.
20 Let's -- level playing field. Let's be
21 transparent. State what you guys need, what you're
22 looking at, and in these denials who's reviewing
23 them, provide the names, provide the rationale and
24 the, the documentation to support that. Let's be
25 fair. That's all these people want to be.

1 **MR. ENSMINGER:** Brad, you mentioned in 2011,
2 when you first started coming to the CAP meetings,
3 that you actually sat down and laid out the
4 requirements to file a service-connected claim. And
5 you did. But now you've added different hurdles in
6 there. When you described it to us, you were
7 forming the Louisville -- you formed the Louisville
8 office to review all Camp Lejeune claims. But now
9 you're throwing in these other hurdles. These SMEs
10 that you -- or so-called SMEs. That was never part
11 of the mix. That was added later. So I mean, you
12 got people out there that go to their oncologist.
13 They get the nexus letters that you recommend. And
14 then not only are you questioning them, now you've
15 gone and got these other people to counter the, the
16 professionals on their nexus letters. I mean, how
17 do you win?
18 **MR. DEVINE:** Can we, can we have -- maybe talk
19 about the oncologist issue that both Mike and now
20 Jerry have brought up real quick?
21 **DR. BREYSSE:** Sure. And then I'd like to -- we
22 need to come to some closure on this. We're about
23 15 minutes behind schedule, which is okay, but I'd
24 like to get us to kind of have lunch around -- you
25 know, before too long. And so I know Christopher's

1 got a question he wants to add once Dr. Heaney
2 responds. Then we have two more action items we
3 have to review. So let's proceed in that order. So
4 Dr. Heaney?
5 **DR. HEANEY:** Yeah, I'll be quick. Just earlier
6 it was brought up the issue of an oncologist, for
7 example, writing an opinion, and then putting that
8 up for a family practitioner or an occupational
9 medicine physician to go against it. And we're not
10 diagnosing or treating the condition. That's what
11 you need an oncologist to do. We don't do that. We
12 use their information to put that in our reports to
13 show that it was diagnosed.
14 What we're doing is looking at causation, which
15 involves looking at the literature and toxicology,
16 et cetera, and most specialists don't know how to do
17 that. They see the patient, they diagnose the
18 patient --
19 **MR. ENSMINGER:** Neither does she.
20 **DR. HEANEY:** -- they treat the patient. They
21 have not done literature reviews. They have not
22 looked at the toxicology of chemicals. And so we
23 are being asked to do that part of it, and that is a
24 part that another oncologist probably couldn't do.
25 **MR. TEMPLETON:** Well, I debate that. A lot of

1 times they ask for risk factors, and so they do at
2 least delve into that a little bit.
3 **DR. HEANEY:** Yes, they do ask for risk factors
4 but that's about it.
5 **MR. PARTAIN:** And is it not through even family
6 practitioners or oncologists that often identify
7 increased cancer risks that begin asking the
8 questions that lead to cancer incidence studies or
9 cancer studies?
10 **DR. HEANEY:** I'm not sure what you're asking.
11 **MR. PARTAIN:** Historically, physicians are
12 often the vanguard at finding and identifying cancer
13 clusters and cancer incidences and things like that,
14 that ultimately end up in the review of
15 epidemiologists and stuff. Is that not the case?
16 **DR. HEANEY:** Some oncologists, some family
17 practitioners do research? Is that what you're
18 asking?
19 **MR. PARTAIN:** Well, aren't there -- isn't
20 there -- what I'm asking, isn't their input also
21 important for people like Frank and Dr. Cantor to
22 find and study cancer clusters, cancer incidences
23 and stuff like that? I mean, they're often the
24 vanguard to help identify where there's a public
25 health risk.

1 **DR. HEANEY:** Yes, but that's not the same as
2 being the ones to assess the causation, and that
3 doesn't involve looking back at all of the
4 literature and the toxicology. Bringing to the
5 forefront something that they noticed clinically is
6 not the same thing.
7 **DR. BREYSSE:** All right, so Chris, you've been
8 waiting patiently.
9 **MR. ORRIS:** Yes, thank you.
10 **DR. BREYSSE:** Please introduce yourself.
11 **MR. ORRIS:** Yes, this is Christopher Orris; I'm
12 a member of the CAP. And my question's actually for
13 Brady. Brady, I'd like to circle back to the VA
14 family members program. Specifically I'd like to
15 ask you, what is the amount of time that it
16 typically takes for a family member to be deemed
17 administratively eligible or ineligible?
18 **MR. WHITE:** Generally we've got performance
19 metrics for each stage of the process. And right
20 now for the VA staff in ^, which is where we're
21 based out of, there's a 30-day time frame to
22 determine administrative eligibility.
23 **MR. ORRIS:** Thank you. So would it be your
24 recommendation, then, that all family members of
25 Camp Lejeune exposed veterans go ahead and get

1 administratively eligible right now, so that when
2 they do get sick, they skip that 30-day wait time
3 frame?
4 **MR. WHITE:** Absolutely.
5 **MR. ORRIS:** Is that something that you would be
6 willing to put on your website to recommend?
7 **MR. WHITE:** Sure. Yeah, we can do that.
8 **MR. ORRIS:** Thank you. Now, my next question's
9 going to be to Mr. Erickson. Due to the fact that
10 the science is coming in fast and furious, and we
11 are finding more and more conditions that are
12 related to the exposure, would the VA welcome an
13 agency such as ATSDR being in charge of modifying
14 the legislation to add these conditions moving
15 forward, and would you recognize that if it was
16 Congressionally mandated?
17 **MR. ENSMINGER:** Can't do that.
18 **DR. ERICKSON:** You know, my sense is that the
19 Congressmen and women are elected officials and
20 actually be in charge of that with the aid of their
21 staffers. But, you know, we've already committed
22 that we'll work together in this, you know, whether,
23 you know, their name is in the marquee and ours is
24 in small print, that doesn't really matter to me,
25 one way or the other. The goal is the same. You

1 know, and that is to take care of the Camp Lejeune
2 veterans and family members, to do the right thing.
3 We have -- again, we've had significant
4 discussions already. We expect to have more in the
5 future, and I think we're on the right path. But in
6 terms of who gets credit or who carries the bigger
7 bucket of water, you know, we're going to
8 collaborate on this.
9 **DR. BREYSSE:** I think at the end of the day,
10 speaking in the same voice will make it stronger.
11 So that's why we want to identify those things that
12 we agree on. And we'll push those forward and we'll
13 more than likely be successful and work together.
14 **MR. ORRIS:** Thank you. And then my last
15 question is for Frank and Perri. We've known for
16 quite some time that TCE and PCE exposure causes
17 birth defects, specifically congenital heart
18 defects. I'd like to have an action item created to
19 where you can link the science together in an
20 official ATSDR memorandum that we can present to
21 Congress, so that we can start getting that illness
22 covered as well.
23 **DR. BREYSSE:** **O**kay, put that on the list. And
24 that's also part of, I think, what we’ve just talked
25 about. So I think this message to Congress, when it

1 comes from both of us, will resonate better.

2 **MR. ORRIS:** Thank you.

3 **MR. TEMPLETON:** And to the VA, and thank you
4 guys for being here today, and please understand
5 that our spirited discussion is not an indication of
6 disrespect or anything like that to you all. It is
7 a dialogue that needs to happen. It needs to happen
8 more often. And, you know, we do have a lot of
9 questions. I appreciate y'all being here and thank
10 you all for taking our questions today.

11 (Applause)

12 **DR. BREYSSE:** Angela, have we knocked off the
13 last couple of action items?

14 **DR. RAGIN:** Yes. The CAP requests an update of
15 the Louisville claims statistics, and we have
16 information from Brad. Brad, would you like to give
17 a summary or we could just mail it out to the CAP
18 members.

19 **MR. FLOHR:** We can talk about -- do we have
20 time after lunch?

21 **MS. FRESHWATER:** Yeah. Can we have it after
22 lunch? So we don't have to rush through it?

23 **MS. STEVENS:** And then what I'll do -- what
24 I'll do is, after today, after this meeting, I'll
25 send a copy of what Brad sent me to all the CAP

1 members so you have it.

2 **DR. BREYSSE:** Is there a way to photocopy it

3 during lunch and hand it out to everybody?

4 **MS. STEVENS:** It would be easier for me just to

5 run upstairs than to make photocopies at this hotel.

6 (Multiple responses)

7 **MS. STEVENS:** Oh, I see what you mean, so

8 people can actually look at it?

9 **DR. BREYSSE:** Yeah, they want to talk about it

10 after lunch.

11 **MS. STEVENS:** Let me see -- what if I could put

12 it up on the screen? I might be able to do that.

13 **MR. PARTAIN:** Can you send it to us

14 electronically, too, Sheila?

15 **MS. STEVENS:** Yeah, that's what I'll do.

16 **DR. RAGIN:** And the last action item: The CAP

17 requested a presentation on family benefits at the

18 next CAP meeting.

19 **MR. WHITE:** That's what I'm prepared to do.

20 **DR. BREYSSE:** Okay, lunch time.

21 **MS. FRESHWATER:** Can I just say -- sorry.

22 **DR. BREYSSE:** Oh, yeah, yeah. Sorry, I forgot.

23 **MS. FRESHWATER:** Just one quick question. What

24 is the criteria for choosing the subject matter

25 expert?

1 **MR. DEVINE:** There are -- we have 26. And it
2 is -- was originally, if I remember right,
3 originally it was the division directors chose the
4 occupational specialists.
5 **MS. FRESHWATER:** Can you speak -- I know I'm
6 too loud but...
7 **MR. DEVINE:** I'm sorry. The time -- I'm trying
8 to get -- actually, instead of me messing this up,
9 Deb, are you able to get on and explain it better
10 than me?
11 **DR. HEANEY:** Yes, I'm here. I believe they are
12 initially selected by a DMA based on what they know
13 of the clinicians in the field. Those with the most
14 experience who have dealt with issues of toxicology
15 in the past. And then there's a group of SMEs, we
16 review the -- their CVs and their credentials, and
17 speak with them. And then we select -- well, I
18 don't -- the DMA selects the one, and we do a
19 training. And some people work out and at times
20 some people don't work out.
21 **MR. DEVINE:** And the visiting directors,
22 though, are also part of that whole process,
23 correct?
24 **DR. HEANEY:** The visit -- I have no idea.
25 **MS. FRESHWATER:** So we would definitely want

1 some clarity on that process, how the subject --
2 what is the criteria for the subject matter experts
3 to be chosen, and what makes them a subject matter
4 expert.
5 And then just real quick, the reason that he
6 was gracious enough to let me speak before we go to
7 lunch, there's a -- someone in the room behind you
8 there, that he went to the VA and had his white
9 blood count showed up as being bad -- wrong. And he
10 was told probably, I think, allergies or I'm not
11 going to get this right. And it was known that he
12 was at Camp Lejeune. And then a country doctor
13 found out he had leukemia. So my question to you is
14 what are we doing to make sure that people across
15 the VA, again, it's about being proactive thing and
16 preventative medicine, because it's going to cost
17 the government less, which I'm assuming, Dr. Heaney,
18 is, part of your goal, right, is to cost the
19 government less money. So if like we are
20 preventative and we are looking out for someone, and
21 we find their leukemia on time as opposed to after
22 they're already dying and critically ill, what are
23 we doing proactively to make sure, because we're
24 getting emails at the CAP email address to say, can
25 you help us with some resources. From the VA

1 employees.

2 **MR. DEVINE:** The outreach to all of our
3 clinicians was something that I had already noted
4 last night, that I want to make sure to focus on. I
5 think that we need to be careful on what we said
6 there: Our goal is to save money by not diagnosing.
7 I don't think that was a fair thing to say.

8 **MS. FRESHWATER:** Okay, I --

9 **DR. BREYSSE:** I think if you -- if you diagnose
10 it earlier, you can save money.

11 **MS. FRESHWATER:** Right, that's what I'm saying.

12 **DR. BREYSSE:** Yeah, that’s fine.

13 **MR. DEVINE:** But when it comes to giving them
14 the treatment, I am absolutely a hundred percent all
15 for it, so are other people. I would like to say
16 and I want to say that Bob McDonald, and this is one
17 of his big things, that customer service, veterans’
18 experience kind of thing, that we do need to get
19 better, definitely think that. Like I said earlier,
20 you go to Spokane, Washington, and you have an issue
21 out there, our folks should have some kind of
22 knowledge, has the VA associate, so.

23 **MS. FRESHWATER:** And it's a cultural thing as
24 far as the VA goes, if someone comes to them and
25 says, I was at Lejeune; should I be screened for

1 anything? If the person they're dealing with,
2 instead of thinking this person's going to want
3 something; this person's going to be a can of worms,
4 and I'm not accusing anyone of having that attitude;
5 I'm just saying this is what I get back from the --
6 anecdotally. Then instead of that, why not have the
7 culture of, well, we'll -- let's jump in and, and
8 start looking at this person and try and get them
9 before they get sick. If you actually do accept the
10 scientific studies. Does that make sense? Just a
11 whole cultural kind of change as far as --
12 **MR. DEVINE:** When it comes to exposures, and
13 Lejeune isn't the only one. We also have Gulf War,
14 several other issues with the Gulf War, which -- the
15 exposures, I think, is our future in terms of
16 disability.
17 **MS. FRESHWATER:** Right.
18 **MR. DEVINE:** So there does need to be more
19 education more widespread. Because it is a smaller
20 slice compared to the 7.8 million that we treat
21 annually.
22 **MS. FRESHWATER:** But as you mentioned, I feel
23 like our work here is really important because there
24 are so many veterans who are going to be coming
25 forward now.

1 **MR. DEVINE:** I hope so. I absolutely hope so.
2 **MS. FRESHWATER:** And the burden hits, and
3 that's becoming a very big issue, and Parkinson's,
4 as we age, that's going to become a bigger issue.
5 **MR. DEVINE:** Yeah, I heard that one last night.
6 **MS. FRESHWATER:** So, yeah, I mean, you see
7 where I'm going with this as far as -- and I don't
8 mean to keep mentioning the PowerPoint, but we
9 really need to go really far away from where that
10 was into a whole different way of looking at things.
11 **MR. DEVINE:** We can be in support of where we -
12 - Would you help us to --
13 **MS. FRESHWATER:** Absolutely.
14 **MR. DEVINE:** And I'm glad you're mentioning
15 this because --
16 **MS. FRESHWATER:** Absolutely.
17 **MR. DEVINE:** -- it does allow us to take back -
18 – At least that’s my take on this, that VSOs are
19 absolutely essential.
20 **MS. FRESHWATER:** Yeah, I have great hope that
21 things are going to get better and we're going to
22 work together and do that.
23 **MR. ENSMINGER:** That's why I want to be on the
24 working group.
25 **MR. TEMPLETON:** I'd like to throw in a comment

1 concerning the SME program. We do need to know a
2 lot more about the SME program. At this point I've
3 had the opportunity to review a few of the denials
4 and some of the opinions that were written by SMEs.
5 I'm going to try to be nice here, and they were
6 horrible. They, they were -- there is much room for
7 improvement, and maybe we can improve that. I'd
8 like to see that.
9 **DR. BREYSSE:** Yes. I think you need to clarify
10 more about that program. It's clear, and we had
11 that written down. Couple of more topics, and I
12 think we really need to -- I think we'll all feel a
13 little bit better with a full stomach. Maybe a
14 little bit sleepier might be better. Tim -- or
15 Chris?
16 **MR. ORRIS:** I have, I have two last questions,
17 and my first question is going to be, in light of
18 the fact that the VA is recommending that all family
19 members at Camp Lejeune register for administrative
20 eligibility, what kind of outreach will the VA do to
21 ensure that the many people spread across all 50
22 states and pretty much around the world, are aware
23 that they should, in your own words, become
24 administratively eligible as soon as possible?
25 **MR. WHITE:** That's going to be part of my

1 presentation after lunch.
2 **MR. ORRIS:** Thank you. And then my last
3 question: Dr. Heaney, how long have you worked at
4 the VA?
5 **DR. HEANEY:** Since 2009.
6 **MR. ORRIS:** Thank you.
7 **DR. BREYSSE:** All right. Unless there's
8 something really burning, I think we all need to
9 have some lunch.
10 (Lunch recess, 12:35 till 1:36 p.m.)
11 **DR. BREYSSE:** All right. I'd like to move
12 things along. If we can get started, I know people
13 are still trickling in, because we want to review
14 the statistics that was the last action item. And
15 Brad's got to catch a flight so he's got to leave at
16 2:00, so that doesn't give us much time. But these
17 are the data that were provided by the VA in
18 response to the requests. Brad, you want to just
19 walk us through it?
20 **MR. FLOHR:** Sure. There was -- Mike, you
21 brought up something about the grant rate having
22 gone down a lot. Actually that's not -- it hasn't
23 gone down that much. It's just a different way that
24 we have gathered data. When you said we had granted
25 like 25 percent at one time, that was when

1 Louisville was keeping their own stats, and they
2 were only looking at the -- like the top 15
3 conditions from the NRC report. And they were -- I
4 think the grant rate was around 25 percent back
5 then. It was, again, in 2010 --
6 **MR. PARTAIN:** Well, it was up until like a year
7 or two ago from that. And that's coming from what
8 we got from our central office. I believe it was
9 for all conditions.
10 **MR. FLOHR:** I don't know if it was all. I can
11 check when I get back 'cause I got to look at my
12 reports. But currently, okay, we've got 10,569
13 veterans who have applied for Camp Lejeune benefit,
14 and we've completed -- that's actually the number
15 that we have completed, and there are 3,814
16 pendings, so we have about 14,000 Camp Lejeune
17 veterans that have never filed a claim for any
18 disability. And I don't know if that's because they
19 don't know about it or if they're not getting sick.
20 I don't know why that is. Out of 720,000
21 population, I can't explain it.
22 Let's go to the next slide. Our data staff is
23 now keeping all the statistics. Every month they
24 provide this report. When I talked about the breast
25 cancer issue last time, Mike, I said we've reviewed

1 all the granted and denied claims, and that’s the
2 present we coded some of them. They all showed up,
3 and there was only like 43 actual breast cancer --
4 male breast cancer claims. That's out of 117 that
5 we tracked. Those are the ones that we built
6 diagnostically. And you asked if we could separate
7 that out. I'm going to work on our data staff when
8 I get back, and I think we can do that, which would
9 show a more -- the real picture of actual breast
10 cancer cases, granted and denied.
11 Currently, as you can see, 35 -- or there's
12 28 percent of breast cancer cases altogether have
13 been granted. This report, again, contains not
14 actual breast cancer. We have like 17 percent,
15 18 percent bladder cancer, 14 percent liver cancer,
16 15 percent kidney cancer, 17 chronic renal disease,
17 20 percent for leukemias and lymphomas. And what --
18 what you see is the total primary disease
19 categories. These are the NRC 14th and 15th edition,
20 plus we added a couple of others, which we thought
21 were of interest, prostate and one of the others.
22 That has gone down. I know last month it was like
23 16 percent was the total primary disease category
24 grant rate. That's gone down this month to
25 13 percent. It changes every month based on of

1 course what type of issues are decided every month.
2 But what drives this down to five percent
3 overall grant rate is that 19,000 of the total of
4 25,000 claimed condition, almost 20,000 of them are
5 miscellaneous: Arthritis, back pain, headaches,
6 erectile dysfunction, foot fungus. We get all those
7 kinds of claims. That takes up our time, and part
8 of that is because on your website you tell veterans
9 to file a claim for everything they've got, and
10 that's what they're doing, even though they're not
11 at all associated.
12 **MS. FRESHWATER:** Which website?
13 **MR. FLOHR:** On the (indiscernible).
14 **MR. PARTAIN:** Where do we actually say to file
15 a claim for everything on there?
16 **MR. FLOHR:** It was on there when -- originally
17 when it came out I saw it on there. But I don't
18 know if it's still on there.
19 **MR. PARTAIN:** I don't know, 'cause since I got
20 involved in 2007 I don't recall that being on there.
21 **MR. FLOHR:** I remember seeing it.
22 **MR. PARTAIN:** But going back with the claims,
23 you've got 99 male breast cancer claims; is that
24 correct?
25 **MR. FLOHR:** Yes.

1 **MR. PARTAIN:** And of that 99 --
2 **MR. FLOHR:** Now, that's --
3 **MR. PARTAIN:** -- those are all --
4 **MR. FLOHR:** -- that's, again, that 99 may not
5 be actual breast cancer. That's people who have
6 either identified as breast cancer or they had
7 gynecomastia or breast nodes, and those are all
8 'cause of the way we capture that --
9 **MR. PARTAIN:** Okay, I understand.
10 **MR. FLOHR:** -- data. It may not actually --
11 'cause remember, there was only 43 --
12 **MR. ENSMINGER:** How the hell do you keep track
13 of this?
14 **MR. PARTAIN:** Okay. But going with the
15 veterans, you asked the question, or posed a
16 quandary, of why there's so few veterans have filed
17 and stuff. You know, we -- there's, you know,
18 notification's a big issue. I mean, I get emails on
19 a daily basis. Jerry gets emails on a daily basis.
20 There are people here today that are just finding
21 out about this. And so knowledge is -- knowledge is
22 one thing, and I don't want to steal too much time,
23 but one of the reasons why we're here today versus
24 Atlanta is to get these meetings out to the
25 community so the community can be aware of it. And

1 I'd like to see this continue. But you know,
2 notification's a big thing, Brad, so --
3 **MR. FLOHR:** I have a hard time understanding
4 that. I mean, the Navy sent, what, 200,000 letters
5 to the Marines they could identify. And you and
6 Jerry have been on documentaries, on TV, on *60*
7 *Minutes* and all kinds of programs. It's not like,
8 like it should be something that people don't know
9 about.
10 **MR. PARTAIN:** We've done a lot of --
11 **MR. FLOHR:** You've done your part in getting
12 the word out. And I don't know why it's not out
13 there more.
14 **MR. ORRIS:** Well, Brad, I can probably identify
15 a little bit of that. The Department of the Navy
16 refuses to communicate with any of the children born
17 at Camp Lejeune, at all. It doesn't matter their
18 age. And I've asked Melissa multiple times why the
19 Department of the Navy will not communicate with the
20 children born at Camp Lejeune. And they simply
21 state that they've sent the letters to the parents,
22 even though they're all adults.
23 **MS. CORAZZA:** Yeah, my mom got four letters,
24 one for herself and the three of us that were born
25 at Camp Lejeune, to her home address when I haven't

1 lived there for 17 years.
2 **MR. TEMPLETON:** Is there any way that the
3 miscellaneous conditions can be maybe broken out a
4 little bit? 'Cause I mean, if we take the 15 --
5 let's say -- let me elaborate just for a moment on
6 that. But if we take the 15 that we've got in
7 there, but then now we've got 19,000 miscellaneous
8 conditions. There's more conditions other than the
9 15 that we've been talking about here, and in
10 studies and so forth. I'm curious how many of the
11 miscellaneous conditions fall into the other
12 diseases that have been identified outside of the 15
13 that's -- I mean, lumping them like that, you know,
14 I think that deserves a little bit more visibility
15 on those, especially since it's such a large group.
16 **MR. FLOHR:** Yeah, I think we can get some
17 information on that. But like I said, there are
18 really things like arthritis, things that are not
19 really...
20 **MR. TEMPLETON:** Well, I have a comment on that,
21 too, 'cause I do feel like that in some cases they
22 are related, because there are some things, like
23 let's say for example if you happen to have
24 chemotherapy. When you have chemotherapy, then you
25 also have --

1 **MR. FLOHR:** Absolutely, yes.
2 **MR. TEMPLETON:** -- other conditions.
3 **MR. FLOHR:** Yes.
4 **MR. TEMPLETON:** And so those conditions are
5 related to what, what got you there in the first
6 place.
7 **MR. FLOHR:** Well, that's -- one of them I
8 mentioned, erectile dysfunction. If someone is
9 service-connected for prostate cancer, which is, as
10 you can see, we've granted 14 percent, and they have
11 surgery, and they have erectile dysfunction based on
12 that, that would be service-connected as well. So
13 it's -- but whereas granted for a thing all by
14 itself without any cause, then that's the kind of
15 thing that --
16 **DR. BREYSSE:** And Brad, I mean, it would also
17 be interesting to have those broken out 'cause it's
18 conceivable that there could be other conditions,
19 other clusters associated with this combination of
20 exposures that haven't been discovered yet. But if
21 there did appear to be some unusual number of some
22 rare condition, it might be worth exploring it in
23 more detail, if we had some greater resolution of
24 what this last category is.
25 **MR. FLOHR:** It could be quite lengthy, and I

1 don't know how that works in our data, but I'll take
2 that back when we go. At least I can get some
3 information for next time on what they all are.
4 **DR. BREYSSE:** Appreciate it, great. Yes.
5 **MR. HODORE:** I don't know if y'all are aware
6 that the VA have changed the regulations on filing
7 claims called the intent to file process. And most
8 veterans now have to go on e-benefits to even file a
9 claim. And if they don't get this 21-90, I think,
10 66 form, for the intent to file form, then the VA's
11 not even going to move forward on file -- even doing
12 anything about the claim.
13 **MR. FLOHR:** You know, I know something about
14 that, and I have not been involved in drafting
15 regulations on that. The purpose was because we're
16 all going totally electronic in the claims process.
17 We have like 96 percent of all of our claims are now
18 done electronically.
19 **MR. HODORE:** Okay.
20 **MR. FLOHR:** And so we came up with the idea,
21 okay, let's put a form out there that a veteran can
22 access through e-benefits.
23 **MR. HODORE:** Okay.
24 **MR. FLOHR:** You can complete it online, submit
25 it online, and it goes right into an electronic

1 file. No more claims folders and it's easier for
2 them to work with and to move around. Like if
3 someone files an appeal, we just transmit their
4 electronic form for the appeal, instead of sending
5 in a claims file and all that. So it's much
6 quicker.
7 So the intent to file, though, it's not
8 requiring. We recommend that people file through e-
9 benefits, and I know that e-benefits sometimes is
10 not that easy to get into. But --
11 **MR. HODORE:** But I have a concern --
12 **MR. FLOHR:** -- it's not necessary. You can
13 also call and they will mail you a form.
14 **MR. HODORE:** Okay.
15 **MR. FLOHR:** Contact them and they'll mail you
16 the form and you can submit it.
17 **MR. HODORE:** Well, one of the veterans brought
18 it to my attention that, if you did file with the
19 intent to file process, that the VA wasn't going to
20 be working on the claim until you file the
21 21-5-26EZ. So it's -- they're not going to even
22 work on a claim until they get the intent to file
23 process. What happened with all those veterans who
24 have filed the claim prior to this new law on
25 March 24th?

1 **MR. FLOHR:** They're still in the system. What
2 is going to happen is those are all going to one of
3 our scanning facilities, and an electronic file is
4 going to be created, and the documents will then go
5 away.
6 **MR. HODORE:** Okay. Thank you.
7 **MR. FLOHR:** But again, you don't have to file
8 through e-benefits. We want you to because it's
9 going to make it easier, quicker, for everyone. But
10 if you contact VA and say, I can't file through e-
11 benefits and I've got a computer -- lot of people
12 don't access computers still.
13 **MR. HODORE:** Okay.
14 **MR. FLOHR:** We will send you a form, a 5 or
15 6EZ, and you can mail that.
16 **DR. BREYSSE:** Thank you. Any more questions
17 for Brad? I know he's got to run.
18 **MS. FRESHWATER:** Just going back to the
19 website, Brad, the -- that website that you're
20 referring to is not the official website for the
21 Community Assistance Panel.
22 **MR. FLOHR:** I'm sorry, which website?
23 **MS. FRESHWATER:** The website that you said,
24 said to file -- everybody should just file for
25 anything including toe fungus. So this, starting

1 now, again, in the spirit of going forward, the
2 Community Assistance Panel actually does have an
3 official website, and so I'll send you a link to it.
4 And you can certainly give us information to post
5 that you feel like it would be helpful to get to the
6 veterans, like please don't file for toe fungus.
7 So I mean, we'd be happy -- again, we would be
8 happy to go back and forth and help you inform
9 veterans, and then also, you know, there might be
10 things on there that you could help us with as well.
11 There is an official -- you know, and it's, it's not
12 verified with a little checkmark but it's one that
13 we all can use. We have a Twitter account and a
14 Facebook account that we're all a part of now.
15 That's one -- because there's so many groups, we
16 wanted to have one place.
17 **MR. FLOHR:** I appreciate that, Lori. I do.
18 **MR. PARTAIN:** And if you would, Brad, you know,
19 I don't recall that part on the website, but I will
20 deal with the administrator, if that is on there,
21 take it down. It may have been on a bulletin board
22 that someone posted on there.
23 **MR. FLOHR:** May have been, may have been.
24 **MR. PARTAIN:** But I know that didn't come from
25 Jerry and I, 'cause we don't -- you know, we don't

1 ask people to file frivolous claims.
2 **MR. FLOHR:** I don't remember where it was or
3 who posted it. I do remember it said, file a claim
4 for everything 'cause you never know when they'll be
5 presumptive.
6 **MR. PARTAIN:** That sounds like someone posting
7 on a board.
8 **MR. FLOHR:** It very well could be.
9 **MR. PARTAIN:** 'Cause we don't encourage that.
10 I mean, 'cause we've seen claims, like for example,
11 we have a veteran with kidney cancer who was denied
12 kidney cancer but was awarded hypertension, which we
13 don't understand, and I can -- one of the male
14 breast cancer guys was actually awarded male breast
15 cancer -- or having to do with Vietnam and Agent
16 Orange, which was -- he had to go back and correct
17 that. So I mean, it's going both ways. So --
18 **MR. FLOHR:** You know you've contacted me in the
19 past about specific claims, and I've done what I can
20 to --
21 **MR. PARTAIN:** I know. But if there's something
22 on the website specifically, please send me a copy
23 of it, you've got my email, I'd like to see it.
24 **MR. FLOHR:** I'll do that. Thank you.
25 **MS. FRESHWATER:** We have a phone call that

1 Kevin wanted to get in, from a veteran, before Brad
2 leaves.
3 **MS. STEVENS:** I got something on that. So when
4 we do the CAP updates, we will -- the line'll be
5 open for the one that Kevin has mentioned, so -- but
6 I do have a presentation that Brady needs to do
7 still.
8 **MS. FRESHWATER:** So we can't get that in --
9 **MR. PARTAIN:** They got to go. They have ten
10 minutes.
11 **MS. FRESHWATER:** We can't get that in before
12 Brad leaves.
13 **MS. STEVENS:** I would prefer to do that during
14 CAP updates. Thank you.
15 **MS. FRESHWATER:** I'll do a little email, a
16 narrative of it.
17 **MR. FLOHR:** Okay, great.
18 **DR. BREYSSE:** And also while we're switching to
19 Brady's presentation, I assume Dr. Heaney's not on
20 the line anymore, and I was remiss when we took a
21 break. I wanted to thank her. If you can relate
22 back to her and thank her for calling in. We
23 appreciate her being here and making herself
24 available. I was remiss in mentioning that before
25 we broke for lunch.

1 Brady, you want to come up or are you going to
2 do it from there?
3 **MR. WHITE:** Probably from here.
4 **DR. BREYSSE:** Okay. Thank you, Brad.
5 **MR. WHITE:** Okay. So my name is Brady White,
6 and I am with the Camp Lejeune Founding Members
7 Program. Just within the past couple weeks my role
8 is evolving a little bit more to also involve
9 veteran healthcare, so I might be going over both
10 aspects of the healthcare side of the program.
11 And somebody mentioned earlier, Lori, I think
12 it was you, about the -- some of the confusion that
13 might be out there regarding healthcare versus
14 compensation, and I think that's very true, and I've
15 even seen it here in some of the questions that were
16 asked. So maybe next time we can definitely help
17 resolve some of that and then focus a little bit
18 more on that aspect of it.
19 **MS. FRESHWATER:** I appreciate that. I think it
20 would be helpful. I mean, it's hard for me to
21 understand, you know, 'cause I've never gone through
22 the system at all, and so I guess I'm a good test
23 case as to somebody who's trying to figure it out
24 from the outside.
25 **MR. WHITE:** Yeah, yeah. I think that'd be a

1 great idea.
2 **MS. FRESHWATER:** Could I ask you, would we be
3 able to get a digital copy of this PowerPoint?
4 **MR. WHITE:** I don't see why not.
5 **MS. FRESHWATER:** That'd be great. I'd just
6 like to put it on our website so people can see it
7 who aren't here today.
8 **MR. WHITE:** Okay.
9 **MS. FRESHWATER:** Thank you.
10 **MR. WHITE:** So this is just the recap of what
11 the law covered, and it's basically all these
12 cancers you see and the other conditions: Female
13 infertility, ^, miscarriage, neural behavioral
14 effects, renal toxicity and scleroderma.
15 Now, let's talk a little bit about veteran
16 eligibility, because I saw even in the last CAP
17 meeting there was a little confusion about when a
18 veteran's covered and when a -- again, I'm just
19 talking for healthcare, not for compensation. So to
20 be eligible for healthcare they must have served at
21 Camp Lejeune on active duty status during the
22 covered time frame, and that's from August 1 of
23 '53 through the end of 1987, and that he had -- he
24 or she has to have been there for 30 or more days,
25 and it doesn't have to be consecutive days but just

1 a total of 30 days.

2 And I really want to emphasize this next point.
3 The veteran does not need to have one of the 15
4 conditions in order to be eligible to receive
5 healthcare through the VA, okay? That's a
6 misconception that we really need to help rectify,
7 and make sure that that's not -- that that's not
8 thought of.

9 **MR. ORRIS:** Brady, I have a question for you.
10 By a veteran, do we mean active duty personnel? Do
11 we mean service? Do we mean --

12 **MR. WHITE:** That's an excellent question. And
13 the five points for veterans, and I made sure that I
14 had these listed out so I didn't fudge it, so a
15 veteran -- veterans who would have otherwise not be
16 eligible due to income are now eligible, just for
17 being at Camp Lejeune during the covered time frame.
18 They are eligible for enrollment now. They still
19 have to meet the definition of a veteran, and I
20 think that's what you're referring to. Veteran
21 service time, character discharge, serving in the
22 active military, naval and air service.

23 **MR. ORRIS:** So that would exclude National
24 Guard and reservists?

25 **MR. WHITE:** It would. They are eventually

1 going to be -- are you familiar with the priority
2 groups? So a Camp Lejeune veteran is going to be
3 Priority Group 6. So if they were Priority Group 8
4 before, because of their income and not receiving
5 the benefits, now they can be.
6 So they do not pay copayments for third-party
7 billing for any of the 15 covered illnesses, and as
8 an enrolled veteran, they may receive any care
9 provided in the medical benefits package, but may
10 pay a copayment or have third-party billing for care
11 not related to the 15 conditions.
12 **MR. TEMPLETON:** Brady, I've seen quite a few
13 people say that they have been placed into Priority
14 Group 8 temporarily, and that eventually they were
15 supposed to be possibly moved to 6 but they haven't
16 been.
17 **MR. WHITE:** Yes, sir. That's due to a
18 limitation of the system. So right now there's an
19 effort underway to update the system so that they
20 will be put into the proper priority group.
21 **MR. TEMPLETON:** So is there a time frame on
22 that?
23 **MR. WHITE:** I believe there is. From what I
24 recall, and again, I'm new to the veteran side of
25 things, I believe it's going to be by the end of

1 this calendar year they're hoping to have that in
2 place.
3 **MR. TEMPLETON:** Thank you.
4 **MS. CORAZZA:** Brady, can I just ask, and maybe
5 you can clarify, so even if you are -- the new VA
6 has now thrown out that you don't have to claim your
7 assets, just your actual income. I think that's a
8 valuable point. And with the copayments, the max
9 per day for healthcare is $50 a day copayments and
10 $8 for prescriptions; am I correct?
11 **MR. WHITE:** That's a good follow-up question.
12 I'm going to have to get back with you on that.
13 **MS. CORAZZA:** Yeah, it's a -- it's a valid
14 point only because if you have to see more than one
15 specialist, because you're sick, even if you don't
16 meet the 15 criteria, if you stack your
17 appointments, $50 a day is a lot cheaper and/or
18 $8 per 90-day prescription, than going to see a
19 civilian provider. So I was thinking maybe the
20 audience might like to be aware of that fact.
21 **MR. WHITE:** Okay. Thank you for bringing that
22 up. And I forgot to mention this at the beginning.
23 I'm deaf in my right ear and my left ear is not so
24 good. That's why I was unable to actually serve in
25 the military. So it's hard for me to tell direction

1 of sound, so if I don't -- I mean, if you just start
2 asking me a question, I might not immediately tell
3 where you are.
4 **MS. CORAZZA:** Thank you.
5 **MR. WHITE:** So where was I? Okay, next point
6 is veterans do not need to have service-connected
7 disability to be eligible for receipt of healthcare
8 benefits. Okay, I want to make sure everyone
9 understands that.
10 And I just went over this thing about the
11 copayments and again about the Priority Group 6. So
12 any questions on veteran eligibility for healthcare?
13 **MR. ORRIS:** Is there ever any intention of
14 supplying reservists and National Guard with the
15 same benefits as the active duty?
16 **MR. WHITE:** Excellent question. We have to
17 forward a proposal in order to cover the reservists,
18 and it's now with our Office of General Counsel.
19 Okay, for family members to be administratively
20 eligible, remember I said there were three criteria:
21 You have to have a dependent relationship with a
22 veteran during the covered time frame; you have --
23 the family member has to have resided in Camp
24 Lejeune or been in utero during that covered time
25 frame for 30 or more days; and the thing I'm missing

1 up here, that the veteran also has to be in Camp
2 Lejeune during that covered time frame.
3 Then in order to actually start receiving the
4 reimbursement for the healthcare, they have to have
5 been approved for one of the 15 conditions.
6 **MR. ORRIS:** I need some clarification. Why
7 does the veteran have to be there if the child is in
8 utero on the base at that time?
9 **MR. WHITE:** Why does the veteran have to be?
10 **MR. ORRIS:** You just said that if a child, even
11 if they were exposed in utero, the veteran had to
12 have been there for that 30-day period as well.
13 **MR. WHITE:** That's just one of the stipulations
14 in the law, that the veteran has to be stationed at
15 Camp Lejeune for the family member to have been
16 there with them.
17 **MR. ORRIS:** Well, what if he was deployed?
18 **MR. WHITE:** What?
19 **MR. ORRIS:** What if he was deployed?
20 **MR. WHITE:** As long as he was stationed at Camp
21 Lejeune. Doesn't have to physically be there.
22 **MR. ORRIS:** Thank you.
23 **MR. WHITE:** Good question.
24 **MS. FRESHWATER:** Brady? I have a woman who
25 just wrote me, and she says her son was carried five

1 months on base in utero. Is he considered a
2 civilian? She goes on to give more details. And
3 she was exposed on base, Building HP-902. So then
4 that would mean that her son would be considered
5 eligible in utero.
6 **MR. WHITE:** Well, without knowing all the
7 specifics --
8 **MS. FRESHWATER:** Right. Obviously, I'm not,
9 I'm not saying that, you know, you're approving her
10 claim or anything, but I'm, just as a hypothetical,
11 I'm using this.
12 **MR. WHITE:** Sure, sure. They have to have
13 resided on base, right, if they -- unfortunately the
14 way the law is written, if they did not reside on
15 base, this, this law would not cover them.
16 **MS. FRESHWATER:** Five months on base is what
17 she's saying.
18 **MR. WHITE:** Okay, yeah. Some people think that
19 they resided on base when maybe they actually lived
20 off base and maybe they worked on base, so that's
21 different.
22 **MS. FRESHWATER:** Okay. Thank you.
23 **MR. WHITE:** So for the veteran program, as soon
24 as the President signed it into law on August 6th,
25 veterans were starting to be seen in the VA

1 healthcare system. And the regulations, the final
2 regulations, were published in September of 2014.
3 And then some statistics here. We've provided
4 healthcare to over 3,600 veterans to-date, and 1,700
5 of those have been treated for specific, one of the
6 15 conditions under Camp Lejeune. And but 16,000, a
7 little over 16,000, are actually eligible for the
8 Camp Lejeune program. So one of the outreach
9 efforts that I'm going to do, 'cause I just saw this
10 stat not too long ago, is follow up with those other
11 veterans and find out, number 1, why aren't you
12 using the VA's healthcare; and number 2, if they
13 have a family member, have they applied?
14 **MR. ORRIS:** Quick question for you. What is
15 your VA estimate on the number of veterans who will
16 eventually apply, and also the same numbers for
17 family members?
18 **MR. WHITE:** I'm going to have to get the
19 veteran side back. So did you have a follow-up
20 question for that? On the family members the
21 initial estimates were -- we figured there might be
22 about 1,133 family members made eligible each year.
23 **MR. ORRIS:** For how many years?
24 **MR. WHITE:** I don't know.
25 **MR. ORRIS:** Over a ten-year period of time

1 we're talking about 11,000 people who were made
2 eligible for this program. That's less than the
3 number of children that we know were born on the
4 base.
5 **MR. WHITE:** Again, I'm not aware of all the
6 exact readings for the epidemiology that went into
7 it. But this -- they figured out that, of the total
8 percentage of family members potentially eligible,
9 maybe 25 percent of those would potentially become
10 part of the Camp Lejeune family member program.
11 **MR. ORRIS:** And it's still your recommendation
12 that every person who might be eligible should
13 become administratively eligible as soon as
14 possible?
15 **MR. WHITE:** Well, and after you asked that, I
16 thought about it for a while, and I think it would
17 be probably a good idea to encourage that. The flip
18 side of it is, as mentioned earlier, the VBA is, you
19 know, you know, I guess they've had a lot of claims
20 for toe fungus and whatever else, so it kind of jams
21 up their staff for doing stuff that is just not
22 going to fly. But I think the benefit of getting
23 people onboard and getting them enrolled sooner
24 rather than later would probably outweigh the risk
25 of the system or us being overloaded with claims,

1 and then creating this huge backlog. For family
2 members that may actually have one of these
3 illnesses, it just takes them longer to get to it
4 now because there are a lot of people in the system.
5 **MR. ORRIS:** We're not talking about people with
6 health claims, sir; we're talking about people being
7 determined administratively eligible. That would be
8 a different piece, wouldn't it?
9 **MR. WHITE:** Well, no, it's all part of the same
10 process. You have to go through the process for
11 somebody to be eligible. So if somebody doesn't
12 have a condition and they apply, then we have to go
13 through the same process for determining their
14 eligibility and if it's favorably, then we would --
15 somebody with one of the conditions.
16 **MR. ORRIS:** Sure, so it's determine as many
17 people administratively eligible as soon as
18 possible. That way you can focus on people with
19 health conditions as they appear.
20 **MR. WHITE:** Maybe we can have a sidebar
21 conversation.
22 **MR. WILKINS:** Brady? My name is Kevin Wilkins.
23 That 1,731, I'd like to find out if I'm included in
24 that number. I've been treated for three of the
25 conditions at the VA hospitals.

1 **MR. WHITE:** Do you remember if you told them
2 you were at Camp Lejeune?
3 **MR. WILKINS:** Oh, yeah. Oh, yeah.
4 **MR. WHITE:** Okay. Then chances are that you
5 are, but give me your information after this and
6 I'll follow up.
7 And then here at the bottom is the phone number
8 to call for people that -- for veterans that want to
9 enroll in the Camp Lejeune program.
10 **MR. ORRIS:** One, one final question for you.
11 Looking at this number totaling 16,000 veterans in
12 four years since the law has been passed, would you
13 deem that as a success or as a failure?
14 **MR. WHITE:** I have no idea.
15 **MR. ORRIS:** What would you deem a success or
16 failures, the numbers? What would you --
17 **MR. WHITE:** Again, Christopher, I'm new to the
18 veteran side. So I don't know what would constitute
19 successful numbers.
20 **MR. ORRIS:** I mean, we know potentially a
21 million people were exposed. And we're talking
22 between the two programs, less than 18,000 people in
23 two and a half years going through your system. I
24 think if I -- anybody could make the logical
25 assumption that something's not working correctly.

1 **MR. PARTAIN:** But in fairness to the VA,
2 Chris -- this is Mike -- it is not a success or
3 failure for the VA's part. Their job is not to get
4 the word out, per se. I mean, they can assist us in
5 doing that. But that's where the Marine Corps and
6 the Department of the Navy have got to get the rest
7 of the families notified and what have you. Their
8 job is to administer the care and track that --
9 track those numbers and everything.
10 So yeah, I agree with you, the numbers are low,
11 and, you know, there needs to be more attention to
12 it, but like I said, judging by just what we get in
13 from the families and people finding out, I mean, it
14 is not uncommon to get several emails, bang, bang,
15 bang, from people who are just finding out. I mean,
16 Lori was asked a question while we were talking
17 here, and I'm getting questions and emails and
18 stuff.
19 But the problem is we are fractured. We are
20 scattered across this country, and internationally,
21 because we have veterans from Camp Lejeune overseas
22 in the Philippines, Thailand, Germany, Italy, all
23 over the place. And we have, as a community, no
24 direct way to speak to these people, and that is a
25 major problem. You know, I cannot reach out and

1 send an email out to the family members and the
2 veterans saying, hey, this is what's going on or
3 even that we'd like to have a meeting. Trying to
4 get information out to these meetings, and we have
5 to rely upon surrogates such as the Department of
6 the Navy, the Marine Corps/Navy and the VA. And
7 that's something that -- you know, I know Jerry and
8 I have brought up to ATSDR, the registry part of
9 ATSDR.
10 We've got to find a better way to communicate
11 to the community. It's not out there. I mean,
12 there's -- I mean, the fact that we got people here
13 today and people asking questions, and the things
14 that I heard last night from the community shows
15 that the community really does not understand what's
16 happened at Camp Lejeune. And that's part of the
17 reason why this meeting took place in North
18 Carolina, and in the short future, I hope we have
19 one in Florida, where we got about 20,000 people
20 registered in the Marine Corps. So I'd like to --
21 and I don't know what the answer to that is, because
22 like I mentioned last night, we have a registry of
23 235,000-plus people with the Marine Corps.
24 So people are out there. Now, whether they're
25 going to show up on the VA's doorstep's another

1 issue, because there's a lot of different things
2 involved in that. But the VA's -- you've got your
3 registry of people coming in. Whether you call it a
4 registry or not, you've got data of people coming
5 in. ATSDR has some data. And we need to find a way
6 to get these government agencies to work together so
7 that there's one message being put out to the
8 families and the veterans, so they can understand
9 what's out there, what they need to do, what
10 benefits are available to them and how to get those
11 benefits.
12 **MR. ORRIS:** Thanks, Mike.
13 **MR. WHITE:** Coming back to the veteran side for
14 a second. One thing we're doing to help, and I
15 mean, this is a bit different than the compensation
16 side, where the veteran, all he has to do, or she
17 has to do, is claim that they were at Camp Lejeune
18 during the covered time frame, and they will be
19 enrolled in the system. Okay? So I wanted to point
20 that out.
21 For the family member side, we launched in
22 October, last year, so a little over half a year
23 now, we've been operating. And the key component of
24 this aspect of the program is we basically reimburse
25 the healthcare for one of the 15 conditions, and

1 only those 15 conditions, or associated conditions,
2 you know, if one of those 15 conditions caused
3 another illness or the treatment caused another
4 illness, we would also reimburse for that. And the
5 reimbursement is as the last payer. So if somebody
6 has other health insurance, we would pay after that
7 other health insurance pays.
8 **MR. ORRIS:** I have another question for you,
9 Brady. Do you hold the same level of what we've
10 seen that the veterans have to go through for
11 approval for a condition that they have -- does the
12 family member have to go through that same process
13 where you argue about whether they smoked a
14 cigarette and got cancer? Is that the same exact
15 process that you require?
16 **MR. WHITE:** Good question. And it's
17 different -- it is different. And this is where
18 some confusion might come into play. Where we're
19 talking about healthcare and providing healthcare,
20 for veterans, once they're made eligible as a Camp
21 Lejeune veteran, they can receive healthcare at a
22 medical center for any other condition, it doesn't
23 have to be for one of those 15 conditions. They
24 just don't pay any copayments.
25 On the family member side, what we've done, in

1 order to be as program-friendly as we can, because
2 again, we know that there's a lack of records for
3 determining administrative eligibility and showing
4 that a family member was actually onsite. So let me
5 tackle your -- the health thing first. So
6 for instance --
7 **DR. BREYSSE:** Brady, I think we need to speed
8 this up. If there are some questions, Chris, I
9 think that you have, maybe we can handle that by
10 email or something that's in detail that...
11 **MR. ORRIS:** I'm asking some of these questions
12 so that the people watching can know what they need
13 to do. I mean, I'm looking at the numbers and we
14 were talking last night and our people have thought
15 -- and he's seeking them in answering these
16 questions --
17 **MR. WHITE:** Maybe I can speed things along.
18 **MS. STEVENS:** Yeah, I think one of our problems
19 is we've got folks that leave around 3:00, 3:30, so
20 we need to move forward with our agenda.
21 **DR. BREYSSE:** Go ahead. Maybe you can speed
22 up --
23 **MR. WHITE:** Okay, so on the family member side,
24 what we've done is if a family member has cancer,
25 one of those eight or nine cancers, we're making the

1 assumption that it was caused by the exposures. One
2 of the other conditions, that's where on the form,
3 the treating physician form, we ask for other
4 medical documents, and the reason we do that, I know
5 you had questions about that, the reason we do that
6 up front is we want to make sure we try to speed the
7 process up. Rather than, you know, getting the
8 application and going back to the family member and
9 asking for the documents, if we can get those up
10 front, then our folks that we partner with over in -
11 - under Dr. Erickson, make that connection.
12 But you're right. So we've had 77 determined
13 eligible for both administrative and clinical, and
14 it's a pretty low number, out of the 700 or so that
15 we've received, 716, that we've received. A lot of
16 those are administratively eligible; they just
17 haven't supplied the medical docs to show that
18 they've got one of the 15 conditions.
19 And then this is a new number. We have a call
20 center that's dedicated to Camp Lejeune family
21 members, that if they call, they should be able to
22 get their questions answered. And we also have a
23 website that, when we rolled out in October, one of
24 my fears was it could turn into the Affordable Care
25 Act, and how that was rolled out. And thank God,

1 everything worked. So we're continuously trying to
2 improve it.
3 The reason for bill denials, this is kind of in
4 descending order. The main reason is it was
5 previously paid by their other health insurance, and
6 they did not have any responsibility for charges.
7 That’s the number one reason for denials. Or they
8 did not submit OHI explanation of benefits that
9 showed that -- we know they had other health
10 insurance, but for whatever reason, they didn't
11 submit the bill showing what their other health
12 insurance paid. And then maybe wrong diagnostic
13 code on there, that it was not for one of the 15
14 covered conditions, maybe it was a duplicate bill or
15 it was outside of the service dates.
16 Communications, we've spent a lot of time on
17 this but we've tried. I know OPH has tried on their
18 side, and we tried on our side as well as far as
19 doing some outreach. Mike, you mentioned, and it's
20 not -- we need to do a better job of coordinating
21 that. I know we have used the Marine Corps'
22 database, and sent out letters. And I added my name
23 to it to make sure it was done, to let them know our
24 program is up and running.
25 And then we've also reached out to the VSOs,

1 but I don't think there's much traction with that,
2 for some reason. You know, the VA has got an
3 official VSO representative, and I know that they've
4 reached out through that means. And maybe if you
5 guys could help me put some pressure on them to help
6 get the word out, that'd be great.
7 And this is just some enhancements that we've
8 done. I won't spend a lot of time on these in the
9 interest of time but -- and you guys will have
10 access to this afterwards.
11 And some of the accomplishments. One of the
12 key things here is the second bullet from the
13 bottom. We didn't anticipate that this was going to
14 be a really large program, initially. But one of
15 the things we knew would help family members would
16 be if we can have this pharmacy benefits manager,
17 which basically -- especially if we're first payer,
18 like if they don't have other health insurance, they
19 go through a pharmacy to get the drugs for, you
20 know, whatever, and some of these cancer drugs can
21 be pretty expensive. Until we get this pharmacy
22 benefits manager in place they have to pay for that
23 up front, and then submit a bill that -- as soon as
24 we get this in place, and it should be any day now,
25 they can go through the pharmacy, show them their

1 card, and then have us pay for those drugs up front.
2 So that's going to be a great benefit. So any
3 questions?
4 **MS. FRESHWATER:** I have a question that someone
5 just wrote and asked me to ask you. If a person is
6 eligible both as a veteran, and then later as a
7 military dependent living on base, they would be
8 fully eligible under both categories. And you're
9 saying they get VH care at the local clinic;
10 however, they live 84 miles one way from the nearest
11 oncologist, so they go to a civilian doctor.
12 They've earned both benefits. So I think the
13 question in there is how do you apply for both
14 benefits? Is there -- you know, can you just kind
15 of shed some light on that?
16 **MR. WHITE:** Yeah. We haven't actually
17 encountered that yet. And again, I'm kind of new to
18 the veteran side of the house. But I believe that
19 they would be covered under maybe the Choice Act.
20 You guys are familiar with the Choice Act? If they
21 do not live within 40 miles of a VA medical
22 center -- it used to be as the crow flies but they
23 recently changed that -- or with more than a 30-day
24 wait, then they can go see a whatever, a private
25 physician. And there's a lot more criteria for

1 that.

2 **MS. FRESHWATER:** But can you apply for both, as
3 a veteran and as a dependent?

4 **MR. WHITE:** Yeah. At this point there's
5 nothing to preclude anyone from doing that.

6 **MS. FRESHWATER:** Okay. All right, thank you.
7 I'm glad the crow flies changed. I didn't realize
8 that had changed.

9 **MR. WHITE:** Yeah.

10 **MS. FRESHWATER:** That's good to know.

11 **MR. WHITE:** Yeah, that was kind of a silly
12 rule. You can take that off the record.

13 **MS. STEVENS:** Dr. Breysse, I have something
14 real quick. So we are planning to have a meeting in
15 Tampa, Florida in the December time frame, and so
16 Brady, the information you provided, this would be a
17 good repeat, maybe, also in Florida, and we'll try
18 to put it on our agenda in the morning. That way,
19 you know, we'll have you earlier in the day to talk
20 and we'll have veteran -- the VA piece earlier. And
21 that way we can cover this kind of information again
22 and for folks that are in the VA -- or that are in
23 our Tampa area.

24 Just so you know, last night and right now as
25 we're speaking, this is being broadcast live on our

1 website. We had 167 hits last night of people
2 watching in so that was -- that's good news.
3 **MR. WHITE:** Yeah, and if you guys want to
4 invite me back, I've got money in my budget. I put
5 it in there to come back each quarter if you need me
6 to.
7 **MS. FRESHWATER:** I would like to officially
8 invite you.
9 **DR. BREYSSE:** There’s not a charge for an
10 official invitation.
11 **MR. WHITE:** I think you were too nice, only at
12 first. But next time I'll be prepared.
13 **DR. BREYSSE:** All right, if no further
14 questions, again, I want to thank the VA folks for
15 coming.
16 And the last segment, part of the agenda is the
17 CAP updates and feedback. So we'll turn the floor
18 over to the CAP.
19 **CAP UPDATES AND CONCERNS**
20 **MR. PARTAIN:** Well, what about audience
21 questions? Do we have time for that too? Does
22 anyone in the audience have questions?
23 **MS. FRESHWATER:** There are a few people.
24 **MS. STEVENS:** It's dependent on your CAP
25 updates.

1 **MR. PARTAIN:** Okay. I think we covered -- I
2 know I covered what I had during the meeting so I'm
3 good.
4 **DR. CLAPP:** I'd like to, if I could, just take
5 a minute and comment on Dr. Heaney. I know she's
6 not on the phone, but the methodology that she was
7 describing is inconceivable to me.
8 I used to teach students that were getting
9 their master's in public health to become doctors
10 like her, and we never taught anything like what the
11 system was that she was describing. It seems
12 totally subjective to me. So I didn't get a chance
13 to say that earlier today, but I was sort of shocked
14 by what I heard.
15 **DR. BREYSSE:** Ken?
16 **DR. CANTOR:** Yeah, it's a -- it's ancillary to
17 this topic, and that is that Lori raised the
18 question about how the SMEs are selected, or who
19 selects the SMEs. I wonder if we could also see the
20 criteria that these selections are -- that the
21 selections are based on, because a certain amount of
22 training and expertise of course is required for
23 this, and it would be good to have that
24 transparency, so I feel it’s worth asking for.
25 **MR. ORRIS:** I would also like to get an update

1 from the Department of the Navy regarding Building
2 133. I want to hear at the next meeting whether you
3 have abated the vapor intrusion that is ongoing at
4 that building and also what kind of notification you
5 gave, because it's my understanding that that is a
6 school. And I want to make sure you have notified
7 each of the people who might have attended class or
8 worked at that building.
9 **MS. FRESHWATER:** Sheila, are you involved in
10 helping Kevin get Willie on the phone?
11 **MS. STEVENS:** Yeah. Well, the thing is we just
12 have to -- is there anybody on the phone right now?
13 Willie, are you on the phone?
14 **MR. WILKINS:** You might want to ask him to go
15 ahead and call in, Sheila.
16 **MS. STEVENS:** Can you call him? I don't have
17 his phone number.
18 **MS. FRESHWATER:** No. Willie, call, call in.
19 Well, he's in a nursing home and this is a story
20 that needs to be heard. He's --
21 **MS. STEVENS:** I mean, I don't have his --
22 you'll have to call him because --
23 **DR. BREYSSE:** No, he can hear you.
24 **MS. STEVENS:** Oh, he can hear us?
25 **MS. FRESHWATER:** So Willie, call.

1 **MR. WILKINS:** Does he need to put that PC in
2 for passcode or just the number?
3 **MS. STEVENS:** Yeah, he needs to put the PC in.
4 **MR. WILKINS:** Well, tell him. Tell him
5 how to call you.
6 **MS. STEVENS:** Willie, if you're on, if you can
7 hear us right now, if you call the phone number you
8 get, and then you'll have an operator call in and
9 says to provide a passcode. You put the passcode in
10 and just shout out and say you're on the line.
11 **MS. FRESHWATER:** So I would like to have
12 audience questions. I don't have any more --
13 anything else to say.
14 **MR. WHITE:** While we're waiting for him, there
15 was a question that was handed to me I neglected to
16 answer. Does the income guidelines for VA
17 healthcare also pertain to those veterans with a
18 link to medical condition respective to Camp
19 Lejeune? So that gets to the Priority 6 group. So
20 based on income, if you're a Priority 8 group, now
21 you would get knocked up to the Priority 6 group.
22 **DR. BREYSSE:** There's some microphones being
23 passed around to the back while we're waiting for
24 Willie.
25 **MS. HOUK:** My name is Sharon Houk. And I spoke

1 last night, but I'm a Marine. I have a question for
2 the VA first. If you are -- you go and you get
3 established as a Camp Lejeune-exposed veteran, then
4 is takes a while, and then they'll come back and say
5 you have a primary care doctor. You go see that
6 doctor.
7 Well, I've been waiting almost two years and
8 mine still says nonservice-connected on every
9 document that I get from the VA. And so the
10 statistics that they had of the affected Marines who
11 are taking advantage of it, am I included in there,
12 since I'm not service-connected or are there
13 thousands of people still in limbo? Is there
14 anybody still from the VA?
15 **DR. BREYSSE:** Unfortunately I think Brad
16 probably was the person to answer that.
17 **MS. HOUK:** And also is there anything that can
18 be done on us, as we're alive or after we're
19 deceased, that can show -- is there any evidence,
20 epidemiology or an autopsy, is there anything that
21 can ever positively show that you were exposed and
22 that that caused it? 'Cause, I mean, we're all
23 basing it on water modeling and what happened 30
24 years ago. Is there no evidence at Camp Lejeune, no
25 skin tissues or biopsies --

1 **MS. FRESHWATER:** Let me just tell you, with the
2 VA question, since Brad isn't here, you can email
3 the CAP gmail account, and I'll pass it along and
4 get an answer.
5 **MS. HOUK:** Well, that was really for the
6 scientists.
7 **MS. FRESHWATER:** No, I'm saying the first
8 question. I just want to clear about that, okay?
9 I'll follow up.
10 **MS. HOUK:** Okay.
11 **DR. CANTOR:** Yeah, the answer, the answer's no.
12 It's clear, it's just in rare types of environmental
13 exposures, and you mentioned asbestos people, that
14 would be one where there might be evidence, either
15 late in life or under autopsy, that that exposure
16 had occurred. Even in the case of arsenic, for
17 example, which we know causes a number of different
18 cancers, there's no evidence other than the
19 epidemiologic evidence, which is powerful,
20 overpowering, that something -- that that caused the
21 disease. But in the case of these solvents that
22 metabolize very quickly, the damages occur, and the
23 damage is what the evidence is, basically.
24 **MS. HOUK:** That's why it's so hard when you try
25 to prove your case -- and I guess my other

1 question's for the VA also, but that people do the
2 research and provide that research that they submit
3 their time as much as you can possibly have, provide
4 that so there aren't as many questions on the other
5 end.

6 **DR. BREYSSE:** Yes.

7 **MS. WELLS:** My name is Denise Wells, and I'd
8 just like to make two very short statements. I am a
9 dependent. I would like you all to know that how I
10 found out about all of this, and I think it's rather
11 interesting, I worked for a major contracting firm
12 in Washington, DC. I happened to be at work one day
13 and I went to the printer and picked up a piece of
14 paper and found out that my contracting firm was
15 actually working with the United States Marine Corps
16 to gather all this information. And so that was how
17 I was notified, and that's the only notification
18 that I have ever received, officially or
19 unofficially, but I've been a part of the program
20 and following you for a couple years now, thanks to
21 the fact that I had a really good job. That's one
22 statement.

23 The second statement that I share with you, as
24 a dependent I have been trying to register with the
25 family member program. I have found that to be a

1 fairly good process. I've probably been at it for
2 about 90 days. I actually went online and
3 registered. I got a letter back within 30 days
4 telling me that they needed some additional
5 information, which I have since sent. I have just
6 recently sent some more information, but I have
7 found the people to be very nice. When you call
8 them a real live person answers the phone. You
9 don't have to push any buttons. You don't have to
10 be on hold for 30 minutes. They answer the phone.
11 They pull up your case on a computer. They can talk
12 to you; they know what you're doing. So I know the
13 VA's been getting sort of a bad rap but that program
14 looks to me like it's working.
15 **DR. BREYSSE:** Fantastic.
16 **MS. WELLS:** My name is Denise Wells. I live
17 here in Greensboro now.
18 **DR. BREYSSE:** Thank you. And I think we have
19 somebody on the line now.
20 **MR. WHITE:** Thank you for sharing that. I
21 appreciate it.
22 **DR. BREYSSE:** We have somebody on the line,
23 Sheila? Are you there, Willie?
24 **MS. STEVENS:** Willie, can you say something?
25 **MR. COPELAND:** Yes, I'm here.

1 **DR. BREYSSE:** All right. Willie, we can hear
2 you. Go ahead and tell us what you have to say,
3 please.
4 **MR. COPELAND:** My name is Willie Copeland. I
5 was stationed at Lejeune from March of '83 to
6 September of '85. After the Marine Corps I started
7 working in law enforcement.
8 In 2003 I had to quit work from kidney failure.
9 My kidneys ^. My teeth started to rot and fall out,
10 and I just got progressively worse. And in December
11 of 2011, the VA amputated both my legs above the
12 knee, and never told me anything about Camp Lejeune
13 and the water. I asked about living in a nursing
14 home, a VA nursing home. They said I wasn't
15 eligible.
16 Eventually I'm a total care patient, bed-
17 ridden. ^ I'm going to need dialysis soon, or a
18 kidney transplant. But I'm bed-ridden at a nursing
19 home, and with no help from the VA and not anyone at
20 the government VA, when I told them about Camp
21 Lejeune, they looked like they don't know what I'm
22 talking about. And I mean, I'm just -- nothing.
23 And you know this stuff that's going on. When I
24 asked -- I was 47 when my legs amputated. And the
25 government VA did all of my medical work and they

1 told me nothing about the contaminated water at Camp
2 Lejeune. And so now I'm in a private nursing home.
3 You know, ^ I just would like for somebody to tell
4 me why the government VA didn't say something about
5 Camp Lejeune or give me any kind of information.
6 **DR. BREYSSE:** Okay, thank you very much. So is
7 there something you can ask, you know, from the VA,
8 concerning -- as I understood it was serious health
9 concerns, a veteran with service experience, and
10 nobody at the VA connected the Camp Lejeune with his
11 possible health conditions.
12 **MR. DEVINE:** If somebody can help me with his
13 personal information, I can try and track that down
14 --
15 **MS. FRESHWATER:** And is he saying he was
16 denied -- he's trying to get it. Since then he's
17 been denied.
18 **MR. WILKINS:** He tried to get into a VA nursing
19 home, and he's in a county home.
20 **MR. ENSMINGER:** Well, he's also -- had filed
21 for service connection, and he's been denied.
22 **DR. BREYSSE:** So Willie, there's a
23 representative from the VA here who asked for your
24 name and --
25 **MR. ENSMINGER:** Contact information.

1 **DR. BREYSSE:** -- and contact information.
2 We'll get that to him and he'll be reaching out to
3 you.
4 **MR. WHITE:** Could you make sure I get that
5 also? The State home program is actually under our
6 directorate. So it sounds like he needed some help
7 getting to --
8 **DR. BREYSSE:** So Lori, can you make sure they
9 get the name and contact information?
10 **MS. FRESHWATER:** Yeah. We'll follow up on all
11 that. Sorry Willie, go ahead.
12 **MR. COPELAND:** Would you like the information
13 now?
14 **MS. FRESHWATER:** No. Don't say it now because
15 it's being broadcast so --
16 **DR. BREYSSE:** You can tell the whole world how
17 to get in contact.
18 **MS. FRESHWATER:** You'll probably be getting a
19 lot of fan mail.
20 **MR. ENSMINGER:** He'd probably be glad to have
21 it.
22 **MS. FRESHWATER:** But Willie, I just want to say
23 that all of us on the CAP have been really greatly
24 affected by your story, and really appreciate your
25 service, and we're going to work to do everything we

1 can to help you out.
2 **MR. COPELAND:** I really appreciate it. I'm
3 glad that I met someone that ^. I just feel like I
4 was, you know, put in the nursing home and forgotten
5 about.
6 **MS. FRESHWATER:** We have one more over here.
7 **MR. KAISS:** Yes, my name is Joseph Kaiss. I'm
8 from Augusta, Georgia. While this wasn't going to
9 be part of my initial question, in regards to
10 Willie, and God bless him, when I went to the VA to
11 initially file my claim, it wasn't specifically a VA
12 representative, but it was someone who must have
13 been contracted. They're on the second floor of the
14 VA hospital, I believe it was veteran services, the
15 woman told me that she didn't know how to file my
16 claim, that I would have to check the other Marines
17 that I knew from Camp Lejeune over 20-plus years ago
18 to find out whether or not I had or they had like
19 and kind diseases as myself. So we had to file on
20 our own. I mean, that was pretty much ridiculous.
21 But my actual question that I wanted to state
22 was that, I guess it goes back to the first
23 question, the lady that asked the first question.
24 You stated that there's nothing that can be done. I
25 think she was -- her question was she was leaning

1 towards a postmortem thing. I have, when I filed my
2 claim, and like I said last night, I was denied last
3 August 8th. I have a nexus letter from my
4 board-certified oncologist, and from what I heard
5 today from the SME, understanding the perspective of
6 some of the board members here regarding her
7 statements and her perspective, her position, it
8 seemed like they were almost irrelevant to the
9 system because the oncologist diagnosed and treats
10 me, and the SME's perspective was, well, they're not
11 qualified to determine anything beyond that. They
12 have their area of expertise; we have our area of
13 expertise, and they don't crisscross. I'm sure my
14 oncologist would love to have a conversation with
15 that woman.
16 But my question is, is there a specific field,
17 if I am financially able to do so, if I have to pay
18 a few thousand dollars out of my own pocket, which I
19 think is ridiculous, but is there a specific doctor
20 or a field of study that I need to go to that will
21 establish a credible link that will satisfy what
22 we -- from what we heard today, what the VA is
23 looking for? If nothing else, my cancers were
24 colorectal cancer, and I'm in Stage IV cirrhosis, of
25 which I was denied on both. The only thing the VA

1 accepted was the fact that, yeah, they contaminated
2 me. If I have to be that first person to establish
3 a link, so be it. But who is it that I need to go
4 to, from what we heard today, to get some kind of
5 credible evidence that it sounds like the VA is
6 going to accept? 'Cause obviously my oncologist
7 didn't work.
8 **DR. BREYSSE:** Well, I think what we talked
9 about last night and this morning, Dr. Heaney is
10 board certified in occupational environmental
11 medicine. The clinics we talked about this morning,
12 the -- I can't remember the --
13 **DR. CLAPP:** The occupational environmental
14 health clinics?
15 **DR. BREYSSE:** Yeah, the AOEC -- If you go to
16 AOEC -- I'm searching on the web to see occupational
17 environmental health clinics. I think if you got a
18 work up by one of those doctors, they'd at least
19 have the same credential that Dr. Heaney has. So in
20 terms of having a physician that -- you know, if the
21 argument is that an oncologist isn't prepared to
22 make an association between an environmental risk
23 factor and a disease, you know, that may or may not
24 be true, but certainly a physician who is similarly
25 board certified as one of the experts that the VA's

1 using, might be the kind of evidence that you're
2 going to need to help with that claim.
3 **MR. KAISS:** All right. Thank you.
4 **MR. PARTAIN:** And if you do reach out to
5 someone like that, let us know what happened, and
6 also --
7 **MR. KAISS:** I’ll let the world know.
8 **MR. PARTAIN:** And if there's any fees that they
9 charge, I'd like to know the cost of those fees too.
10 **MR. KAISS:** I'll let the world know that too.
11 **DR. BREYSSE:** I have a question for the general
12 public. How did you hear about this meeting? We
13 had a nice turnout last night. If we have a meeting
14 in Florida, it'd be nice to get a sense for what was
15 effective in reaching you and how'd you find out
16 about it and what brought you up here, so that we
17 know we can do a better job next time and build on
18 what worked. There's a microphone coming around.
19 Just raise your hand.
20 **UNIDENTIFIED SPEAKER:** I got an email from the
21 Marine Corps.
22 **DR. BREYSSE:** Okay.
23 **UNIDENTIFIED SPEAKER:** My brother received an
24 email, I believe, from your organization, and he’s
25 on a registry that you have. And I didn't, and I am

1 on the registry for the Marine Corps.

2 **DR. BREYSSE:** Okay. The microphone's coming
3 around. Just keep your hands up.

4 **UNIDENTIFIED SPEAKER:** I just happened to get a
5 note from one of my friends that the meeting was
6 going to be held today.

7 **UNIDENTIFIED SPEAKER:** My husband just happened
8 to read it in the High Point Enterprise, and at
9 first we thought it would be a scam. So I went on
10 the internet and found out that this organization
11 was connected with CDC. That put us at ease, and
12 we're so happy that we came.

13 **UNIDENTIFIED SPEAKER:** I was notified through
14 an email but I really couldn't tell who in
15 particular it was, whether it was the Marine Corps
16 or something I had been checking on. I've been
17 checking on so many things.

18 **UNIDENTIFIED SPEAKER:** I received a letter from
19 the VA, a hard copy, that notified me of the
20 letter -- I mean, of the meeting and the substance
21 of it.

22 **UNIDENTIFIED SPEAKER:** I am just lucky to know
23 someone on the CAP, Lori Freshwater. I did not see
24 either an email or internet or articles, anything
25 else. She invited me on Facebook to the event, and

1 I spoke around; I’ve got a couple of my buddies
2 watching on the live stream. But otherwise I had no
3 idea about today.
4 **DR. BREYSSE:** Great.
5 **MR. PARTAIN:** With that note, the notification
6 part of it, you mentioned the Marine Corps and what
7 have you. In 2009 we had the NRC report and the
8 Marine Corps distributed that report, basically
9 saying there's nothing here, move along, you know,
10 we can't prove anything, to all the families and
11 members on their registry.
12 And, you know, I'm hearing some people didn't
13 get emails from the Marine Corps; some people did.
14 We were told that the Marine Corps sent out
15 notifications. I'm not going to debate that there
16 but, you know, I would like to see, as a member of
17 CAP, for ATSDR to request custodianship of that
18 registry and to set up a formal registry so there is
19 no bias or no -- I mean, in the past it's been used
20 as a tool to disseminate the Marine Corps' point of
21 view to the families and to the Marines. And I'd
22 rather see it in a more objective venue and
23 custodialship.
24 **DR. BREYSSE:** So as Frank said that's not --
25 that's more of a mailing list than a registry. We

1 would need something different from that.
2 **MR. PARTAIN:** Well, let's create one, give
3 people a place to go. That's what we need. I mean,
4 I've said it several times during the meeting today.
5 **MS. STEVENS:** So with that, I'm going to
6 just -- Lori asked me to let people know how to
7 contact CAP members. There's three different ways
8 if you want to get a hold of everybody in the CAP,
9 and the first one is an email and it's the
10 *camplejeunecap@gmail.com*.
11 **DR. BREYSSE:** And no spaces, just three words.
12 **MS. STEVENS:** Yeah. *camplejeunecap@gmail.com*.
13 The next one is a Twitter account, and it's
14 basically *@camplejeune*, *@camplejeune*. And then if
15 you go to Facebook, you can find, just search for
16 Camp Lejeune and it'll be right there.
17 **MS. FRESHWATER:** No, Camp Lejeune CAP.
18 **MS. STEVENS:** CAP. Sorry, Camp Lejeune CAP.
19 **MS. FRESHWATER:** And the icon is a Newsweek
20 cover with the Marine.
21 **MR. PARTAIN:** Toxic Marine.
22 **MS. STEVENS:** The toxic Marine.
23 **MS. FRESHWATER:** And I just want to say that I
24 know a lot of the people on Facebook who can't
25 travel, who are in the groups, did a lot to get

1 people watching online. And I just wanted to thank
2 them, because they do -- they work hard too. They
3 just can't make it to the meeting.
4 **DR. BREYSSE:** Great. So we're at 15 minutes
5 past. Morris?
6 **MR. MASLIA:** I've done a fair amount of
7 Facebook notification for my cycling, okay, and one
8 of the things, and I don't know if we're doing this,
9 but you can actually proactively advertise on
10 Facebook. You can spend $5 a day or whatever, and
11 just the -- give you an example, for my cycling
12 group, we had an event. I put $5 a day for three
13 days, and it went -- and I can tell them what area
14 of the country I want to do it. Within 24 hours
15 they had already notified over 1,500 people, where
16 it had reached over 1,500 people. So that is,
17 rather than just passively seeing who your friends
18 are, we may want to look at actually actively
19 promoting the event through a dollar amount or so
20 many days before the meeting.
21 **MS. FRESHWATER:** Morris, did that translate
22 into real life? Because I paid 20 bucks out of my
23 pocket to boost one of the posts about the meeting
24 for Camp Lejeune, for a CAP account. And it said
25 that we had reached thousands of people but I don't

1 know if that really translated to --
2 **MR. MASLIA:** Well, we got a number of people
3 actually contacting me about this particular event.
4 **MS. STEVENS:** Okay. What we'll do is as we get
5 close, like we did last time, we'll have a committee
6 talking about ways to do outreach. Thank you.
7 **MR. MASLIA:** It was just a suggestion.
8 **MS. STEVENS:** Well, you're on the committee,
9 Morris.
10 **MR. MASLIA:** Well, you'll have to put up with
11 my cycling and food pictures.
12 **WRAP UP/ADJOURN**
13 **DR. BREYSSE:** So since we're passed time, we
14 have a number of action items that we would normally
15 review. I want to propose this. We'll summarize
16 them and send them around, and have everybody
17 comment. The purpose of doing that is to make sure
18 we didn't miss anything or everybody was onboard
19 with that. To be honest, in the past that has not
20 been a big problem. So we'll summarize and send
21 those around, and if you think something was missed,
22 respond and we'll try and get a clean final list for
23 all the participants to react to the next time we
24 get together in August. And again, our next meeting
25 is August --

1 **MS. STEVENS:** 27.
2 **DR. BREYSSE:** -- 27th in Atlanta?
3 **MS. STEVENS:** August 27th in Atlanta. We'll
4 have it on our website. Some of you got little
5 cards. It'll be on the website. Because it's in
6 Atlanta, it's on a federal -- on federal property,
7 you are required to register. The only purpose of
8 the registration is to give your name. I'll give it
9 to our security guards to make sure that you can get
10 on our installation. So that's August 27th.
11 **DR. BREYSSE:** All right, and so with that I'd
12 like to again thank all the CAP members for helping
13 us out with this important work. Thank the VA, and
14 I think we heard some pretty encouraging new steps
15 that the ATSDR and VA can take with respect to some
16 of the issues we have dealt with. And again, I'm
17 looking forward to moving those forward.
18 I'd like to thank the Marines, the Department
19 of Defense for being here as well, and thank the
20 public and I'd like to thank everybody who was
21 listening in. It's a great CAP meeting, and we'll
22 see you at the end of August.
23 **MS. FRESHWATER:** Thank you and thank Sheila.
24 **MR. PARTAIN:** And we would like to actually see
25 the Marine Corps here.

1

2 (Whereupon the meeting was adjourned at 2:48 p.m.)

3

1 **CERTIFICATE OF COURT REPORTER**

STATE OF GEORGIA
COUNTY OF FULTON

I, Steven Ray Green, Certified Merit-Master Court Reporter, do hereby certify that I reported the above and foregoing on the day of May 13, 2015; 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 15th day of June, 2015.

____

STEVEN RAY GREEN, CCR, CVR-CM, PNSC
CERTIFIED MERIT-MASTER COURT REPORTER
CERTIFICATE NUMBER: A-2102