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
CONTENTS

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 47
WATER EXPOSURE EVALUATIONS
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.
PARTICIPANTS

(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
PROCEEDINGS

(9:11 a.m.)

WELCOME, INTRODUCTIONS, ANNOUNCEMENTS

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

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

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

MR. NICK WILKINSON: He just stepped out but
he's here.
MS. STEVENS: Thank you. And I have Nick Wilkinson from Senator Tillis's office.

MR. WILKINSON: I'm the guy who just yelled at you.

MS. STEVENS: Oh, thank you. And if I have any other members from the Senate or Congress, if you're in the room right now, would you please stand so I can recognize you?

Okay. So here's what I'm going to do. I'm going to start with having each of our members here in the CAP and on the ATSDR staff and the VA, that are here sitting at the table, they're going to go around the room and introduce themselves. And a reminder to you guys sitting at the table, you have to push the button or it's not going to go out live.

So start with Dr. Breysse. You want to go ahead and -- you can use your microphone.

DR. BREYSSE: So good morning everybody and welcome. My name is Patrick Breysse. I'm the Director of the ATSDR, and this is my second CAP meeting. And I'm happy to be here.

DR. RAGIN: Good morning, everyone. My name is Angela Ragin-Wilson. I'm Chief of the Environmental Epidemiology Branch, and I do a lot of work with Frank and Perri. Thank you for being here.
MR. GILLIG: Good morning. My name is Rick Gillig, and I'm the Branch Chief of the Central Branch within the Division of Community Health Investigations. That's the branch that's redoing the health assessment on the drinking water exposures. And we're also doing the project on vapor intrusion.

MS. FORREST: Hello, I'm Melissa Forrest. I'm here on behalf of the Navy/Marine Corps to listen to your questions and your concerns, and take back action items to the Marine Corps so that we can provide information to the CAP.

DR. CLAPP: Richard Clapp. I’m a member of the CAP. I’m a retired professor from Boston University.

MR. HODORE: Good morning, my name is Bernard Hodore, first time on the CAP.

MR. ORRIS: Good morning, I'm Christopher Orris; I'm a member of the CAP.

MR. MASLIA: Good morning. My name is Morris Maslia. I'm with the Division of Community Health Investigations, and my team did the water modeling that is used for the epidemiological studies and the vapor intrusion studies and to look at the public health assessment.
MR. WHITE: I'm Brady White. I'm with the VA, and I'm the Program Manager over the Veteran and the Family Member Health Reimbursement.

MS. RUCKART: Hi, I'm Perri Ruckart, ATSDR. I work on the health studies.

DR. BOVE: Good morning, I'm Frank Bove. I work on the health studies at ATSDR.

DR. CANTOR: Good morning, I'm Ken Cantor, a member of the CAP. I'm a retired epidemiologist from the National Cancer Institute.

MR. ERICKSON: Good morning, I'm Loren Erickson. I served 32 years active duty in the Army. Now I'm -- have joined the VA. I'm the incoming Acting Chief Consultant for Post-deployment Health. Somewhat new to Camp Lejeune issues but learning a lot. Thank you.

MR. DEVINE: Danny Devine with VHA.

MR. FLOHR: Brad Flohr, Veterans' Benefits Administration.

MR. TEMPLETON: Tim Templeton, a Marine survivor of Camp Lejeune contamination.

MR. WILKINS: Kevin Wilkins, CAP member.

MR. SMITH: Gavin Smith, CAP member.

MR. PARTAIN: Mike Partain, dependent, CAP member.
MS. FRESHWATER: Lori Freshwater, dependent. I lost my mother to two types of leukemia, and two siblings to neural tube defects. CAP member.

MS. CORAZZA: Danielle Corazza, Camp Lejeune family member, CAP member.

MR. ENSMINGER: I'm Jerry Ensminger. I'm on the -- a member of the Camp Lejeune CAP.

MS. STEVENS: Okay, thank you. Just one thing, after the meeting -- towards the end of the meeting -- this is a little different meeting than what we had last night. So in the public meeting, we had people -- we had kind of a Q&A session with the people who were in the audience. At the end of this meeting, when we get towards the end, we will have a microphone for people who have questions, okay? So that's how this meeting works. It's a little different.

So with that, I'm going to turn the meeting over to Dr. Breysse.

DR. BREYSSE: Before we start, I'm going to, on the record, officially recognize the, the team at ATSDR that did the water modeling work, and Morris Maslia was the PI in that. And many of us know that it received the 2015 Excellence in Environmental Engineering and Science Award. And that award was
given by the American Academy of Environmental Engineers and Scientists. So congratulations, Morris.

[Applause]

MR. MASLIA: Thank you.

SUMMARY OF THE MAY 12TH PUBLIC MEETING

DR. BREYSSE: So I'd like to just -- I'd like to briefly review last night's public meeting. So we've had a number of public meetings in the past. As many of you know, I'm new to ATSDR. I've been at ATSDR now for five months.

This is my second CAP meeting. It's one of the most enjoyable and one of the most challenging activities that I've taken on as, as head of the National Center for Environmental Health and ATSDR. But I thought last night was just a wonderful session, and I'd like to just reflect on it for a few minutes.

So I think it's important that people in our position at ATSDR, scientists, people at the VA, take some time to listen. And last night was an opportunity to listen. And I think we heard lots of different things. We heard from a broad spectrum of people about a broad spectrum of concerns that deal with healthcare provisions, about compensation. We
heard a lot of outrage. We heard a lot of concern about responsibility and owning up for what was done and who's responsible for, for, for the situation at Camp Lejeune.

There are lots of questions about what ATSDR's doing and how our science is informing the Veterans Administration decisions. And these are ongoing discussions, discussions that have been happening for a long time and will continue to happen.

I'd like to reiterate ATSDR's commitment to understanding the public health impact of what happened at Camp Lejeune and providing the information to as broad spectrum of stakeholders as possible, to make sure that the best decisions are made to account for that impact and to appropriately take care of people who are damaged and hurt and suffering because of the pollution at Camp Lejeune.

So I'd like to just spend a few minutes and open the floor up to -- if there's anybody else who would just kind of share a thought or two about what they took away from the CAP meeting last night. As we go around the room, a number of us were here at the table. I'd like to just think here for a minute about what people took from the CAP meeting last night. Jerry?
MR. ENSMINGER: Well, there were a lot of people that vented. It was a good release for some people. The only problem was that a lot of them were venting their anger at the wrong either entity or the wrong individual in that entity.

It still disturbs me greatly that the Department of the Navy and the Marine Corps does not send people here who can answer questions. I know they send Melissa over here as a note-taker. But, you know, we don't need a messenger service; we need people from -- representing the Department of the Navy/Marine Corps sitting at these meetings, that can be responsive to the community.

DR. BREYSSE: So I think, if I could echo that, that there's lots of players in this, this tragedy.

MR. ENSMINGER: Absolutely.

DR. BREYSSE: And it's going to work best for everybody impacted if all those players would work together and are committed to addressing what happened at Camp Lejeune. I think that speaks to the Navy, the Marine Corps, to the public health agencies, like the one I head, to the Veterans Administration, as well as other service-related organizations. So I think you're right. I think we have to find a way to work together better, and that
was a message I took from last night.

Anybody else? Well, to make this efficient, if you want to say something, why don't you -- I hate to be disorganized, but if you flip your name card standing upright so that we can see that you want to say something. That way, it would... Richard, you wanted to say something really quick?

DR. CLAPP: Yeah, well, it could be quick -- well, I will be quick. I agree with Pat, last night, that there was powerful emotions in the room and powerful issues raised by people who were affected, and the agency needs to hear that and the public needs -- you know, the general public needs to hear that. So that happened last night. It was, I think, a very successful meeting in that regard.

Also I think there are some updates that happened last night, and you presented the -- and Dr. Bove and Dr. Ruckart -- sorry, I gave you a promotion, Dr. Ruckart -- Presented some of the research that had been done since the NRC report in 2009. And we're in a new day now, and I think those who were responsible for compensating veterans have to address that, and have to realize that time has moved on, and that 2009 report, as we referred to it last night, is hopelessly out of date. So that came
through loud and clear. I’ll stop with that.

DR. BREYSSE: Great. Anyone else?

MS. CORAZZA: I think that there's a lot of room for more communication about how the VA works. I happen to have it because I'm a family member and also a service-disabled veteran who has used the VA for many things. And I really realized last night, listening to people's questions and concerns, that they have very little understanding of the different stove pipes more or less within which VA operates.

I do want to give credit to Brady for standing up and taking some of the fire. And I think very few people realize how limited his particular scope is. So he took a lot of, I think, fire that -- it wasn't deserved. So I'd like to see more clarification from the VA. I would have loved to see the VA give ten minutes on, this is the difference between healthcare part of the VA, and the disability and compensation part, because it isn't clear, if you've not used the system. And I think it does create a lot of unnecessary angst amongst family members, who are, you know, very uninitiated into this side of government.

DR. BREYSSE: And I think that was clear also. We'll have an opportunity today, on today's agenda,
for the VA to maybe help clarify that. But to the extent that I can understand it as well, I'm committed to working with the VA to make sure I understand it, because it is a complex system. And there are different silos and different stove pipes, and trying to understand that is a challenge for me. But I'm, I'm new to the government. But at least if I can understand it, I can help everybody else understand it as well. Lori?

MS. FRESHWATER: Well, just to echo what Danielle was saying, it's hard enough for veterans to navigate the system. So now that we're introducing family members, who have never done it, it's incredibly difficult. They are -- they're lost and they're frustrated and they're -- and by the time they're there they're already ill, and, and having to try and figure all of this out.

So I would agree that I would like to see the Veterans Administration come in and everybody take a step back from -- and have a less adversarial role, and have the VA come in as an educational -- an opportunity to educate.

And we could help; that's what we're here for. We're the Community Assistance Panel. We're not here to work for any entity; we're here to foster
communication among everyone and make sure everybody gets heard. So we could actually be a help to the VA, if we could work together to help people understand what's going on.

And I just want to say thank you for your leadership, because it has made a big difference in the work I do and, and the feeling as though I'm walking forward instead of on a treadmill that's going nowhere. And it's not a criticism of anything else. It's just been really wonderful, and I appreciate your openness. And I want to say a special thank you to the scientists while I have a chance, because they really are amazing, and, and it's very hard for me to communicate people who are angry and sick, that I deal with on social media and most type places, that the scientists are moving as fast as they can. They're doing it as fast as they can. Science is slow. We all want it to go faster. But without the science we have nothing, nothing. So I want to say thank you to the scientists who work very hard every day, and I feel very grateful that we are as far as we are, because a lot of contaminated sites don't have what we even have at this point.

DR. BREYSSE: Thank you for your kind words.
Mike?

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

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

Now the next step is to get the other government agencies talking to ATSDR that can help the veterans and their families, mainly the VA. I did see a lot of dysfunction last night with the VA. The representative up there last night did a great job with the limited -- did a great job of trying to
field questions, but frankly he was the wrong person there. He was the right person for the families, and that's what he was supposed to be there for, but there was no one up there answering questions from the VA to the veterans. And I sat there -- despite the fact that there were several people here. And I sat there and I scratched my head wandering why aren't these people up there talking. Why doesn't the VA, who knew this thing was going to happen, who knew we had a community meeting, and nobody was here to field questions or talk about what these veterans need. You know, the VA's, they're first responders. They're the ones who are going to come in here and help clean up the mess and make what of it, take the wrong that has happened to the veterans and their families, and make it right.

And I would encourage more open dialogue and more discussions between the VA and ATSDR with the science that has been accomplished here. This isn't junk science. I mean, Morris received an award for what he did, and recognized by his professional society. Okay? If it was junk science, he wouldn't be sitting there with a trophy that weighs more than he does.

**DR. BREYSSE:** To be fair, Morris doesn't weigh
that much.

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

MR. PARTAIN: And, you know, the next step of ATSDR is our public health assessment, and when that is released. Hopefully that will be sooner than later.

DR. BREYSSE: And we'll get updates on that as we move forward.

MR. PARTAIN: But, you know, going forward, though, people want to believe and want to trust in our government. This is an opportunity for our government to come and do the right thing.

It is a tragedy, it is -- affected a million people, by estimates and everything, a million Marines and their families are affected from 1953 to 1987.

You know, accidents happen. Who was at fault? That's not the important thing right now. What's important is taking care of these families. I'm dealing with a dying Marine in Florida right now. He's covered by the healthcare. He has kidney cancer, the calling card cancer for Camp Lejeune exposure to these chemicals. TCE was placed as a human carcinogen in 2011 by the EPA because of its
links to kidney cancer. IARC followed suit. Yet this man has been denied from the VA for kidney cancer 'cause he smoked. But yet he has a letter from the doctor explaining that his kidney cancer isn't derived from that, but he's still denied.

The only thing he wants -- he's dying, he's metastatic; he's actually in the hospital right now. And the only thing he wants is to die in peace and to know his wife is going to be taken care of. Is that too hard for the VA to do? Is that too hard for our government to step in and take care of these veterans, who volunteered to serve and protect our country?

And going back to my point with last night, what I saw was dysfunction. What needs to happen is our agencies need to get together. They need to meet. If there's differences of opinion, they need to be resolved. There needs to be disclosure. How does the VA determine who gets benefits, who does not? A clear understandable method.

MR. ENSMINGER: They don't know.

DR. BREYSSE: Thank -- thank you, Mike. I think those are, those are all things that I'm committed to help work with the VA on, and I think --
MR. PARTAIN: One, one last point, and I don't want to blow the VA too much but, but prior to last year, the VA had consistency or consistently awarded around 25 percent of the VA claims being presented for Camp Lejeune. Over the past year, we've had four scientific studies of the water model come out that have shown connections. And the body of science has gone in one direction, away from what the VA's decision has been, yet the VA's award rate has dropped from 25 percent to around 5 percent. It's counterintuitive to science, and they -- and it cannot be explained.

DR. BREYSSE: Thanks, Mike. We'll come back to some of these issues later on, but I want to make sure we get around the room before we move on to the agenda.

MR. SMITH: Real quickly, just to follow on everything that's already said, I just wanted to point out the observation I had last night of the courage of people in the room that stood up and shared their stories. There were a couple in particular that... I think you -- when we get involved in some of this, as I deal with families and -- from the civilian side, and I remember my father from years ago, it's a reminder to me. It
was a very visceral reminder to me of what we're doing here, and the courage it takes to step forward and share. I know someone mentioned that, especially for the Marines, that usually we're taught to suck it up and deal with it, and not to admit it. So to come here, to speak out, to show that courage, to find other people and to connect with them and to get them involved and to make sure that everyone is taken care of and working together and be involved, I think, is a real testament to the strength of the Marine Corps from Camp Lejeune and all the people involved. So thank you for that.

DR. BREYSSE: Tim?

MR. TEMPLETON: Being the last guy, I think everybody pretty much covered it. But one thing that I would like to say is, from last night, it was great to hear everyone get the opportunity to air their concerns. A lot of those concerns, again, and I know this is going to sound like I'm beating a dead horse, but a lot of those concerns did have to do with the VA. I'm really encouraged that we have several VA representatives here today. I'm looking forward to some cooperation and partnership moving forward.

DR. BREYSSE: Okay. Brad?
MR. FLOHR: Yeah, I'd just like to say that I've been coming to these CAP meetings since the first one in 2011, I believe. And I've been the only VA person here for a lot of that time, and I've only missed, I think, one CAP meeting in that time. And the very first one I came to, I gave a presentation on the disability claims process, what we need, the evidence we look at in the decisions that we make. I know there's a lot of new CAP members here. I would have been glad to have done that last night, had I been asked but I was not. I would be glad to do it in a future CAP meeting, for those that, that are new and want to know about the claims process. Like I said, I'd be glad to do it.

MS. FRESHWATER: I think we want initiative from the VA. I don't -- we're dealing -- we understand you're busy but we're dealing with an awful lot. So I think what we would like is for the VA to step up and say, hmm, there are a lot of people out there that are -- the whole new program with the family members. There's a whole lot of people filing now. I bet it would be helpful to go through the system. You know what I mean? I appreciate what you're saying but, I, I think we're looking for the VA to come forward and be active
and -- that's what I meant by as opposed to an
adversarial role. We need the VA to be not passive,
here to defend; we need the VA to be here to help
actively.

DR. BREYSSE: More proactive?

MS. FRESHWATER: Yes.

DR. BREYSSE: Any other senses from the CAP
meeting -- or from the public meeting last night?
Richard?

DR. CLAPP: This is very brief. This is my
brief thing. I mentioned a website last night to
you and it was a com, and it's not -- the Clinics
for Occupational Environmental Medicine website is
aoec.org. So I'll just correct that on the record.

DR. BREYSSE: So that's the Association for
Occupational Environmental Medicine Clinics; is that
what AOEC stands for?

DR. CLAPP: It is. There's no medicine in the
website, aoem -- or aoec.

DR. BREYSSE: So a number of people came up to
me afterwards and said, you know, my doctor -- I
have all these complaints about injuries and
concerns about screening for chemicals that I may
have been exposed to or was exposed to, and my
doctors don't know anything about this, and what
resources that may help me. And so this is the resource that's been set up and for exactly this purpose.

These clinics aren't necessarily going to be able to examine everybody but they can provide resources to your doctors to help understand about what should be done. If you're worried about your exposures, this is something you need to talk to your doctor about. These are things your doctor can do in terms of screening and examinations that can be done to minimize your risk. And these are resources to help your doctor understand, you know, what would be appropriate medical tests and diagnosis and screening opportunities be.

Any other feedback on the CAP meeting? I mean, I'm sorry, I mean the public meeting. So like I said, I began saying that listening is important, and we're going to try and schedule other public meetings over the next year or so across the country, recognizing that Marines are not just in North Carolina anymore; they're all over the country. And I think there's a story to be told and there's people who need to be heard. And we're committed to provide an opportunity to tell those stories and, and a venue to listen.
So moving on with the agenda, the next item on the agenda is action items from the previous CAP meeting. And Dr. Angela Ragin, can you review those with us?

**ACTION ITEMS FROM THE PREVIOUS CAP MEETING**

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

The first set of action items is for the Department of Navy. I will read the action items and ask Melissa Forrest to respond. The first action item: The CAP would like the Department of Navy to provide rationale for the status of source documents that is currently being used by the ATSDR.

**MS. FORREST:** For Official Use Only is used to identify documents that may contain information or material which, although unclassified, may not be appropriate for public release. DON, Department of the Navy, expedites delivery of requested documents to ATSDR for their work without the documents undergoing a formal review. These documents are
labeled FOUO because they must be returned to the DON, Department of Navy, for formal review and compliance with the Freedom of Information Act prior to any requested release to the public.

MR. ENSMINGER: Now FOUO, is that an official classification under the Freedom of Information Act now? No, it's not.

MS. FORREST: I, I can't answer that question.

MR. ENSMINGER: FOUO is crap, okay?

DR. BREYSSE: So other than that colorful description, can you help explain to me what FOUO stands for again, and what's the significance of that with respect to -- the issue here is that ATSDR, we need as much information as available about what might be known about the chemical contamination at Camp Lejeune. And much of that information needs to come from the Navy. And so in that context, what does FOUO mean?

MS. FORREST: Well, what we're saying is, you know, when you ask us for large amounts of documents, we're trying to get the information to you as quickly as possible. If it's something that you want to be able to release to the public, it has to go through an official review. So to try and expedite you getting the information you need, we
are just marking it all FOUO so that it can go over
to you and you can --

**DR. BREYSSE:** So we have access to it.

**MS. FORREST:** Yes. If we want to release it to
the public, the whole group or any one particular
document, then we have to do a review of it. We
can't just send over mass amounts of information and
say it's okay to give it out; we have to do a
review. So we're sending it in lumps like that with
that classification to try and expedite your
scientific process. So I don't know if there's
something that we can work on, you know, to...

**DR. BREYSSE:** So, so it's clear from our
perspective that we need it for our scientific
process, but the community will also benefit from
seeing these documents as well. So if there's a
process through which we could expedite that
assessment, once we had our look at the data,
obviously it is a priority to extract the
information we need for our studies, I think that
would be -- you know, it would be helpful.

**MR. ENSMINGER:** Well, also, to make your
science valid, you've got to be able to reveal the
sources and make the sources of your information or
your studies available to the public and available
to anybody that wants to try to replicate it.

**DR. BREYSSE:** Absolutely.

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

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

**MS. FORREST:** Yes.

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

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

**MS. FRESHWATER:** I, I want a better explanation as to why documents that are not classified, that are nowhere near classified, that have never been in a classified universe, are not open to the public. Because it feels like it's just CYA, and it feels like if we go and -- through a process to file a Freedom of Information Act, you know, it's just slowing everything down.

And the public, the Marines and their families, who drank water that have made them sick, should be able to see documents that are not classified. I mean, these are old documents. There's not -- one example that was so absurd was not wanting the location of the water towers to be known. The water towers are red and white checkerboard. They're, they're famous. You know, you can see them from like South Carolina. So that is just an example, and I am not taking it out on you, and I don't think you're, Jerry, just a note-taker, Melissa. I've found you very -- I've, I've enjoyed working with you, and I know there's only so much you can do.

But I want you to find a very direct way to -- I want a very clear answer as to why, if documents aren't classified, the public cannot see them.
Because I don't buy that they have to look at them
before the public can see them. I mean, these,
these people are public. They work for the
government but they're not -- they don't have -- do
you guys have any clearance? Do you have any --
have you been up and been cleared for, you know,
classified documents?

**MS. FORREST:** I, I think that --

**MS. FRESHWATER:** Do you see what I'm saying?

**MS. FORREST:** I do. I think the review process
that we're doing is to ensure that we aren't
releasing anything we shouldn't.

**MS. FRESHWATER:** But why -- what would be in
there that shouldn't be seen? Give me one example.

**MS. FORREST:** I, I don't know. I'm just saying
there's a process we have to follow. And I, I hear
what you're saying, and I think that we can work on
something that ensures that you get the information
you need quickly, and we can still do this review,
and you can still have access to it.

**DR. BREYSSE:** So Melissa, let's just put that
down; we'll do that today. What Jerry said is
absolutely right, though. For us to use the data at
the end of the day, the public needs to see what
data we're using. People who don't agree with us
and want to double-check, who do our peer reviews, need to see that data, so everybody can check our science. So the science is not defensible unless all the sources, all the resources, that go into that are publically available. So it's crucial for us to defend what we do at the end of the day. We can do our work while we sort this out, but we have to make sure what we use is more broadly available. And we have to stand up to the scrutiny of public inspection of what we do, of scientific inspection of what we do, and all that is based on making this information widely available.

**MS. FORREST:** So I'm hearing two things to work on, which is the process to make sure you are able to release the information you need to release, and you want a clear explanation, Lori, of why --

**MS. FRESHWATER:** Like a list.

**MS. FORREST:** -- if you could just help me formulate your question so I make sure I take back the correct question.

**MS. FRESHWATER:** I would like a list of reasons, you know, like Danielle just mentioned, personal information, okay? So that's one of the reasons that they're going to say. I would like a full list of the reasons that we cannot see every
single document. As people who are working on this and trying to help Marines and their families, I, I would like to know exactly every reason that they're -- that these documents that are not classified, that we can't have them.

**MS. FORREST:** And I don't know that I'm explaining it well enough, and if I want to take it back and get an accurate answer. I think what -- the answer to that is you can see things that are not classified. We just have to ensure that the information that we're sharing with you does not have anything in it that does need classifying or sensitive nature. And I --

**MR. PARTAIN:** Melissa, can I cut to the chase with this? Those lists have been provided by the Marine Corps in the form of FOIA exemptions, things like attorney/client privileges, where the JAG attorney was advising them on press releases on what to say or not say to the public of Camp Lejeune, you know, personal information or what have you, or just whatever, you know, FOIA exemption they stick on there, and they provided that list to us when they released the Navy portal.

Interesting enough, a lot of this document discussion at issue really became a problem after
2008, when we released our first timeline that was
taken with the initial batch of documents that were
dumped on ATSDR by the Marine Corps. In fairness to
ATSDR and the work, the things that we were finding
were not scientific in nature, quantities, things
like that; they were historical information of what
happened on the base, for example, the fuel issues
with benzene in the water.

And as it became apparent that we were taking
this information and making it useful and coming out
and writing ATSDR with other avenues to look into,
the Navy and Marine Corps began clamping down on
what they released, how they released it, and
redacting the information.

But as far as the reasoning that Lori is asking
for, that has been provided in the form of FOIA
exemptions and also the use of FOUO, which is not,
as Jerry mentioned, not a legitimate redactable
excuse. So I didn't mean to jump in but then I
guess that some of this has already been answered.

**MS. FRESHWATER:** I would like to review that
again now, you know, now that we've moved further
down the road.

**DR. BREYSSE:** Okay. I think that -- we have a
number of action items so I think we, unless there's
something new to add to this, I think that we, if we have time, we need to --

MR. ORRIS: Well, I do have something new to add to this, because I happen to have one of those documents that's (inaudible) dated from July 24, 2013.

DR. BREYSSE: Can you speak into the microphone?

MR. ORRIS: Oh, I'm sorry. I happen to have one of these documents that the Department of Navy doesn't want to hand to us, and it's dated July 24 of 2013. And it's a technical memorandum, final, issued by CH2M Hill, regarding Building 133. Now, it came as quite a shock to me when reading this document, and I saw that there's PCE concentrations that more than double exceeded generic ^ for Camp Lejeune. However, since there's only that one VOC that was detected above the screening level, you decided that it was not necessary to account for cumulative non-cancer risks. Those non-cancer risks are only things as birth defects in women of child-bearing age, liver and kidney damage. And it's, it's quite shocking to see that there is vapor intrusion potential in the training room at Camp Lejeune in July of 2013.
Now, you know, this is just one document out of the many documents that are out there, but it's, it's -- I can understand why you don't want to give those documents to us, because we keep finding documents that show that there's ongoing problems at the base. And I would really like to know whether you have notified the people who work in Building 133 of the potential vapor intrusion. I won't hold my breath waiting for your response, 'cause I know you have to go back to your bosses, but if I worked at that building, I'd hold my breath every time I went in there.

   **DR. BREYSSE:** That's a sudden different issue, but we'll make sure we capture it. But I think it's clear that there's a barrier that we need to understand and we need to either break down or figure out a way to work around it.

   **MS. FRESHWATER:** Chris, were they notified at all? Not just about vapor intrusion but was anyone in the driving school notified that there was contaminated soil in 2012?

   **MR. ORRIS:** I wouldn't have that. I can't answer that question. That's going to be from the Department of the Navy whether they're notifying their personnel of ongoing exposures in this.
MS. FRESHWATER: It's a good question, isn't it?

DR. BRYESE: Yeah. Great question. Angela?

DR. RAGIN: The next action item for the Department of the Navy. This is in reference to notification of women who may have been exposed to TCE vapor intrusion at Camp Lejeune. The CAP would like to know how and when were the women notified, and was this notification timely?

MS. FORREST: As explained in a response to a September 2014 action item, comprehensive vapor intrusion studies are ongoing in several locations on Camp Lejeune for multiple ground water contaminants, including TCE.

In recent years, multiple fact sheets and other forms of information have been provided to workers to notify them of plans and findings throughout the vapor intrusion investigation process. The term timely was used in our response to the September 2014 action item to explain our plans for notification that may be needed in the future, because each site is different and issue is different and would require a different timeline for response.

For future TCE vapor intrusion issues, as with
other such issues that may arise, our goal is to provide appropriate, accurate and timely notification to our workers.

**MR. ORRIS:** Melissa?

**MS. FORREST:** Yes.

**MR. ORRIS:** It only takes one instance of exposure for a baby in utero to be given a life-threatening birth defect. What exactly does the Department of the Navy consider timely, given the extreme severity of TCE vapor intrusion?

**MS. FORREST:** I can't respond other than what was in the response, that, you know, it depends. It's a site-specific issue. We don't -- there's not an answer for timely for each situation.

**MR. ORRIS:** I don't think that that answer is good enough for women of child-bearing age on the base who might be exposing their children in utero today. I don't think that that's good enough, and I think it's a disservice to every man and woman in the armed services who put their lives on the line. They don't need to expose their children because of their job. And I don't think that we're providing a timely notification. But I'm looking at this study, and I know you're not.

**DR. BREYSSE:** So can we ask the Navy/Marines to
be more specific about what timely means and --

MR. ORRIS: Well, the EPA considers it such an important issue that they are going through their Superfund sites and shutting down any locations where there is TCE vapor intrusion because of the risk of cardiac defects. And I'd like to know why the Department of the Navy is not following suit.

MS. FRESHWATER: And I think that maybe we should do a better job of getting out to the national media and getting more information out that there is risk on base, on Camp Lejeune, today. And then maybe they, the people that are on base, the Marines there now, could demand a definition of timely. 'Cause that's really what I want. I want a definition of timely. I want, what does that mean?

DR. BREYSSE: Okay. Angela?

DR. RAGIN: The next action item for Melissa: The CAP would like for the Department of the Navy to provide the model number for the GCMS and information for when it was first purchased.

MS. FORREST: The Marine Corps would like to provide clarification on this action item. We are not asking for the GCMS model number to prepare a response. The initial action item referenced a document which can provide us with context and
background information for our research so that we look into the appropriate records. We will be more than happy to continue to look into this; however, as we indicated previously, we need the reference document, originally promised by the CAP.

   DR. BREYSSE: So there's some feedback --

   MR. PARTAIN: It was, that document was sent at the last CAP meeting. I just resent it this morning.

   MS. STEVENS: You sent it. We got it. Okay, we don't need it. We got it. Melissa, we'll send that to you.

   DR. BREYSSE: It didn't get to the main --

   MS. STEVENS: We just got it. Just got it. Well, we got it for the second time but we'll send it to you.

   MS. FORREST: And I will take that back for us to begin our research.

   MR. ENSMINGER: And the GCMS did not come from the Marine Corps; it came from the Navy Environmental Health Center in Norfolk.

   MS. FORREST: This is why we need the documents, so we make sure we are looking into the right instance, the right equipment, answering your question appropriately.
DR. BREYSSE: Angela?

DR. RAGIN: The next set of action items for the ATSDR. ATSDR leaderships and experts will discuss a request from the Department of the Navy a database with all information of environmental data related to Camp Lejeune that is functional and easy to use for review by scientists and CAP members. And Rick Gillig will respond to that action item.

MR. GILLIG: We had a discussion about this database in the context to the soil vapor intrusion project. We do have the files for the soil vapor intrusion project. We're using various computer programs to search those files. So rather than a relational database, we can use keyword searches to find the information of interest to us and pull out that information.

DR. BREYSSE: Next?

DR. RAGIN: The next action item: ATSDR and the CAP will review VA's Camp Lejeune research and studies, web page, and provide recommended updates and corrections to Brad Flohr. Brad will keep the CAP informed of any updates that are made to the website. I will turn over to Frank Bove.

DR. BOVE: I actually don't have that in front of me. There were -- there are still some issues on
the VA website, under the compensation part of the website, where there -- a statement about the fact that we still don't know the extent of the contamination at the base, and also a statement that was equivocal about kidney cancer and trichloroethylene, so those are still there as far as I know. But I checked a couple days ago.

**DR. BREYSSE:** All right. Brad, these are the two things we mentioned -- I mentioned to you last week. So we can get those exact URLs to you guys as well. Any other concerns about the VA website?

**MR. ORRIS:** Yeah, I, I brought this up at the last CAP meeting as well, for the family benefits section. You're still -- have that form up, that for authorization of medical release. That form that you have up is a VA-to-VA form that is in reference to HIV and alcohol abuse, which, I think, is highly inappropriate for family members to fill out.

And I also still think that you should not be asking for comorbidities and risk factors from family members' physicians, when they apply for benefits. That should be something that is completed by your team in your investigation and not provided up front from a doctor. No doctor's going
to, you know, put that information anyway. And it just seems to me a tactic to limit applications. So again, please address those issues.

DR. BREYSSE: Chris, can we -- so we're clear, can you put that in writing, so the VA can have something concrete to respond to?

MR. ORRIS: Absolutely.

DR. BREYSSE: Thank you. Angela.

MS. STEVENS: Chris, just send that to me when you get it, and I'll make sure it gets to Brad.

DR. RAGIN: The next action item for ATSDR: It was a request that ATSDR update their tox fact sheet on TCE. And I have copies here of the tox facts sheet. It was updated, and some additional language was added to the fact sheet, and I'll just read the language for you. But I do have some copies here. The language that was added to the fact sheet: The International Agency for Research on Cancer and the EPA determined that there is convincing evidence that trichloroethylene, or TCE, exposure can cause kidney cancer. The National Toxicology Program is recommending a change in cancer classification to known human carcinogen, and we have a website here where that information can be found. And if anybody wants a copy of the fact sheet, they can see me, but
it can be found on our website.

MR. ENSMINGER: When was that made? 'Cause I looked at it over the weekend.

DR. RAGIN: The update was made --

MR. ENSMINGER: Yesterday.

MS. STEVENS: Yesterday.

MR. ENSMINGER: Gee, only took three years, you know.

DR. BREYSSE: Angela?

DR. RAGIN: The next action item: ATSDR will review and consider adding or incorporating details for Mike Partain's timeline on our website. The action item was addressed to Mike. Mike, do you want to clarify or respond?

DR. BREYSSE: So the discussion was -- I remember the discussion.

MR. PARTAIN: Yeah, getting my timeline over to you, which I will.

DR. BREYSSE: Yeah. And it turns out we had a timeline on our web page. At the time it wasn't clear that we did have a timeline, so I think, rather than put yours on, I think we decided to just stay with the timeline that we have, which is consistent with what you have.

MR. PARTAIN: Okay, 'cause I don't recall
seeing that timeline. Is it the annotated documents and things or?

**DR. BREYSSE:** I don't believe it's annotated like that.

**MR. PARTAIN:** Okay, 'cause I think that would be -- well, I'll take a look at the timeline.

**MR. ENSMINGER:** I'll guarantee you it's not --

**MS. FRESHWATER:** Yeah, the -- his timeline, the importance is the documents, because people can go through and look at every single document that backs up exactly what we're saying. So if -- and I understand if you don't even want to put the whole timeline but a link. Let Christian put, you know, or email, that type thing. At least people have access to Mike Partain's timeline 'cause it should be famous. It's amazing.

**DR. BREYSSE:** We'll take that under further consideration.

**DR. RAGIN:** The next action item for the ATSDR. The CAP requested ATSDR invite a Department of Labor claims representative relevant to civilian employees at Camp Lejeune to attend the CAP meeting. And we are waiting for some information from the CAP.

**MR. SMITH:** Right. I'm actually working on collating some questions from the civilian community
now, and I'll get those in. I want to try to get those in so that we can at least get their presence for the next meeting.

**DR. RAGIN:** ATSDR was asked to provide the revised CAP guidance document to the CAP for review, and comment. And I think that was accomplished, and the guidance document has been posted on ATSDR's Camp Lejeune website.

And we have quite a few action items for the VA. Would you like to hold those at that session or continue?

**MR. ENSMINGER:** Well, I think there was an action item for ATSDR about the public health assessment too, the reissuance of the public health assessment and where that's at in the review process.

**DR. BREYSSE:** Well, we'll cover that when we do update of our studies.

**MR. ENSMINGER:** Okay.

**DR. BREYSSE:** So we're at a point right now where we should be transitioning to the soil vapor intrusion work. Why don't we hold off the action items for the VA until we have a session about VA input into the process. Anybody have a problem with that?
So Rick, you want to give an update on the soil vapor intrusion and drinking water exposure evaluations?

**UPDATE ON SOIL VAPOR INTRUSION AND DRINKING WATER EXPOSURE EVALUATIONS**

**MR. GILLIG:** Sure. Jerry, to address the issue you just raised about the status of the health assessment on the drinking water exposures, that document is in clearance. That document, we look at exposures to drinking water, both through drinking water, we also look at exposures that are related to using the water for showering, for bathing, for swimming pool recreational use, Marines in training in the swimming pool or the pool facility. We're also looking at exposures to workers in dining facilities, both workers working the serving lines as well as those washing pots and pans and dishes. We're also looking at exposures to workers in the laundry facilities.

So we're covering a broad range of exposure scenarios with that document. Again, that's going through clearance at this point. We hope to have that document out for peer review this coming summer. The CAP members will receive that as one of the peer reviewers.
MR. ORRIS: Rick, I have a question for you. Are you using the detection screening methods provided by EPA or are you using the values provided by the Department of the Navy? 'Cause I noticed that the Department of the Navy is still, even to this day, using the industrial indoor air screening level for their vapor intrusion models. And I know that that is a different valuation than what the EPA recommends.

MR. GILLIG: You know, the health comparison value and the health endpoint we're using we're basing on the studies done by the EPA.

MR. ORRIS: Okay. Thank you.

DR. CANTOR: Rick, I have a question as well. This is Ken Cantor. So in your comments yesterday you mentioned inhalation several times, but also there's an issue about dermal exposure and transdermal conveyance of TCE and other molecules such as this. So I wondered to what extent is dermal exposures included in your evaluation?

MR. GILLIG: We did evaluate dermal exposures. As far as the extent, I couldn't tell you. I know it's covered in the document. I know that was a concern that Jerry had also raised about health program -- healthcare workers with frequent hand
washing. So that, again, that is addressed in that document.

MR. ENSMINGER: And food service.

MR. GILLIG: And we -- I did talk about food service, yeah, both the line workers as well as people washing dishes, pots and pans.

MR. TEMPLETON: This is Tim Templeton. Real quick question. And I know we've had just a short discussion over email about MEK, one of the stabilizers that may have been used in TCE. There's an effect with -- currently with dioxane and/or MEK has on TCE's ability to people -- to do damage to bodies. Is that accounted for? Is the MEK accounted for in any way?

MR. GILLIG: Our document focuses on the VOCs, the VOCs that were at the highest levels. Again, our document is based on the modeling that Morris Maslia and his team conducted.

DR. BREYSSE: So does that mean MEK was not part of the assessment?

MR. GILLIG: What I've seen of the MEK levels, they were very low, so it was not part of the assessment.

DR. BREYSSE: Morris?

MR. MASLIA: Just to reemphasize and clarify,
the water modeling looked at the VOC chain and
degradation from PCE to TCE, DCE to various
conjoiners; DCE, vinyl chloride, and then of course
benzene in the industrial area. We've not separated
out components of TCE or things of that nature.

DR. BREYSSE: Any other updates, Rick, on the
soil vapor or the --

MR. GILLIG: Yes, for the soil vapor intrusion
project, I had quite a few updates at the last CAP
meeting. We've completed the index of approximately
23,000 electronic files. Those are documents we've
obtained from EPA, from the Navy, from the State,
the North Carolina Department of Environment and
Natural Resources, also documents we obtained from
the CAP.

We've loaded these files into a SQL database.
That SQL database allows us to rapidly do keyword
searches. We'll also be using Adobe Acrobat to do
keyword searching. That program identifies the page
number from the various documents that we want to
look at those page numbers that indicates what
keywords and what page numbers those are on. We
want to review those to make sure the SQL Server
keyword search is as robust as the Acrobat keyword
search. So it's kind of doing double duty on it.
We've completed our review and removed duplicates, and created an index, and put these documents on the FTP site. So we put the CAP-provided files on the FTP site, those provided by the North Carolina Department of Environment and Natural Resources. We had some files from the data mining, ATSDR's data mining, technical work group. And we also had underground storage tank documents provided by the Navy, and some of those are available on the FTP site.

I want to let you know that we have received funding from the Department of the Navy to hire the contractor. We're in the process of selecting a contractor, and this contractor will assist us with reviewing the electronic files to identify those with information of interest. And then we'll be pulling out that information and using that as a basis for our soil vapor intrusion project. Any questions?

MR. TEMPLETON: Are you assigning keywords to the PDFs that are all raster paper-scanned -- scanned documents in there? They don't -- they're not paper documents?

MR. GILLIG: I'm not sure I understand your question, but we'll be searching all of the files
using keywords.

**MR. TEMPLETON:** I noticed that there were several of the PDFs that were -- that are scanned documents, and so they'd use optical character recognition, OCR --

**MR. GILLIG:** Correct.

**MR. TEMPLETON:** -- on them. So there's a way to add the keywords to a PDF document that are pulled out. I don't know, other than OCR, how you would do that, unless you just reviewed the document visually and said, okay, this one says Building 1101, and then you made that one of the keywords that was part of the PDF file itself.

**MR. GILLIG:** We've had people whose computer skills are so far above mine, and they've provided great -- a great resource. They told us how -- exactly how to do it.

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

**MR. PARTAIN:** And Rick, throw something out there, of course with Dr. Breysse's permission, but as you're going through these documents, understand that we're not dealing with just a small amount of documents. You're dealing with thousands upon thousands upon thousands of pages. So, you know, the keyword searches and identifying these things,
even with the keyword search, you're still dealing with thousands of pages of documents.

I, for one, on the CAP, and anyone else who would like to be lumped in here, would be more than glad to do -- to assist you guys and do some close reading of the documents, because even though a keyword search may turn up things, just like when we did the timeline back in 2008, a closer reading of the documents that frankly, I know you guys are pressed for time and resources, would it be something that you're not -- it's a resource that you don't have necessarily available to you. But as a CAP, we would be glad, if you come across something that you think may be important or a document that needs a closer reading and historical interpretation, that may point you in a direction somewhere else; for example, what happened with the benzene issue in 2009, we would be glad to do that. Just, you need to let us know what document or documents that you want us to look at or interpretation. I would encourage, if that's possible, to get that feedback back to us.

I know it occurs with the Marine Corps, when you guys have questions on their source documents and things, and I would encourage you to engage the
community as well, 'cause we would be more than happy to do that. I know I will.

**MR. GILLIG:** Okay. I’d like to put that down as a follow-up item. And we'll discuss that with Dr. Breysse.

**MS. FRESHWATER:** Yeah, I think the diversity of the CAP would help in that instance, you know, being able to see different contexts and connections.

**DR. BREYSSE:** So that's a great suggestion. We'll take it into consideration at a minimum with the document uploads. We're happy to have the CAP, the VA, Navy, anybody looking over our shoulders, going through the same documents, making sure that we didn't miss anything. So whether we invite you to help out early in the process or it comes, you know, after the documents become publicly available, that input's going to be valuable one way or the other.

**MR. ORRIS:** Rick, I have a question regarding the dates that you were looking at. What data period are you looking at for the vapor intrusion study?

**MR. GILLIG:** We made the request for documents back in 2013 so we're looking 2013 backwards. But I believe our -- the documents that we have, we have
2014 documents as well. So I can't tell you the exact date, the most recent document, but the document that you referenced earlier is one that was placed on our website, or the FTP site rather. So we know we have documents well into 2013, and I assume we also have some from 2014.

MR. ORRIS: So when you update your public health assessment, you're also going to update whether or not there is any current vapor intrusion occurring at the base?

MR. GILLIG: Yes.

MR. ORRIS: Thank you.

DR. BREYSSE: Anything else, Rick?

MR. GILLIG: That's all.

DR. BREYSSE: Any more questions for Rick?

So why don't we switch now to the updates on the health studies, and then we'll take a break, and after break we'll come back and discuss with the VA. So Perri and Frank?

**UPDATES ON HEALTH STUDIES**

MS. RUCKART: I just have a couple of updates where we are with the studies that are in progress that we mentioned last night. The male breast cancer study, it's completed in terms of the agency review. It was submitted to the journal
Environmental Health on April 20th. That's the same journal where the other four health studies were published. It'll be a minimum of six weeks until we get a response from the journal, so we're still within that six-week time frame here. And then if it's accepted, we need to respond to their peer reviewers' comments. So just to let you know, we still have a little bit of time here before it's actually published.

**DR. BREYSSE:** If all goes well, it could be a couple months from now, but it's --

**MS. RUCKART:** Right. I'm estimating late summer would be a best-case scenario, but it could be beyond that.

The health survey, we're continuing to analyze the data, and we expect to have a draft report available to start the agency clearance by the end of the summer. That's just a really massive effort with upwards of 60 outcomes and the five chemicals, so quite a bit of work there.

The cancer incidence study, the protocol is undergoing agency review, and the next steps are submitting for institutional review board approval. That's when the subjects just get into, that you are properly working within the subjects, and working
with our procurements and grants office to award a contract. Any questions?

   **MR. ENSMINGER:** Yeah, where -- the cancer incidence study protocol?

   **MS. RUCKART:** Right. That was the one I said is currently undergoing review by the agency, and the next steps are the human subjects.

   **MR. ENSMINGER:** Yeah, but we could never get an explanation about the agency's review process, and who is included in that black hole, I like to refer to it as, because nobody can ever tell me what kind of procedures do you have in place for your internal review process? How long is somebody given to allow this thing to languish in their in-box or on their desk or until the NCAA basketball season's over with, and they can finally put their attention to it.

   You know, this is crap. I mean, this is why we talk about bureaucracies. This is very important. And, you know, when I was in the Marine Corps, as a senior staff NCO, when I got an action item, I was given a limited amount of time, and it was put right on there when I received it, on the cover letter, how long I had to review that thing and get my comments back in.
DR. BREYSSE: Jerry, I'm with you a hundred percent. So -- remember, I'm new, but let me tell you what I think -- what we started to do. So for the male breast cancer study, this worked really well. There was a linear process that we had where we sent it to one person to review it and approve it, sent to another person to review it, and then another person, go up the chain. And in talking to Frank and Perri, it turns out there was -- every level had the same sort of comments, so they were addressing the same comments multiple times, all the way up the chain.

So what we did was, we sent it to everybody in the chain at once. We said, send your comments to Perri and Frank, and have them address them, and we'll all meet as a group and we'll talk about the comments. Because sometimes I would suggest something that would be different than what they already changed, because somebody else had suggested it when it got to my place. So it was a very inefficient unacceptable process.

So we did it that way for the male breast cancer study, we short-circuited a lot of the review, and it was approved a lot quicker, and we're doing the exact same thing for this study.
So right now, the cancer incidence protocol is on the desks of five or six people. We were given 'til -- we're given a date, I can't remember the exact date, this Friday or next Friday, send comments in. Once the comments come in, we're going to ask the investigators to digest them, summarize them, and we'll have a meeting where everybody who commented will sit down, and we'll hash that out as a group, and then it'll be done. So we're going to have the process take a couple of weeks rather than six months.

MR. ENSMINGER: Thank you.

DR. BREYSSE: Any other updates on the health studies?

Once the cancer incidence study gets going, it'll be -- it'll probably be more informative to fill you in where things are, but at this stage of the study, unfortunately, we have to let the review take its toll. So if there's no other questions, we'll take a break.

MR. ENSMINGER: Weren't we going to cover the revised public health assessment in this portion?

DR. BREYSSE: Jerry, you got a phone call right when Rick did that -- and he'll do it again. You stepped out.
MR. ENSMINGER: Oh, is that right? I'm sorry.

MR. GILLIG: I think you had that planned.

DR. BREYSSE: Real quick.

MR. GILLIG: So Jerry, the document is going through clearance.

MR. ENSMINGER: Yeah, here we go again.

MR. GILLIG: Expect to release it for peer review this summer. Members of the CAP will be one of the peer reviewers.

DR. BREYSSE: So Rick, this is not one that's come to my attention about doing the kind of a short-circuit review process. Can you make sure that we talk about a way to expedite the review process, like we did for these other documents?

MR. GILLIG: Yes, yes.

DR. BREYSSE: I think we can do that.

MR. ENSMINGER: You know, but Mike, in his opening remarks, brought up about, you know, science is slow. I mean, most people don't understand that. I didn't understand that until I got involved in the Camp Lejeune issue, and I finally saw how long it takes to actually do good science. It takes a long time. But the water part of the public health assessment, I mean, the water models have been completed for a long time, and -- over three years --
- and we still don't have the revised public health assessment. I mean, three years? Really? I mean, the science is done. It took over three years to write this revised public health assessment? Just, just on the water.

**DR. BREYSSE:** I understand, Jerry.

**MR. ENSMINGER:** That's not science; that's bureaucracy at work.

**DR. BREYSSE:** You're absolutely right. We can do better and we will do better. It shouldn't take that long.

**MR. PARTAIN:** Dr. Breysse, revisiting the timeline, I finally got my computer to get on the internet. The timeline that y'all have posted is from '89 to the present, with ATSDR's activity, and what we were looking for is more of an historical timeline of the contamination event at Camp Lejeune, which is what we -- you know, what we did the research on.

And that's what -- you know, basically our timeline goes from 1942, with the inception of the base, to 1989, when it's listed as a Superfund site, and has everything annotated and linked to a document. That's what we were asking to get published onto the site.
DR. BREYSSE: Yeah. We'll take a -- we'll look at that again.

MS. FRESHWATER: And I think that goes back to the importance of having more eyes on the documents, because the more Marines and families we have seeing these documents, the more they might connect and say, well, what about this or what about that?

And so you -- and I have one really quick question for Rick. I found an old photo in an officers' wives cookbook of Paradise Point Sitter Service, from 1968. And I had never heard of Paradise Point Sitter Service, so I'm wondering does anyone know where that was? Like as far as -- you know, we've talked about where the current Tarawa Terrace School is and whether that's on the same ground as the one that was torn down.

And I'm just wondering -- I want to put that out there. I'd love to know where this -- I have pictures of these kids, and I have no idea where they are. It's another sitter service.

MR. GILLIG: Lori, honestly, I've never heard of that.

MS. FRESHWATER: Do you mind if I let her help me?

DR. BREYSSE: Yes, please. Can you step up
here? Introduce yourself, please.

MS. GRESS: I'm Bonni Gress. I'm a Marine's wife. Paradise Point Sitter Service was behind -- there was a BOQ across from the club, from the officers' club.

MS. FRESHWATER: Right.

MS. GRESS: And behind the BOQ was a building, and that was the sitter service.

MS. FRESHWATER: Okay. Okay, great. Thank you.

MS. GRESS: Kind of in the area where the golf course --

MR. ENSMINGER: Yeah.

MS. GRESS: -- and back behind BOQ was the sitter service.

MS. FRESHWATER: Okay, 'cause the golf course is one of the sites that we look at, so that's really great information to have. Thank you so much.

DR. BREYSSE: And so Lori, what we can do is we can add that to the keyword search to documents to see if that's referenced in any of these documents.

MS. FRESHWATER: I'll send you the photograph with the notation, and they just -- it says, children learn to play together, share their toys
and eat together at the Paradise Point Sitter Service.

DR. BREYSSE: And where'd you find that picture?

MS. FRESHWATER: An officers' wives cookbook. I was going through my mother's things, and they have some old photos. And I haven't finished going through it yet, but I hope to find more. And I'd never -- I knew about the base sitter service but I never knew there was one at Paradise Point.

MR. GILLIG: If you come across the building number, I would love to get that.

MS. FRESHWATER: Okay, I think -- from what she's telling us, I think we can probably figure it out.

MR. GILLIG: Okay. Thanks.

DR. BREYSSE: Any other questions for Rick or Perri or --

MR. TEMPLETON: Rick, I just -- one more, real quick. I noticed that in some of the documents that we've had opportunity to review, that there were fuel tanks that were in Paradise Point, Midway Park and Tarawa Terrace. There were several, in fact. And I think it was in Midway Park, there may have been 44 of them, command and underground storage
tanks that were in there for heating oil and so forth. So those are considered in the vapor intrusion piece? Great. Thank you.

MR. GILLIG: Yeah, we have found oil storage tanks, heating oil, in many areas of the base.

MR. ORRIS: Rick, I have one final question for you also. In your opinion, in your scientific opinion, would you agree or disagree with the Department of the Navy's assertion that contamination on the base ended in 1989, based on the work you have done with the vapor intrusion?

MR. GILLIG: Chris, I'm not sure of the context of that statement, but the contamination did not end in 1989.

MR. ORRIS: Thank you, Rick.

DR. BREYSSE: Any last questions or concerns for the ATSDR scientists' studies?

It's 10:30. Why don't we take a break. When we come back we'll spend some time in discussion with the VA.

(Whereupon, morning break ensued, 10:26 till 10:50 a.m.)

DR. BREYSSE: All right. Are we assembled? So we talked about clearance and security a few minutes ago, and I just want to tell a story as people are
assembling. So in my previous life as a university
professor, I wrote a report for the Department of
Energy on some worker exposures at the Los Alamos
National Laboratory, using only publicly available
docs. And I wrote the report and we sent it to
Los Alamos.

And a week after we sent the report, some DOE
security people came to my office and said, we're
confiscating your computer, and we need to know
every computer that has a copy; we have to collect
all those computer systems. And I said what do you
mean? Because my personal computer at home and my
laptop had it, and there was five other people who
were writing this thing, and we had no idea how
many...

So it turns out that we had taken two pieces of
information that were not secure, but we put them
together in a way that they'd never been put
together, when somebody at the Department of Energy
decided that the combination of this information was
something, a whole story that they didn't want the
world to know, and they couldn't tell me what it
was, but they said your report's got, you know,
secure information in it, and you're in trouble.

So we got the university attorneys involved,
and they agreed not to take our computers. They
wanted to do a quick security clearance, and so at
the end of the day, they reviewed it, and they
decided to clear the information that we had in our
report, and not tell us what it was. So that got us
off the hook.

And so there was a week where I was calling all
my colleagues and saying, somebody may come take
your computer, and I just signed an agreement that
says nobody -- you're not to leave anything in that
computer for the next week while this determination
is made. So I'm very careful about secure documents
and things, and we'll take that seriously as we work
with the Navy to make sure that stuff is releasable
when we can.

MR. PARTAIN: I say, Dr. Breysse, that's
actually a good segue to it, I need to ask the
Marine Corps.

DR. BREYSSE: Go ahead, Mike.

MR. PARTAIN: A few days ago I noted the Marine
Corps has revamped their website for Camp Lejeune,
in the bottom right-hand corner of the front page of
Camp Lejeune historical water.

When you go -- and this is a problem that came
up several years back, and it actually took Congress
hanging the Marine Corps to fix it. It has resurfaced. When a -- a family member just pointed out to me, and she asked -- she went to register for the Marine Corps -- on the Marine Corps' web page for the Camp Lejeune registry, and there is a page, when you go to register, or go onto the site, it pops up and says, the certificate for this page is invalid. It's not -- you know, do not proceed. We don't recommend you proceed.

MR. ENSMINGER: The security.

MR. PARTAIN: Yeah, the security certificate, which is very disturbing, especially for someone who has no idea what they're looking at. And it gives you two options: One, to abandon the page and leave, and the other is to, you know, ignore the advice and go forward.

I sent an email to the Camp Lejeune water email address last week. I've yet to get a response. But being that this problem is something that has been in the past, I'd like to see if the Marine Corps can get it fixed sooner than later.

MS. FORREST: I will definitely take that back.

VETERANS AFFAIRS UPDATES

DR. BREYSSE: All right, so we'd like to spend some time now with the update from the Veterans'
Affairs, the VA. And before we get in -- and we opened the telephone line. Is there anybody on the telephone line?

DR. HEANEY: Yes.

DR. BREYSSE: Could you introduce yourself, please?

DR. HEANEY: Yes, I'm Dr. Debbie Heaney, and I am one of the subject matter experts.

DR. BREYSSE: Thank you. All right, so Brad, any updates from the VA?

MR. FLOHR: Yeah, Angela, you want to go down our action items?

DR. RAGIN: Sure. The first action item for the VA: The CAP asked that the VA share ATSDR's updates and recommendations on the VA Camp Lejeune research and studies web page with the Veterans' Health Administration.

MR. FLOHR: Yes, and at the last CAP meeting, I went back and I talked with Dr. Erickson and others in public health, and they looked at their website, and they did make some changes.

DR. ERICKSON: This is Loren Erickson. Let me just mention that we have hot links, which I just checked yesterday, to the ATSDR websites, a couple different hot links, that go directly to those
valuable studies.

DR. RAGIN: The next action item: The CAP requests a representative from the Veterans Health Administration to attend the CAP meetings in-person.

MR. FLOHR: We have three of them.

DR. RAGIN: Okay.

DR. BREYSSE: Well, it says three. They get credit for three meetings then.

MR. FLOHR: We can skip the next one then.

DR. RAGIN: The next action item: The CAP asked if the Veterans Administration accepts ATSDR's work and findings on Camp Lejeune.

MR. FLOHR: For me personally, yes.

MR. ENSMINGER: What's that mean?

MR. PARTAIN: We appreciate that, Brad, but what about the agency?

MR. FLOHR: I think the agency does, yes, as far as I know. I have no reason to believe that they don't.

DR. ERICKSON: Let me make a comment. It's probably a good time to talk about what we were talking about. I mentioned that I'm somewhat new to the Camp Lejeune issues, and I'm currently the incoming acting chief consultant for post-deployment health. We very much value the interactions that
we've had with our ATSDR colleagues, and we've had a number of meetings.

I've mentioned to some members of the CAP already that there is activity that's occurring outside the CAP between these two federal agencies that isn't always apparent. In many cases we're discussing the very studies that have been presented today. We've got some of the plans that are in place for these new studies, finalizing such, discussing what these studies mean. And in fact even this morning Dr. Breysse and I were having breakfast together. And we want the same thing. We want to do right by the Camp Lejeune veterans and family members. We want to have a solid and scientific evidence base that we can work from and have actually good policy.

And Ms. Freshwater, I think your comment earlier was right on the money in that we want to have understandable policy, policy that is clearly communicated. And we want to have a very cooperative non-adversarial relationship. And I'm very hopeful. Hopefully I'm not naive in this regard.

I'm very hopeful and I'm encouraged by the types of things that we've worked on. In fact even
this morning, when Dr. Breysse and I were talking
about a way forward being able to review the
existing 15 conditions that are in the Camp Lejeune
legislation, and then matching that up with the most
recent studies, to have a discussion about what are
those gaps? What is the new information since the
legislation came out? What would be recommendations
that we would make?

And just as an aside, it was asked last night
why is VA, why is ATSDR not lobbying Congress? And
of course by law, we cannot lobby, and maybe the
individual didn't mean that word. So we can't
formally lobby but we can certainly interact with
our representatives, with their staffers. We do
that not on an infrequent basis, and in fact we're
looking forward to opportunities to actually come
forward in a united front, the ATSDR and the VA
together, to talk about, you know, where are those
gaps and where might be some suggested legislative
changes for the Camp Lejeune law.

Dr. Breysse, I don't know if you wanted to add
to that.

MR. ENSMINGER: I have a question about that.

DR. BREYSSE: Can I interrupt real quick?

MR. ENSMINGER: Yeah.
DR. BREYSSE: Can I just have a second? I think, Jerry, before you jump in, there are things that we agree on, that we can move forward. There are things that we might not agree on, that we need to discuss about that. But what we are able to agree on, I think, it's in everybody's interest that it's our moral imperative to identify those and start moving things forward along those lines. And I think that's what we agreed to this morning.

MR. ENSMINGER: Okay. You talk about new science that has come out since the law was passed and signed into law -- when the bill was passed and then signed into law. You just had a report come out in March that was commissioned by the VA on Camp Lejeune with the Institutes of Medicine, the IOM for short. Yeah, I mean, and they came up with all kinds of recommendations, I mean, where are you at with that?

DR. ERICKSON: Sir, I'm glad you asked, and that's why I have the report in front of me. Just for everyone's sake, this is also available on the Institute of Medicine website. This is entitled: Review of VA Clinical Guidance for the Health Conditions Identified by the Camp Lejeune Legislation.
You already have heard from Mr. Brady White concerning the program; it seems he's actually managing that program. I am really delighted to tell you that we have had a work group that has been looking at this intently, to write clinical guidance policy, to respond to what the IOM has said. And what's important here is not for you to appreciate that we have a bureaucracy like ATSDR and things take time, but rather to understand that to deal with the recommendations, the intricacies that the IOM has brought forward, and there are a lot of recommendations that were in there, is going to take some time because it involves translating their recommendations into our document and our way of doing business, so that then we have a clear way forward.

And, you know, in fact even just this week, I was sent a copy to review of the draft of new guidance. And, you know, we are making progress on that. I don't have a date for completion, 'cause that might be your next question. But I will tell you that we very much appreciated the work of the Institute of Medicine, and that they are an independent body that is, I don't think, unduly influenced by outside forces. They agree with us in
some areas of our existing clinical guidance, and said, you're right on track, and some other areas they said, you need to be looking more broadly.

Chris and I were talking about this this morning. I think some of the changes that are coming, though it's pre-decisional, I think people will find to be encouraging. I don't want to usurp, you know, the authority of leaders that are over me to state exactly what those might be at this time, because it is in process. But I think we're on the right track.

And again, the goal here is for us to put proof to the fact that VA wants to be a learning organization, that we realize that publishing the first set of clinical guidelines was good and was appropriate and got the program running, but that we want to continue to learn and bring new information to bear such that these are updated. And sometimes, because we don't necessarily have the full array of experts that we need, we call upon places like the Institute of Medicine to bring in experts from around the country, to then actually provide us with additional guidance. And so I'm actually very encouraged, and I thank you for your question.

MR. ENSMINGER: Well, you were discussing this
work group that you formed. How many representatives from the community do you have on your work group?

**DR. ERICKSON:** Brady, you're on the work group. Can you answer that?

**MR. WHITE:** That dealt primarily with the three clinicians that we have, with the four related illness and injury study set. And then I was there kind of representing the process and the program.

**MR. ENSMINGER:** I'm asking you how many people from -- representatives from the community, if any? You have nobody -- nobody represents the community on this work group. I mean, that's the problem with the VA, is the transparency, okay? There is none.

I mean, your own Secretary gave a speech on the 24th of April to the Association of Healthcare Journalists, and they questioned him about VA policies, including the agency's notorious opaqueness with the public. And McDonald readily acknowledged that the VA has had what he called a Kremlinesque mentality, and told a room full of journalists that he was trying to change it. And he said, he's trying to promote a culture of openness.

I mean, if you're going to have a culture of openness, you have an Institute of Medicine report,
you form a working group, and yet you don't have any experts or any members of the community on your work group.

DR. BREYSSE: Danielle, do you have something to add to this?

MR. ENSMINGER: Now, I don't know if I can volunteer Dr. Clapp or Dr. Cantor to that work group; I wish I could.

DR. BREYSSE: Danielle?

MR. ENSMINGER: And I'd love to sit on it.

MS. CORAZZA: I wasn't going to ask for quite such a big ask. My question was, can we, as family members and/or chronically ill patients, submit recommendations? And specific, the IOM report recommended that, unless somebody has been formally diagnosed, it's not being treated or covered. The ongoing monitoring of some diseases, like scleroderma, which I happen to have markers and/or some symptoms of, is very expensive. So something as simple as, as long as it's acknowledged you have the blood work that shows it and we need to monitor it. Or another example, my mom had breast cancer. She was a Camp Lejeune active duty service member at 36. So I have to have ongoing mammograms. And again, these are very costly tests that are doctor
ordered and approved. But somewhere where we could submit feedback along those lines or, hey, I live in DC; I'm happy to come and sit silently and quietly in the corner of a meeting, would be helpful, because these are feedback -- this is feedback that's viable and valid, especially for the family members, who are not veterans and who are not receiving regular healthcare from the VA.

DR. BREYSSE: So is the VA open to considering some external participation in the working group? I’m not saying any of you are, but are you open to considering it?

MR. WHITE: For the clinical guidelines group, if both the agencies is willing to look at that, I wouldn't have an issue with that obviously.

So but getting back to your question about the prescreening, right now, for family members, and I'll be going over this in a little bit more detail later, to qualify for the program you have to have administrative eligibility clinically. So once you meet that administrative eligibility side, you have to have one of the 15 conditions, and then we can reimburse you. Now once that happens, if you save your bills, we can reimburse you back to two years from when you received treatment.
DR. BREYSSE: But that's something that might be considered. Has anyone considered that or -- we're hearing that there's a big burden of screening associated with being at-risk but short of having the disease, that the --

MS. FRESHWATER: Well, what it comes down to, and I think, Brady, you've maybe run into this in the past, is the legal interpretation of the wording. So if you say diagnosis, and my doctor says you've got all the markers and life's really going to hurt after 40, we need to continue to screen you because you have this active blood work and some of the symptoms. Depends on who you ask and how it's interpreted.

So my feedback would be, if you're going to apply it and the VA's open to it, maybe we need to change the wording to, if you have diagnostic markers that indicate the disease is coming, or something along those lines, if that makes sense.

So my question -- I'm worried about the interpretation and how that's going to kind of come down the pike. And so my feedback would be let’s maybe make that clearer so that the clinicians and/or the, you know, program managers, can say yes or no without having to go back case by case, and
fight the battle.

DR. ERICKSON:  Yeah, your point's really well taken. I'm taking lots of notes for many different things that you guys have shown us, but for that particular -- if you've not been to the IOM website, you can just Google IOM, you know, VA clinical guidelines, and you'll find this. It's free, you know, you can go right to the pages.

But if you see the section on scleroderma, you saw that the IOM made some very direct comments that we are responding to. I want to encourage you in that regard.

MR. PARTAIN:  I'd like to take a moment to step back from when we got started here, we were talking about the studies at the ATSDR, y'all mentioned the word accept. Can we define that? Because, you know, I understand that you've accepted the reports but what does that mean? Is the VA in agreement with the findings from ATSDR? Are you disputing the findings of ATSDR? Where does the VA stand with that work?

DR. ERICKSON:  You know, maybe you can help us understand the wording stuff. But I can speak to, you know, the way I look at this, and I shared this with our scientific colleagues here from ATSDR.
There's no question that the work that they've done is incredible in that it took a tremendous amount of effort from initial conception of the plans through execution, through analysis, et cetera.

The studies are in the peer-reviewed literature. It is an important part of a broad body of knowledge about these chemicals, about the exposures, about the health effects, about this particular population, all of which is important in total.

When you say accept, I don't know -- I'm not sure which direction you're going. I value the work that they've done. I recognize the value with -- of the work that they've done. There may be some differences in some of the details here and there and the interpretation. And the reason why I say this is, you know, there's jokes about epidemiologists, you know, that you get a bunch of -- Frank's already smiling; he probably knows this one -- whatever, scientists or epidemiologists, you get them in a room, and we're at a large conference, and one is presenting their work, there's always discussion about the interpretation. And how deep that interpretation goes, how strong can be the recommendations or the discussion that
follows those results.

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

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

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

DR. RAGIN: Yes.

DR. ERICKSON: So I don't know where that word
DR. RAGIN:  It was raised at the last CAP meeting.

MR. PARTAIN:  No, I asked you.  I asked you to report, and the word that you guys responded back was, we accept the report.  I'm asking you what does that mean?  I mean, you can accept a report and not agree with it; you can accept the report and agree with it.  Because part of the reason why I'm asking this is, as I said earlier this morning, there is a body of evidence with science, post-NRC report, that is showing connections between exposure, occupationally and so forth, with TCE and adverse health effects.  And the VA's approval rates are counterintuitive to what science is saying.

Their approval rates have dropped from 25 percent from a couple years ago down to five percent, with the last information that my senators supplied -- or provided me.  So going back to the word accept, what does the VA -- how does the VA see ATSDR's work?  Are you accepting it as legitimate science?  Are you accepting the conclusions of the reports and the findings of the reports?  Are you in dispute of that?  Are you disagreeing with ATSDR's work?  This needs some solid ground to make the
Jello a little bit harder so we can stand on it here.

**MS. FRESHWATER:** Why aren't the veterans getting the benefit of the doubt if you are accepting the science? Why are we trying to find ways to deny it instead of ways to support and...

**MR. FLOHR:** As Dr. Erickson said, yes, we accept and value all the work that went into these reports. They're very valuable. We use them in making determinations on claims.

**MR. PARTAIN:** I understand that. What do you accept about the reports and what do you value about the reports? I'm asking for something more concrete than a generalized statement. Does the VA accept the findings of the reports or do they not? Yes, they accept the finding of the reports.

**MR. FLOHR:** Absolutely.

**MR. PARTAIN:** Okay. And --

**MR. FLOHR:** Why would we not?

**MR. PARTAIN:** Well, I mean, that's what I'm --

**MR. FLOHR:** Scientific studies.

**MR. PARTAIN:** -- trying to get to. Okay.

**MR. FLOHR:** There's a lot of scientific studies.

**MR. PARTAIN:** I understand that. And the --
but that's what I'm trying to get at. What do y'all mean by accept? That you're saying that you accept the conclusions of ATSDR's work?

MR. FLOHR: Yes.

MR. PARTAIN: VA does.

MR. FLOHR: Sure.

MR. ENSMINGER: Dr. Erickson and I had a brief discussion during the break. And there is a -- we have to get past stuff that's been committed by representatives of the VA in the near past, that have been committed against the Camp Lejeune community. And one of those was a training PowerPoint that was created by Dr. Walters that was used to train clinicians who were going to be examining Camp Lejeune veterans and family members. That training PowerPoint was a road map for denying people, number one.

Number two, the description of the typical -- of her view of the typical Camp Lejeune veteran's spouse, in that training PowerPoint, was obscene, demeaning. She described her view of the typical Camp Lejeune veteran spouse as fat, toothless, diabetic, had a history of, family history of breast cancer, homeless, car-less, --

MS. FRESHWATER: On public assistance.
MR. ENSMINGER: -- Medicaid, which means they're on welfare. I mean, that, that was a slap in the face.

And ever since Kevin got his hands on that training PowerPoint, we have not seen Dr. Walters since. She would not show her face. She got on the phone a few times, and then claimed that she was having technical difficulties with the phone and hung up. And then she, she absolutely just refused to discuss her training PowerPoint. I mean, just outright refused to discuss it. And this was what was used to train clinicians. Brad was at the training.

DR. BREYSSE: So Jerry, you want to ask a question about --

MR. ENSMINGER: Yeah, I mean, you know, we've got amend this distrust. I mean, you've got to fix this.

And you're not doing a very good job because now, you went and hired these -- well, I don't know if you hired them by contract -- these SMEs, that you call them, that are make -- giving their opinions which you're basing your denials on.

DR. BREYSSE: But Jerry, can you ask a question, just to be fair to the VA and me?
MR. ENSMINGER: Yeah, I mean, what are you going to do to repair this damage that you've done to this community with that, that PowerPoint?

MR. DEVINE: I think the PowerPoint that you're talking about was used in support of the healthcare law versus what SMEs use to adjudicate the claims. So I think there is a little bit of a difference.

MR. ENSMINGER: This was in training of your clinicians. Brad, you were in it in Salt Lake City.

DR. BREYSSE: Can we focus on going forward with the question how do we repair the damage rather than debate this --

MR. ENSMINGER: Well, I want to get it clarified what it was used for.

MR. FLOHR: And that -- actually I was at Salt Lake City, and New York also, Albany training session, I was not there at any time when Dr. Walters was there. She was there earlier, then headed back to DC.

I was there just to talk about the claims process and how we use medical opinions and how important it was for us to get good medical opinions, to consider all the science and make a good reasoning for their determination. But I wasn't actually there when -- this was not just Camp
Lejeune; it was for all types of occupational exposures. It was for commissions that provide occupational health.

MR. ENSMINGER: But it was mainly --

MR. FLOHR: No, it wasn't actually. She was only there for a very short period of time, maybe an hour.

MR. ENSMINGER: I'm not -- but that whole damn PowerPoint was almost all Camp Lejeune. It had a couple pages at the end about what this would mean for other DOD sites, yeah.

MR. FLOHR: What I'm saying is there was a lot more in the sessions than just that PowerPoint.

MR. ENSMINGER: And it mentioned the C-123 aircraft, Agent Orange, at the end, but that was it. The rest of the -- the body of the thing, 20-some pages, was about Camp Lejeune.

MR. DEVINE: But again, it's the difference between what is in support of the healthcare law or what the SMEs use in reviewing veterans' claims.

MR. ENSMINGER: Yeah?

MR. DEVINE: There's a world of difference.

MR. ENSMINGER: But, but they were training the clinicians that were going to be screening these people coming into the program. And it was -- she
was prejudicing people right, right from the get-go.

**MR. DEVINE:** So let me -- let's go back to the beginning, and it goes to what I think you were talking about: How do we clear this up? And I've been talking to Danielle a little bit about what is the process and what's the difference between doing the healthcare law and taking care of veterans and dealing with those kinds of issues. They're two different worlds. And what we tend to do, because it can be confusing, is to intermingle all of this.

So what I would like to commit to, and mind you, I just volunteered to do this ten days ago, so I'm relatively new to this, but I think what we should do, each and every single one of these meetings, I don't care how many times or how many times you have seen or heard the presentations, Brad's stuff and that VHA stuff should be put up on the screen, whether it's five minutes, ten minutes, whatever it happens to be. So we have an understanding that there's two, two worlds here in dealing with claims and how those folks were trained and dealing with the healthcare law.

Frankly the healthcare law, I think, is very important. Getting you folks into treatment, getting you guys taken care of is going to lead to
us finding the answers on many of these things. So I'm really in support of the healthcare side of it and anything that we can do to broaden that scope, I think, is great.

MR. ENSMINGER: So what's your position?

MR. DEVINE: I'm with DMA. I'm one of the senior folks with DMA. I'm neither a doc nor a scientist.

MR. ENSMINGER: What's DMA?

MR. DEVINE: Sorry about that. Disability management assessment.

MR. ENSMINGER: Oh.

MR. DEVINE: We're the folks responsible for taking care of claims inside the healthcare side. So I apologize for that. It was a good question.

I'm one of those that got to come down because of your request for a VHA in-person representative. So I volunteered to do it. And so I came on down to listen to the stories and things that I heard, and there's some very simple things that I think we should be doing. And we are not doing it as a community. And I would point to the VSOs.

One of the gentlemen last night was talking about, I think he was with the Marine Corps, I am very surprised at how little the VSOs know, or the
MSOs for that matter. The veteran service organizations, the military service organizations. You folks, any of your people, should be able to go to one of these people and say, I'm a Lejeune guy, I'm a Lejeune family member, and they should go ding, ding, ding. Maybe they don't have all the expertise but they should know where to go and not leave you with a struggle.

I want to take that on as a responsibility, and I've already hired Brad on to help me do this. We want to talk to these folks, but not the executive directors of DC, because you love bureaucracy so much --

MR. ENSMINGER: I do?

MR. DEVINE: There was sarcasm. But the executive directors, while they're, you know, obviously good guys, they deal with legislation mostly inside the Washington offices. We need to get to the service officer training corps. And those are the folks that I want to focus on, so that when your folks go out there, no matter where they are in the country, there's a decent understanding of what to do.

MR. ENSMINGER: Okay, in the current law, as it stands, has 15 ailments on it. And the IOM has
recognized that there was a shortfall of it because of the science that's been done. And ATSDR also agrees that there are other ailments that need to be included in that law, so for the Congressional delegation back there, especially Senator Tillis's office and Senator Burr, who originated this law, and Senator Tillis is now on the Veterans' Affairs Committee, we need to amend that law and include these scientifically proven health effects to that law. We need to expand that list.

**MR. DEVINE:** The beauty of what you've done is you've formed the baseline. Science continues to march on building on everything else that we already have established. Great.

We begin to see -- just like almost any other law that's out there, that's a first thing you do is you go back, take a look and say, we missed certain issues, new science, new things come up. We can amend to make it better. And I think that's the position that we're in.

And the things that you guys have brought up, I’ve read the transcripts, the things that you guys brought up are absolutely essential. I mean, I can bet that's why these two are back there, but you can bet that the folks in DC, who actually have to do
the amendments, have an understanding. I think you've heard the doctor here talk about it's probably a good idea. It's time to start doing that. And it's going to be an evolving process, because you guys are doing that groundwork finding new things. That's why the healthcare side is important, and that's going to find all kinds of other issues as well.

MR. ENSMINGER: Well, it's ended. Senator Burr's staff, Brooks Tucker, has an encyclopedic knowledge of this issue. I mean, I've worked with Brooks now for five years. I mean, and the man knows this issue inside and out. He is a wealth of information. You got to tap it.

MR. DEVINE: Well, let me suggest one thing that Dr. Erickson was talking about. We have lots of conversation with folks. We have lots of telephone calls with --

MR. ENSMINGER: I know.

MR. DEVINE: But let me also suggest something else, and while you tend to demean or degrade our SMEs, those are the other folks that you have to consider to be on your side as well, and here's the reason why. They're the ones, more than Brooks, more than those two back there, more than me, that
do this every single day. They're the ones who help inform people up here, folks up front. Those people are exceptionally important to the entire process.

MR. ENSMINGER: But --

MR. DEVINE: No, no, no.

MR. ENSMINGER: No, no wait a minute, wait a minute.

MR. DEVINE: Wait a minute.

MR. ENSMINGER: When I look at it --

MR. DEVINE: I'm asking --

MR. ENSMINGER: When I look at a denial --

MR. DEVINE: Wait a minute.

MR. ENSMINGER: Wait a minute. When I look at a denial for kidney cancer from one of your subject matter experts that wrote that opinion on that thing, and they said they looked at two decades worth of scientific studies, and meta-analysis, and could find nothing that linked TCE to cancer --

MR. DEVINE: Jerry, wasn't that --

MR. ENSMINGER: -- I said, really?

MR. DEVINE: Wasn't that also the one where we said that that has been changed. You've got to get passed that.

MR. ENSMINGER: Yes.

MR. DEVINE: Wait a minute. This is why --
DR. BREYSSE: Jerry, let him finish.

MR. DEVINE: This is why this is so important. You've got to quit demeaning these folks because what they do is learn from it. They are experts in the field. So that when you guys bring up these things, it is a terrific learning experience, and we can move on and get these things done correctly. We've already -- we've already worked on, I believe, the case that you're referring to.

MR. ENSMINGER: Yeah, and you changed it and dropped off all the -- dropped out all the incorrect --

MR. DEVINE: Jerry, we are going to move forward. These are the kinds of things I'm suggesting that we need to do. We found, we found what happened; it got changed. The rest of the SMEs were notified or talked to about what was found, and we're moving on. This is why this is an evolving process and why this is so important. And instead of us berating each other or criticizing what they do, there's no way in hell that I can sit here and accept that these folks want to deny stuff on purpose. There's no way in hell.

MR. PARTAIN: Okay, but --

MR. ENSMINGER: Well, well, now wait a minute.
You said they corrected it. What they did, they took all the incorrect stuff that they put in their opinion off of it, and still denied the guy his benefits for kidney cancer.

MR. PARTAIN: Okay. Quick, Jerry, let me jump in here, please.

MR. ENSMINGER: Go ahead.

MR. PARTAIN: Okay. You're talking about, first of all, when you mention demeaning people, this is not demeaning people, okay? We're looking at the process. And the first step in the process is transparency.

Now I understand that there's guidelines, there's guidance and things that are given to the SMEs. The criteria that you're evaluating these claims, I think, should be public. There should be some transparency in that. We should know what you guys are looking at when we're dealing with these claims for Camp Lejeune. It's not a matter of being a personal bias or anything against one particular individual.

Now, when we find inconsistencies and there's a name attached to it, yes, we're going to bring that individual up but that doesn't mean we're demeaning that individual. Now, this is a -- this is
something that came from the VA just last month, and I will quote, and this is why I was going about the accept and trying to pin down the accept and you -- Dr. Erickson made a comment about, I think it was something about along the lines that unbiased studies or studies with -- from outside influences. This is a quote from the VA that went back to Congress. Quote: Although there is a conflicting scientific evidence regarding long-term health effects of potential exposure, there is limited or suggested evidence of an associated -- association between certain diseases, particularly kidney cancer diseases, cancer of leukemia and lymphomas, and the chemical compounds found at Camp Lejeune during the period of contamination. VA considers disability compensation claims based on exposure to the contaminated water at Camp Lejeune on a case-by-case basis with difference in medical opinions provided by experts in environmental medicine. Okay?

If you want to get back to a degree of trust, a dialogue, let's start with transparency. What directions are you giving to these SMEs? How are these claims being evaluated? What criteria are you weighting your evidence on? Which studies are you using? Let's, let's get this out into the public.
And that's where the dialogue's going to begin. Otherwise we're just going to be bantering back and forth and, and going nowhere.

**DR. RAGIN:** Let me just mention something here, to Mike and Jerry's point. This is an action item that has been going on since the September 11th CAP meeting. The CAP requested a copy of the training materials that are given to the examiners, or the SMEs, that are used to evaluate claims. And they made that request in September, so I just wanted to make everyone aware of that.

**MR. ENSMINGER:** That was a year ago in September.

**MR. DEVINE:** The -- there was a FOIA request, and I believe it came from a CAP member, and it was -- the materials were provided through that FOIA process previously.

**DR. BREYSSE:** I can second what Mike says. I agree. I also have similar concerns about what weight of evidence is given to the decision-making process for deciding when a disease is service-related or Camp Lejeune-related. I know it's a complex medical decision but that decision-making framework has to be clear. How do you weight other risk factors, like obesity, versus
TCE exposures, and when, when a letter comes back saying we've denied the claim because we don't think it's service-related, it does nobody good if it's not clear how that decision was made.

And I understand that's a complex medical decision but I think there can be, I think, guidelines that are provided to help the service members and scientists like myself understand how those decisions are made.

MR. DEVINE: So in the conversations that have been had between our two organizations, that hasn't come up yet or we've been dancing around it.

DR. BREYSSE: It's come up but I've not received any clear --

MR. DEVINE: So it's still being danced around.

DR. BREYSSE: Yes.

MR. PARTAIN: And these SMEs need to be public knowledge. Who -- the SMEs themselves -- the veterans, a lot of times, unless it's by accident, their names or organizations or where they're from or who they are, that are making these life and death decisions, are not known to the veteran. I mean, it goes against our country's due process. If someone's going to be making a decision on my health, and granted, I would not be putting a VA
claim in as a veteran for Camp Lejeune, because I was a dependent, but if my -- if my benefits of my future and the future of my family was being decided upon somebody, and they said that I am not service-connected, especially if it's a disease that science seems to be indicating that's tied to these chemicals, I want to know who that person is. I want to know their background; I want to know their qualifications.

Because in the past, and part of the reason our angst that you're seeing here today, is we find somebody's name, and then we go out and find that you have a general practitioner contradicting an oncologist. And how does that -- I mean, where's, where's the reasoning in that? An oncologist is a specialist in the field of cancer. And you have somebody who's a general practitioner saying no, and their weight is being -- is overriding an oncologist. And that's where you're seeing the frustrations from the community.

Now, granted, we don't get all the denials from these veterans, because a lot of these veterans don't know we exist, don't know we're out there, and you know, 17 years with Jerry, seven for me, we're still trying to get in touch with them. And
that's another thing that needs to happen is we need to get together and outreach to these people, and include the community, like Jerry was saying, because we have been treated like the red-headed stepchild for -- since the beginning of this issue.

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

**DR. BOVE:** Can I say something? One of the things that might help the trust is if the VA would acknowledge what's been done by other agencies. For example, the agencies that are mandated to evaluate the carcinogenicity of a compound. I mentioned this last night. We have EPA, we have IARC, and now we have NTP all saying the same thing, that kidney cancer -- TCE causes kidney cancer.

It would be helpful if the VA would at least acknowledge those three agencies' inclusions in their statements, in their opinions, in their -- on their website. So they -- I don't think they even talk about ATSDR's work. There are three agencies whose mandate it is to examine this issue. The NRC report is not an agency that is supposed to assess this; EPA, IARC and NTP are, and that's what needs to be stated in these -- in these statements that the VA's making.

Then you can say, well, give -- even though
these agencies have said this, we'll deny or we'll do this action because of something else, maybe the person wasn't there long enough, whatever opinion you have. But at least start off by saying that you acknowledge that these agencies have, have concurred. Okay?

**DR. BREYSSE:** And I would take it one step further. Also include in the training or instructions for SMEs, that you should -- as part of these medical records reviews, you shouldn't be second-guessing the carcinogenicity of these compounds. There should be just this given as a known fact that TCE causes kidney cancer. And there should be no ambiguity about that in these medical record assessments, especially when they come back, you know, as a reason for denial, because in part we're not sure whether TCE causes kidney cancer.

And I've seen some denials that have been sent through CAP members, earlier this year, that they're still claiming, in their written correspondence back, that TCE -- it's not clear whether TCE causes kidney cancer.

**MR. ENSMINGER:** I mean, when you told me that you had these experts that write these opinions, and these people are experts --
DR. HEANEY: Can you hear me?

MR. ENSMINGER: -- then --

MR. FLOHR: Is that Dr. Heaney?

MR. ENSMINGER: Yeah, well, wait a minute.

DR. BREYSSE: Dr. Heaney, hold on one second.

DR. HEANEY: No problem.

MR. ENSMINGER: -- that these people are experts. If they're experts, then they would know what the EPA classified TCE in September of 2012, reclassified it. They would know that IARC has reclassified it. They would -- if they did a thorough review, an exhaustive review, I believe the wording was, of all the studies that have been -- decades of studies that have been done, and the meta-analysis of those studies, then they would know that TCE causes kidney cancer.

But that one claim that I -- denial that I was referring to, this person went as far as to say they had looked at all this stuff, and there was no evidence that TCE causes cancer at all.

DR. BREYSSE: Okay. Dr. Heaney? You have the floor.

DR. HEANEY: Yes, I'm here. Well, there are a few things I can talk to. First of all, we do know that TCE is a carcinogen, and that it can cause
kidney cancer. We know that. But that's not the same thing as saying, in these specific situations, with the length of time of exposure, with the route of exposure, and with the other factors involved, that it causes kidney cancer in those situations. So recognizing that something is a hazard doesn't mean it's causation in a specific case.

**MS. FRESHWATER:** What about the law?

**MR. ENSMINGER:** Wait a minute. I got a question, Dr. Heaney.

**DR. HEANEY:** Sure.

**MR. ENSMINGER:** Number one, are you a -- are you a VA employee or are you a contractor?

**DR. HEANEY:** I'm a VA employee.

**MR. ENSMINGER:** So you're on the VA's payroll.

**DR. HEANEY:** I am.

**MR. ENSMINGER:** Okay. So you're not contracted at all?

**DR. HEANEY:** No, I'm a VA employee.

**MR. ENSMINGER:** Okay. Now, what crystal ball do you have, when you look at these things, that tells you exactly at what levels and how long a person had to be exposed to this stuff to make your, make your determinations?

**DR. HEANEY:** Well, we don't have crystal balls,
obviously, but we try to compare the risk factors to see which is most likely -- to see if the exposures at Camp Lejeune reach a less likely -- I'm sorry, at least as likely as not threshold.

So even if we are to go by the mortality study of -- that was done by ATSDR, they list the ratio of increased risk of kidney cancer as 1.9-something, 1.98. So then we look at the specific case, and we look at the risk factor: obesity, hypertension, family history, smoking, et cetera, and we look at the increased risk caused by those factors, and certainly it becomes additive with the different factor. And then we can weigh the evidence to give us a picture of the likely causation in the case.

MR. ENSMINGER: Okay. And out of all the Camp Lejeune cases that you've reviewed thus far, since you've been doing this, how many have you recommended approval of for service-connected benefits?

DR. HEANEY: Well, I don't recommend approval or denial. VBA does that. We just give our opinion of causation. But I haven't kept a list so I cannot answer that question.

MR. ENSMINGER: Well, I'd be interested to see the ones that have been approved, to see what kind
of science and what the threshold is for approval.

DR. HEANEY: Well, it's not a threshold.

MR. ENSMINGER: Evidently there is.

MR. PARTAIN: Dr. Heaney.

DR. HEANEY: Based on -- uh-huh?

MR. PARTAIN: Just out of curiosity, 'cause I've never met you, and I've just seen your name in passing, but --

DR. BREYSSE: Could you introduce yourself since she can't see you, when you started speaking.

MR. PARTAIN: This is Mike Partain, I'm a member of the CAP.

DR. HEANEY: Okay.

MR. PARTAIN: I'm just curious and interested in your background. We were talking about this earlier, with transparency. If you don't mind, what is your background and your degree and specialty? You mentioned -- I understand you're a VA employee, but just out of curiosity.

DR. HEANEY: Certainly. I received my undergraduate degree and my medical school degree at Emory University in Atlanta. I did my residency in occupational medicine at the University of Michigan, and as part of that, received my master's in public health. I am board-certified in occupational
medicine. I am a fellow of the American College of Occupational and Environmental Medicine, and the past president of the Michigan Occupational and Environmental Medical Association.

MR. PARTAIN: Now, besides the VA, do you do any other employment or have a business of your own?

DR. HEANEY: I do some private consulting, separate from the VA.

MR. PARTAIN: And what is the nature of that private consulting?

DR. HEANEY: That's not related to my work at the VA; it's not relevant.

MR. ENSMINGER: Oh, really?

MR. PARTAIN: Is it health consulting or is it -- I'm, I'm just curious. I mean, like I said, we're looking at transparency.

DR. HEANEY: Transparency from the VA. I don't think that means transparency as part of people's personal lives and work outside of the VA.

MR. PARTAIN: And my final question, in your opinion, is there a difference between an occupational exposure to VOCs, such as TCE and PCE, and a lifestyle exposure, where you're immersed in it 24 hours a day, seven days a week, 365 days a year?
DR. HEANEY: Well, I don't -- if you're talking about occupational versus environmental, yes, I think there's a difference. I don't think that -- if you're talking about Camp Lejeune, for example, I don't think people are immersed in an exposure 24 hours a day. But typically the levels of exposure in occupational studies are greater than the levels in environmental studies, and also the length of time working in an occupation is higher -- is greater than the cases that we've seen, or most of the cases we've seen as far as time at Camp Lejeune.

MR. PARTAIN: Well, the -- you know, on the -- the lifestyle was what I referred to as --

DR. HEANEY: Yeah, I don't know what that means.

MR. PARTAIN: Well, what I mean by that is very clear in the fact that, you know, we lived on the base 24/7. I was conceived and carried onbase and born at the base hospital, all of which were contaminated, including the water bottle my mother used to make my formula with. These Marines and service members who were at the base, the vast majority of them lived on base, whether it be the barracks or married housing, so they were exposed in the showers; they were exposed in the mess hall,
which used steam to cook; they were exposed in their
occupational settings; and on top of all that, they
were drinking the water on the base as well.

So there is -- I, I feel there's a difference,
and that's what I was getting at, between an
occupational exposure and what I would deem as a
environmental or slash lifestyle, because, you know,
like in my case, I was made in these chemicals.
And, you know, I underwent the unfortunate
experience of developing male breast cancer at the
age of 39. And, you know, I hear and I see these
denials, obesity and smoking and things like that
being thrown out there like -- almost like playing
cards. In the case of male breast cancer, I've seen
several denials where obesity was cited as a factor.
One veteran was called obese, and I mean, the guy's
a bean pole. And if obesity was such a great
risk -- risk factor for male breast cancer, I would
think that a good portion of our society should be
getting tested or mammograms on a regular basis,
because, you know, there is quite a bit of obesity
out there.

But anyway, that's what I have.

DR. BREYSSE: So, so Mike, let me -- if I can
add to that. Dr. Heaney, I think the gist of the
question is, how do you weigh, when you said that you look for the weight of evidence and decide whether it's at least as likely or not, how -- what -- how do you weigh those? How do you decide whether this TCE exposure, which has been characterized, but is perhaps underestimated or uncertainty about the estimation, we have disease risk factors that have point estimates that may be 0.9, but if you look at the upper boundary of the point estimate, it might be much higher. How do you weigh the uncertainty of that point estimate, given the uncertainty of the personal risk factors to come up with a weight of evidence to suggest it's less likely than not? That's not clear to me. This is Pat Breysse, speaking, from ATSDR.

DR. HEANEY: Thank you. You know, each case is different. And it's not yes, someone was exposed or no, someone wasn't exposed. It's not they're obese or not obese. We look at the specifics of the case. Certainly how long they were at Camp Lejeune. We look at what their occupation was at Camp Lejeune. As far as other risk factors: How long they smoked, when they stopped smoking, if they smoked, what kind of thing they smoked, cigars or cigarettes. We look at the length of time of obesity. We look at so
many different things. And we put it all together, and we do our best in weighing the evidence and seeing what it shows.

So a lot of these studies that show -- some show an increased risk; some don't, but in the ones that do, a lot of them are occupational studies where the person has been exposed for five, ten, 15, 20 years. And we do get some cases where people were at Camp Lejeune for only a few weeks, and that's a different case from someone who was at Camp Lejeune for five years.

So each case is different. I can't say that it's a situation where a risk factor is always a risk factor is the same risk factor. It depends on the case.

DR. BREYSSE: Dr. Cantor from the CAP would like to ask you a question.

DR. HEANEY: Certainly.

DR. CANTOR: Hi, Dr. Heaney. I'm a retired epidemiologist from the National Cancer Institute in the environmental -- occupational environmental group there. Have you considered interactive effects in your assessment? And what I mean by that is, and not additive but multiplicative effects, which are quite common in cancer epidemiology. I'll
give you an example. It doesn't have to do with TCE, but it's something that we saw in a study of kidney cancer which did not involve chemical exposures; it involved obesity and hypertension. And for each of those alone, the relative risk is maybe 2 or 2.5, but for a person with obesity and hypertension, the relative risks were in the order of 8 or 10.

So therefore if a person was TCE exposed, even for a maybe relatively brief period, and they are smokers or they have hypertension or they are obese, there might well be interactive effects that would put them over the edge of having the cancer or not. So I wonder if you have considered these interactive effects, and if so, how you've done so.

**DR. HEANEY:** Yes, I'm familiar with the hypertension and obesity studies. In fact that's something that I cite in my report. I'm not -- I don't know of any specific solvent studies with the other conditions but would love to review them if you have them.

**MS. FRESHWATER:** That's not his question. Can you clarify, Dr. Cantor?

**DR. CANTOR:** Yeah. That wasn't my question. It's, it's --
DR. HEANEY: No, I understand --

DR. CANTOR: It's simply the possibility, and we know for example asbestos and cigarette smoking. There are lots of examples in the literature. We don't have examples, as far as I know, of solvent exposure and these other risk factors. But it is probable that it is, it's happening. And so that is the basic question: Have you considered the possibility in your evaluation that this is going on?

DR. HEANEY: Yes. I understood the question. I haven't considered that possibility. But even with situations such as asbestos and smoking, certainly they're multiplicative; we know that. And certainly asbestos could perhaps tip the scale, and I suppose that's what you're talking about with solvents. But what we're being tasked to do is not say, is any part of the development of this cancer due to solvents. We're being asked to say is there a 50/50 threshold. And I don't think that's the same as, is there part of it that contributed to it. And I don't have any numbers to go by as far as the multiplicative effect.

MS. FRESHWATER: Can I ask a non-scientific, layman question?
DR. BREYSSE: Could you introduce yourself?

MS. FRESHWATER: I'm Lori Freshwater, and I'm a dependent, on the CAP. How do you know which thing tipped it? So if it's --

DR. HEANEY: You don't.

MS. FRESHWATER: Okay. So if you don't know which thing tipped it, then how can you deny that it was the chemical that tipped it?

DR. HEANEY: Because it's not -- we're not looking for the chemical that tipped it. We're looking for --

MR. ENSMINGER: What?

DR. HEANEY: -- were solvents at least as likely as not the cause. So which tipped it, we're not being asked that question. Which was the final straw? There's no way to answer that.

MS. FRESHWATER: Well, if there's no way to answer that, how do you -- how can you tell a veteran that it wasn't exposure to a chemical that made them sick?

DR. HEANEY: We're looking at a 50/50 threshold. And that's the way that we do it. We can't say if a -- if we recommend -- or if we say that it's less likely as not, that's not the same as saying the solvents didn't in any way contribute to
it. That's not what we're saying. We are saying it's not a 50/50 situation of causation, that we think it's a 50 percent likelihood that the solvents were a cause.

**MS. FRESHWATER:** Okay, so when you're doing this 50/50 threshold, like you yourself, do you know how many -- what the average amount of water that a Marine in training, in August, in North Carolina, drank?

**DR. HEANEY:** Well, we have estimates but I don't know exactly.

**MS. FRESHWATER:** So you are factoring that in in your 50/50 though? You're factoring in that a Marine would drink more water by large amounts than a typical person.

**DR. HEANEY:** Absolutely.

**DR. BOVE:** Let me ask a couple of questions.

**DR. BREYSSE:** This is Frank Bove.

**DR. BOVE:** This is Frank Bove from ATSDR.

**DR. HEANEY:** Yes.

**DR. BOVE:** First of all, I've gone through the literature, and there's no minimum amount of exposure that's known that causes kidney cancer. The Scandinavian studies have relatively low level of exposure, the occupational Scandinavian studies,
had a relatively low level of exposure to TCE.

And in our paper on the mortality study of
Marines, we estimated that the exposures on a daily
basis to Marines, combining both residential and
training exposures to the drinking water, were
probably equivalent to what was going on in the
Scandinavian countries. So we don't -- you know,
again, it's not clear to me what the minimum level
that you're thinking about when you're wondering
whether it's 50 -- above 50 or below 50.

Also there's no information on the duration of
exposure necessary for causation. So I don't,
again, wouldn't understand how you're going to make
that decision.

The first thing is, when you mentioned smoking,
just so you know, if you don't, there was a meta-
analysis done by IARC researchers back in 2008,
looking at smoking and kidney cancer and other
cancers. And for kidney cancer the meta-analysis
indicated that the actual overall relative risks
were very similar to kidney -- TCE and kidney cancer
that were found in all the meta-analysis, done by
NCI and the EPA and so on. And so -- and in fact
TCE might be a tiny bit stronger risk factor than
smoking, for kidney cancer. Are you taking that
into account as well?

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

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

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

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

**DR. HEANEY:** Yes.

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

**DR. HEANEY:** Well, in the National Toxicology Program profile, they listed the article as low to moderate utility. And then they described that. So
there wasn't --

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

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

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

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

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

MR. PARTAIN: Sure.

DR. BREYSSE: -- before we consider. The previous question was talking about the Canadian study and that evidence versus just relying on the EPA, IARC and other reviews.

DR. HEANEY: About using -- why is the NRC report used? Is that?

MR. ENSMINGER: Yeah, why is it even --

DR. BREYSSE: Yes, yes.

DR. HEANEY: Okay. I guess I'm confused why there's an issue with it when if it is used for the conditions in the healthcare law; it is used for the conditions that the veterans who apply for claims use as thinking that there should be compensation because of those conditions. So I guess I'm confused how there's a problem with us citing it, yet the information on it is being utilized.

MR. PARTAIN: Have you read the NRC report from cover to cover?

DR. HEANEY: Cover-to-cover, no.

MR. PARTAIN: You might want to do that. That would answer your question.

DR. BREYSSE: No, I think the concern is that
it's outdated. Its conclusions are no longer relevant given the IARC and the EPA and the NTP review of now, respective to the weight of evidence in TCE and kidney cancer, for example.

**MS. FRESHWATER:** And it was on the PowerPoint as well, that's training people.

**DR. HEANEY:** That PowerPoint has nothing to do with the subject matter experts and the claims. I've never even seen it. That was, from my understanding is that was related to healthcare. And the clinicians who were showed that, and I don't know who was shown it, but I presume those were primary care physicians who were going to be treating the veterans. It had nothing to do with the clinicians who are doing the compensation claims.

**MR. ENSMINGER:** And to answer your question about the health -- the health outcomes that showed -- ended up in that law, that bill was constructed in 2010, okay? And that's why they used the NRC report to construct that bill, which finally became the law for the health outcomes. So since that time, in 2012, in 2013, the EPA and IARC have reclassified TCE. There's been all kinds of new information come out on TCE. So that's why you
should not be using the NRC report. And furthermore --

**DR. HEANEY:** But it doesn't make sense with the healthcare law.

**MR. ENSMINGER:** And furthermore, you want to talk about a biased study, or it wasn't even a study; it was a review. I know all about the NRC report 'cause it was my fault that the damn thing got done in the first place. But I had trust and confidence in somebody who initiated that and put it in an amendment, and that was Senator Dole. And I was told that, not only would the Department of the Navy fund, they -- the only thing that the Department of the Navy would have involved in that would be the funding. And Congress was going to write the charge. Well, the Department of the Navy funded it and they wrote the charge to the NRC. So that thing was biased from the get-go.

**DR. HEANEY:** Okay. That's good information.

**MR. PARTAIN:** Not to mention the peer review coordinator for the NRC report was a former executive from -- was it Honeywell?

**MR. ENSMINGER:** Yep.

**DR. BREYSSE:** Okay. Brad Flohr would like to jump in, Dr. Heaney.
MR. FLOHR: Yeah. You know, this has been a very good discussion. I think it really points to the complexity of the issue. There's a lot of different studies, a lot of different reports, and a lot of people looking at them. The SMEs, like Dr. Heaney, provide medical opinions. They do not make decisions on claims. Those are made by the claims processors in our Louisville regional office. It is a piece of evidence.

We have granted claims when we've had a negative VHA opinion, when we've had a really good private opinion which raised it to the level of reasonable doubt. And once we get to that level, we grant the claim. Best thing that a veteran can do is, and I know they can't all do that, is really get a good medical opinion to submit with their claim. Sometimes we wouldn't even ask me -- or ask for a VHA opinion, if we have a really good medical opinion.

MS. FRESHWATER: I just want to say real quick, very quickly, when you say the complexity of all the studies and there's so many studies out there, I feel like that's muddying something that we're trying to clarify, because what we're talking about is using the latest science instead of old science.
that's outdated. So I just wanted to say it's not that there's so many studies that contradict, it's that the VA is using studies that have been proven wrong and that are outdated.

MR. FLOHR: What I mean by that is there's a lot of studies on other risk factors besides TCE that can cause kidney cancer. There's a lot of them. They're not outdated. They're still good.

MS. FRESHWATER: I understand; I just wanted to make that clear.

MR. PARTAIN: Brad, the people making decisions, when they get a report back from --

MR. FLOHR: They don't make decisions; they provide opinions.

MR. PARTAIN: The people who make the decisions, when they receive the reports back from the SMEs, when you get a statement like this, and this is a report -- this is from an SME, actually this is from Dr. Heaney, and I do want to go back to my question that I asked that we had to come back to, but anyways: There is no clear increased risk in the development of renal cell carcinoma from solvents even with occupational exposures of five years or more. With a statement like that, I mean, it's -- that's dumb.
How -- what person would award a benefit or a consideration for a veteran after reading that sentence? And by the way, they go on -- Dr. Heaney goes on to reference the report that Jerry was talking about, which is: Risk of selected cancers due to occupational exposure to chlorinated solvents, in a case control study Montreal, Chris Christianson, MBA, blah-blah-blah. And there's no counterpoints.

And that goes back to the transparency question that I began earlier with this conversation. There needs to be transparency from the VA on what you guys are looking at, when a decision's made, they need -- the person making decisions needs to break down the pro and con reports that went into the basis for those decisions, so that there's no rabbit coming out of the hat. We need to understand how that rabbit got there and what basis that rabbit got there -- I mean, how do you determine, what basis, what reports.

And going back -- I'd like to go back to address my question about mixed solvents.

**DR. BREYSSSE:** Well, what was that dated?

**MR. PARTAIN:** That was -- by the way, this denial was dated February of 2015 and the report was
February of 2013, was when the -- the report that
she cited as the basis for denial. But going back
to it, I'll read it again for emphasis. There is no
clear increased risk in the development of renal
cell carcinoma from solvents, even with occupational
exposures of five years or more. Okay?

Going back to my question. We have mixed
solvents, we have people who are living on the base
24/7 and working on the base. What weight is given
to that versus someone that goes to work in a dry
cleaner for eight hours a day for five days a week?
I mean, is there -- and the question I'll follow up
with Dr. Heaney here, is there -- when you're
dealing with a carcinogen, are you looking like a
low dose load? I don't know the scientific term for
it, but are you looking at it -- you get exposed to
a certain amount of chemicals over time, and then
that may give cancer, or is there a risk at every
exposure, from day one? I drink a glass of
TCE-laced water; am I at risk from drinking that
glass? Can you say professionally that I can drink
that glass and I'm not going to be at risk, but it's
going to take me 15 glasses of TCE water over two
years to be at risk? Help me understand where that
threshold is.
DR. HEANEY: Yeah, no, I'm not saying that there's no risk, or none of us is saying that there's no risk. The question is, is the risk great enough to rise to the level of 50/50 causation?

MR. PARTAIN: What about the mixed solvents question?

DR. HEANEY: A lot of the studies actually were done on mixed solvents rather than simply on TCE alone or PCE alone. So we're looking at research that shows the risk of those.

MR. ENSMINGER: Dr. Heaney, this is Jerry Ensminger. What's your affiliation with the Heaney Group?

DR. HEANEY: That's a private consulting.

MR. ENSMINGER: And who do you consult?

DR. HEANEY: Again, that is unrelated to my work for the VA.

MR. ENSMINGER: Well, I mean, do you -- you consult --

MR. DEVINE: I think you need to take this --

MR. ENSMINGER: No, you consult industry.

MR. DEVINE: You asked the question who does she work for. She gave you her credentials, her bona fides. That's the answer to the question.

MR. ENSMINGER: Yeah, but she's an industry
consultant.

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

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

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

**DR. BREYSSE:** She's not, she's not, she's not going to answer that question.

**MS. FRESHWATER:** I know. Well, I'll just put it online then.

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

**MR. TEMPLETON:** Thank you. Been waiting for a while. I got a quick question for Mr. Erickson. The working group you were talking about; is that by chance the Camp Lejeune task force?

**MR. WHITE:** The working group that I believe Dr. Erickson was referring to earlier was the clinicians that we have at the VA who make the determination on the healthcare side. We've had a working group a few weeks ago in DC, where they went over the IOM report, and looked at the clinical guidance that had been developed at that point, to see where it could be adjusted.

**MR. TEMPLETON:** So if you don't mind me asking, just asking for a yes or no, is the working group the Camp Lejeune task force, the VA Camp Lejeune
task force?

MR. WHITE: I don't think so. I think the task force was originally set up that encompassed a number of agencies within the VA, that were -- it was kind of implemented to start this program.

MR. TEMPLETON: That's, that's one. Did you have something -- not -- okay. A couple other quick things; I'll try not to take too much time here. There's been some new science obviously since some of the claims were decided, and we want to move forward, and I understand that, but there have been some claims that have been denied in the meantime. Are we going to do anything to go back and look at those claims that were denied through the new lens of the new science?

MR. FLOHR: Once a claim is denied, it can be reopened. We can re-look at it. What an individual would need to do is send letters based on new science and we'll take a look at it.

MR. TEMPLETON: Is there a way you can do that without the person who -- the claimant having to do anything where we can review those in light of the new science?

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

MR. TEMPLETON: I really would like to see
that, especially since this issue has evolved as
much as it has over a period -- a short period of
time that we've had, so I'd really like to see that.

Okay, one other quick, quick question, and then
I'll make a point. I've read the law several times,
and I'm not an attorney. I'm a professional but I'm
not an attorney, but I have read several contracts
over a fair period of my time in engineering, and I
don't understand why, with the way that it's worded,
it says that the VA is supposed to provide care,
notwithstanding, that's the keyword, notwithstanding
that the health conditions cannot be proved to be
tied to the contamination -- okay. Notwithstanding
means despite the fact that we cannot prove that
those health conditions were caused by those
chemicals, be able to provide care.

So given that, and if you disagree with me
there, you know, you'll have an opportunity to punch
me, why aren't the 15 health issues, why is that not
presumptive? To me that would seem presumptive. It
seems to me like you -- the law in itself is saying
right there, you will provide care despite the
fact -- for these conditions, despite the fact that
we don't know whether the chemicals caused those
conditions. So to me that seems presumptive, and
I'd really like to -- and I'll give you a chance to answer that one, 'cause that's the one that I really want the answer on.

The other, real quick is, there's been cases of some really strange health conditions by Marines, sailors, people who worked at Camp Lejeune, going back to 50s, while they were working. And so there is, there is an occupational health record there. Has anybody gone back and taken a look at any of those, to see whether there is a story that jumps out at us because of those exposures? I have someone who was a wife of someone who worked at Camp Lejeune, who was aware that this -- and this was in the late 50s, that they had a rare cancer, and that the people on base knew about it and were treating this person, and there's likely several other cases that are similar to that. I don't -- I can't think that they would not be particularly numerous. So why aren't the 15 presumptive, and could we go back and take a look at the -- at folks that have become sick with certain illnesses at Camp Lejeune back in the 50s?

**DR. ERICKSON:** Yeah, this is Loren Erickson. I think the second question may apply more to ATSDR, given that you're doing all the studies.
Your first question is a really good one. And I would ask Senator Burr's office, because at the time that they were drafting legislation, I wasn't there but I'm going to bet that that was part of the discussion as to, you know, exactly, you know, which way do we go? Do we make these presumptives for the veterans, as Congress has done in the case of Agent Orange legislation, or do we do something else? And there was a decision to write the law the way it is, and from my standpoint, I don't know why they did it, but I'd like to know the answer.

MR. TEMPLETON: Yeah, but I guess my question more goes to, given the language is what it is, how could it not be interpreted that that's presumptive? I'd like an answer to that, because I -- I've heard the VA attorneys, your counsel, seems to feel like that it's not presumptive, and that's what's gone out there. But the language on itself, and especially if you take the legal, legal definition of the term notwithstanding, it says that the -- that basically those 15 conditions are presumptive, that you'll provide care even if you don't know that they were caused. So why are we going through the song and dance of trying to determine whether, you know, whether somebody was exposed and how they were
exposed and their lifestyle and all this other stuff, when it says in the law, notwithstanding. It says we don't know whether those caused that or not, but gosh darn it, we're going to treat them. They have to be treated.

MR. FLOHR: The law says that, yes, even though it's not known for sure that they were caused by that, VA will provide healthcare. It specifically excludes confiscation.

MR. PARTAIN: Well, one thing, I'd like to jump in here, Tim, if you don't mind, when we were talking about the IOM and you got the report there; last year, and I'm not picking on you Brad, but this was out of our transcripts here.

MR. FLOHR: You can always pick on me.

MR. PARTAIN: Huh?

MR. FLOHR: You're always picking on me.

MR. PARTAIN: Oh, yeah, you just step out in front of the bus sometimes, but anyways, of interest, and this is a quote from Brad, of interest about ALS, several years ago, about three or four years ago, the Institute of Medicine issued a very small report on ALS that found that there's a greater incidence of ALS in the veterans as compared to the general population, and based on that actual
VA took the steps to make presumptive any veteran who gets ALS is presumed to have caused through their service, and that was a report that came out through the IOM. I'd like to see the same consideration given to the IOM report for Camp Lejeune.

And one last thing, going on what Brad was talking about, with the doctors writing -- physician. Two points with that. One, same denial letter that I read from earlier. In response to the denial you submitted a statement from Dr. blah-blah-blah, a VA physician. The doctor noted that it's possible that the current cancer could be due to living at Camp Lejeune for a few months. The letter did not include any rationale or support to the statement nor did it list any specific studies to discuss your risk factors. Stop there.

**DR. BREYSSE:** What did you just read from?

**MR. PARTAIN:** That was a denial letter for kidney cancer from a veteran that was reviewed by the Heaney -- Dr. Heaney. Going back to this, yes, and Dr. -- I mean, not Dr. Walters, Jim Waters, who testified with me back in 2010 to Congress about Camp Lejeune. He was a kidney cancer patient, had
been denied, and unfortunately he's no longer with us. He died from kidney cancer. He got his review -- he got his service connection partly only because he worked for a school of medicine in Texas. And in his testimony, he asked the question that I'm going to pose right now. These veterans do not have resources to hire an independent physician and pay them thousands of dollars to get a medical opinion.

Now, I understand that you use people like Dr. Heaney and other SMEs, those are resources available to ATSDR -- I mean, ATSDR, to the VA, to do what you need to do. But you're hiring that person and you are paying that person. A veteran doesn't have that. It's an unlevel playing field, okay? And I've seen over and over again in these reports where the VA is coming back to the doctors who are writing nexus letters and saying, provide us a -- basically a signed -- a, a scientific study or whatever, and back this up. No doctor in his right mind is going to do that. Number one, they're not getting paid. They're doing this service for a veteran because they do feel something's there. And now they're being challenged. And you're asking the veteran to come up with the money to pay to get an independent expert to do that. That's unfair, and it goes back
to the transparency that I'm talking about.

Let's make this whole process transparent.

What's -- you know, a veteran might not be able to spend $3,000 for their own subject matter expert but if I know what your subject matter expert is denying my claim based upon, and the studies and the rationale behind that, then I can conduct my own research. And the internet's a great tool for doing that, and that's how we have been successful in getting some of these veterans their claims and their benefits, is because they come to Jerry and I and say, here's our denial. What does this mean? They don't understand this crap. And it usually takes us -- it takes Jerry and I, seeing about three or five denials and seeing the commonalities, and then we start to realize where it's coming from, and then we put it together, and then we help them challenge it. But that comes at my own time or Jerry's own time.

Let's -- level playing field. Let's be transparent. State what you guys need, what you're looking at, and in these denials who's reviewing them, provide the names, provide the rationale and the, the documentation to support that. Let's be fair. That's all these people want to be.
MR. ENSMINGER: Brad, you mentioned in 2011, when you first started coming to the CAP meetings, that you actually sat down and laid out the requirements to file a service-connected claim. And you did. But now you've added different hurdles in there. When you described it to us, you were forming the Louisville -- you formed the Louisville office to review all Camp Lejeune claims. But now you're throwing in these other hurdles. These SMEs that you -- or so-called SMEs. That was never part of the mix. That was added later. So I mean, you got people out there that go to their oncologist. They get the nexus letters that you recommend. And then not only are you questioning them, now you've gone and got these other people to counter the, the professionals on their nexus letters. I mean, how do you win?

MR. DEVINE: Can we, can we have -- maybe talk about the oncologist issue that both Mike and now Jerry have brought up real quick?

DR. BREYSSE: Sure. And then I'd like to -- we need to come to some closure on this. We're about 15 minutes behind schedule, which is okay, but I'd like to get us to kind of have lunch around -- you know, before too long. And so I know Christopher's
got a question he wants to add once Dr. Heaney responds. Then we have two more action items we have to review. So let's proceed in that order. So Dr. Heaney?

**DR. HEANEY:** Yeah, I'll be quick. Just earlier it was brought up the issue of an oncologist, for example, writing an opinion, and then putting that up for a family practitioner or an occupational medicine physician to go against it. And we're not diagnosing or treating the condition. That's what you need an oncologist to do. We don't do that. We use their information to put that in our reports to show that it was diagnosed.

What we're doing is looking at causation, which involves looking at the literature and toxicology, et cetera, and most specialists don't know how to do that. They see the patient, they diagnose the patient --

**MR. ENSMINGER:** Neither does she.

**DR. HEANEY:** -- they treat the patient. They have not done literature reviews. They have not looked at the toxicology of chemicals. And so we are being asked to do that part of it, and that is a part that another oncologist probably couldn't do.

**MR. TEMPLETON:** Well, I debate that. A lot of
times they ask for risk factors, and so they do at least delve into that a little bit.

   DR. HEANEY: Yes, they do ask for risk factors but that's about it.

   MR. PARTAIN: And is it not through even family practitioners or oncologists that often identify increased cancer risks that begin asking the questions that lead to cancer incidence studies or cancer studies?

   DR. HEANEY: I'm not sure what you're asking.

   MR. PARTAIN: Historically, physicians are often the vanguard at finding and identifying cancer clusters and cancer incidences and things like that, that ultimately end up in the review of epidemiologists and stuff. Is that not the case?

   DR. HEANEY: Some oncologists, some family practitioners do research? Is that what you're asking?

   MR. PARTAIN: Well, aren't there -- isn't there -- what I'm asking, isn't their input also important for people like Frank and Dr. Cantor to find and study cancer clusters, cancer incidences and stuff like that? I mean, they're often the vanguard to help identify where there's a public health risk.
DR. HEANEY: Yes, but that's not the same as being the ones to assess the causation, and that doesn't involve looking back at all of the literature and the toxicology. Bringing to the forefront something that they noticed clinically is not the same thing.

DR. BREYSSE: All right, so Chris, you've been waiting patiently.

MR. ORRIS: Yes, thank you.

DR. BREYSSE: Please introduce yourself.

MR. ORRIS: Yes, this is Christopher Orris; I'm a member of the CAP. And my question's actually for Brady. Brady, I'd like to circle back to the VA family members program. Specifically I'd like to ask you, what is the amount of time that it typically takes for a family member to be deemed administratively eligible or ineligible?

MR. WHITE: Generally we've got performance metrics for each stage of the process. And right now for the VA staff in ^, which is where we're based out of, there's a 30-day time frame to determine administrative eligibility.

MR. ORRIS: Thank you. So would it be your recommendation, then, that all family members of Camp Lejeune exposed veterans go ahead and get
administratively eligible right now, so that when they do get sick, they skip that 30-day wait time frame?

MR. WHITE: Absolutely.

MR. ORRIS: Is that something that you would be willing to put on your website to recommend?

MR. WHITE: Sure. Yeah, we can do that.

MR. ORRIS: Thank you. Now, my next question's going to be to Mr. Erickson. Due to the fact that the science is coming in fast and furious, and we are finding more and more conditions that are related to the exposure, would the VA welcome an agency such as ATSDR being in charge of modifying the legislation to add these conditions moving forward, and would you recognize that if it was Congressionally mandated?

MR. ENSMINGER: Can't do that.

DR. ERICKSON: You know, my sense is that the Congressmen and women are elected officials and actually be in charge of that with the aid of their staffers. But, you know, we've already committed that we'll work together in this, you know, whether, you know, their name is in the marquee and ours is in small print, that doesn't really matter to me, one way or the other. The goal is the same. You
know, and that is to take care of the Camp Lejeune
veterans and family members, to do the right thing.

We have -- again, we've had significant
discussions already. We expect to have more in the
future, and I think we're on the right path. But in
terms of who gets credit or who carries the bigger
bucket of water, you know, we're going to
collaborate on this.

**DR. BREYSSE:** I think at the end of the day,
speaking in the same voice will make it stronger.
So that's why we want to identify those things that
we agree on. And we'll push those forward and we'll
more than likely be successful and work together.

**MR. ORRIS:** Thank you. And then my last
question is for Frank and Perri. We've known for
quite some time that TCE and PCE exposure causes
birth defects, specifically congenital heart
defects. I'd like to have an action item created to
where you can link the science together in an
official ATSDR memorandum that we can present to
Congress, so that we can start getting that illness
covered as well.

**DR. BREYSSE:** Okay, put that on the list. And
that's also part of, I think, what we've just talked
about. So I think this message to Congress, when it
comes from both of us, will resonate better.

MR. ORRIS: Thank you.

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

(Applause)

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

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

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

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

MS. STEVENS: And then what I'll do -- what I'll do is, after today, after this meeting, I'll send a copy of what Brad sent me to all the CAP
members so you have it.

**DR. BREYSSE:** Is there a way to photocopy it during lunch and hand it out to everybody?

**MS. STEVENS:** It would be easier for me just to run upstairs than to make photocopies at this hotel.

(Multiple responses)

**MS. STEVENS:** Oh, I see what you mean, so people can actually look at it?

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

**MS. STEVENS:** Let me see -- what if I could put it up on the screen? I might be able to do that.

**MR. PARTAIN:** Can you send it to us electronically, too, Sheila?

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

**DR. RAGIN:** And the last action item: The CAP requested a presentation on family benefits at the next CAP meeting.

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

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

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

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

**MS. FRESHWATER:** Just one quick question. What is the criteria for choosing the subject matter expert?
MR. DEVINE: There are -- we have 26. And it is -- was originally, if I remember right, originally it was the division directors chose the occupational specialists.

MS. FRESHWATER: Can you speak -- I know I'm too loud but...

MR. DEVINE: I'm sorry. The time -- I'm trying to get -- actually, instead of me messing this up, Deb, are you able to get on and explain it better than me?

DR. HEANEY: Yes, I'm here. I believe they are initially selected by a DMA based on what they know of the clinicians in the field. Those with the most experience who have dealt with issues of toxicology in the past. And then there's a group of SMEs, we review the -- their CVs and their credentials, and speak with them. And then we select -- well, I don't -- the DMA selects the one, and we do a training. And some people work out and at times some people don't work out.

MR. DEVINE: And the visiting directors, though, are also part of that whole process, correct?

DR. HEANEY: The visit -- I have no idea.

MS. FRESHWATER: So we would definitely want
some clarity on that process, how the subject --
what is the criteria for the subject matter experts
to be chosen, and what makes them a subject matter
expert.

And then just real quick, the reason that he
was gracious enough to let me speak before we go to
lunch, there's a -- someone in the room behind you
there, that he went to the VA and had his white
blood count showed up as being bad -- wrong. And he
was told probably, I think, allergies or I'm not
going to get this right. And it was known that he
was at Camp Lejeune. And then a country doctor
found out he had leukemia. So my question to you is
what are we doing to make sure that people across
the VA, again, it's about being proactive thing and
preventative medicine, because it's going to cost
the government less, which I'm assuming, Dr. Heaney,
is, part of your goal, right, is to cost the
government less money. So if like we are
preventative and we are looking out for someone, and
we find their leukemia on time as opposed to after
they're already dying and critically ill, what are
we doing proactively to make sure, because we're
getting emails at the CAP email address to say, can
you help us with some resources. From the VA
employees.

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

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

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

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

**DR. BREYSSE:** Yeah, that's fine.

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

**MS. FRESHWATER:** And it's a cultural thing as far as the VA goes, if someone comes to them and says, I was at Lejeune; should I be screened for
anything? If the person they're dealing with, instead of thinking this person's going to want something; this person's going to be a can of worms, and I'm not accusing anyone of having that attitude; I'm just saying this is what I get back from the -- anecdotally. Then instead of that, why not have the culture of, well, we'll -- let's jump in and, and start looking at this person and try and get them before they get sick. If you actually do accept the scientific studies. Does that make sense? Just a whole cultural kind of change as far as --

MR. DEVINE: When it comes to exposures, and Lejeune isn't the only one. We also have Gulf War, several other issues with the Gulf War, which -- the exposures, I think, is our future in terms of disability.

MS. FRESHWATER: Right.

MR. DEVINE: So there does need to be more education more widespread. Because it is a smaller slice compared to the 7.8 million that we treat annually.

MS. FRESHWATER: But as you mentioned, I feel like our work here is really important because there are so many veterans who are going to be coming forward now.
MR. DEVINE: I hope so. I absolutely hope so.

MS. FRESHWATER: And the burden hits, and that's becoming a very big issue, and Parkinson's, as we age, that's going to become a bigger issue.

MR. DEVINE: Yeah, I heard that one last night.

MS. FRESHWATER: So, yeah, I mean, you see where I'm going with this as far as -- and I don't mean to keep mentioning the PowerPoint, but we really need to go really far away from where that was into a whole different way of looking at things.

MR. DEVINE: We can be in support of where we - - Would you help us to --

MS. FRESHWATER: Absolutely.

MR. DEVINE: And I'm glad you're mentioning this because --

MS. FRESHWATER: Absolutely.

MR. DEVINE: -- it does allow us to take back - - At least that's my take on this, that VSOs are absolutely essential.

MS. FRESHWATER: Yeah, I have great hope that things are going to get better and we're going to work together and do that.

MR. ENSMINGER: That's why I want to be on the working group.

MR. TEMPLETON: I'd like to throw in a comment
concerning the SME program. We do need to know a lot more about the SME program. At this point I've had the opportunity to review a few of the denials and some of the opinions that were written by SMEs. I'm going to try to be nice here, and they were horrible. They, they were -- there is much room for improvement, and maybe we can improve that. I'd like to see that.

**DR. BREYSSE:** Yes. I think you need to clarify more about that program. It's clear, and we had that written down. Couple of more topics, and I think we really need to -- I think we'll all feel a little bit better with a full stomach. Maybe a little bit sleepier might be better. Tim -- or Chris?

**MR. ORRIS:** I have, I have two last questions, and my first question is going to be, in light of the fact that the VA is recommending that all family members at Camp Lejeune register for administrative eligibility, what kind of outreach will the VA do to ensure that the many people spread across all 50 states and pretty much around the world, are aware that they should, in your own words, become administratively eligible as soon as possible?

**MR. WHITE:** That's going to be part of my
presentation after lunch.

MR. ORRIS: Thank you. And then my last question: Dr. Heaney, how long have you worked at the VA?

DR. HEANEY: Since 2009.

MR. ORRIS: Thank you.

DR. BREYSSE: All right. Unless there's something really burning, I think we all need to have some lunch.

(Lunch recess, 12:35 till 1:36 p.m.)

DR. BREYSSE: All right. I'd like to move things along. If we can get started, I know people are still trickling in, because we want to review the statistics that was the last action item. And Brad's got to catch a flight so he's got to leave at 2:00, so that doesn't give us much time. But these are the data that were provided by the VA in response to the requests. Brad, you want to just walk us through it?

MR. FLOHR: Sure. There was -- Mike, you brought up something about the grant rate having gone down a lot. Actually that's not -- it hasn't gone down that much. It's just a different way that we have gathered data. When you said we had granted like 25 percent at one time, that was when
Louisville was keeping their own stats, and they were only looking at the -- like the top 15 conditions from the NRC report. And they were -- I think the grant rate was around 25 percent back then. It was, again, in 2010 --

MR. PARTAIN: Well, it was up until like a year or two ago from that. And that's coming from what we got from our central office. I believe it was for all conditions.

MR. FLOHR: I don't know if it was all. I can check when I get back 'cause I got to look at my reports. But currently, okay, we've got 10,569 veterans who have applied for Camp Lejeune benefit, and we've completed -- that's actually the number that we have completed, and there are 3,814 pendings, so we have about 14,000 Camp Lejeune veterans that have never filed a claim for any disability. And I don't know if that's because they don't know about it or if they're not getting sick. I don't know why that is. Out of 720,000 population, I can't explain it.

Let's go to the next slide. Our data staff is now keeping all the statistics. Every month they provide this report. When I talked about the breast cancer issue last time, Mike, I said we've reviewed
all the granted and denied claims, and that’s the present we coded some of them. They all showed up, and there was only like 43 actual breast cancer -- male breast cancer claims. That's out of 117 that we tracked. Those are the ones that we built diagnostically. And you asked if we could separate that out. I'm going to work on our data staff when I get back, and I think we can do that, which would show a more -- the real picture of actual breast cancer cases, granted and denied.

Currently, as you can see, 35 -- or there's 28 percent of breast cancer cases altogether have been granted. This report, again, contains not actual breast cancer. We have like 17 percent, 18 percent bladder cancer, 14 percent liver cancer, 15 percent kidney cancer, 17 chronic renal disease, 20 percent for leukemias and lymphomas. And what -- what you see is the total primary disease categories. These are the NRC 14th and 15th edition, plus we added a couple of others, which we thought were of interest, prostate and one of the others. That has gone down. I know last month it was like 16 percent was the total primary disease category grant rate. That's gone down this month to 13 percent. It changes every month based on of
course what type of issues are decided every month.

But what drives this down to five percent overall grant rate is that 19,000 of the total of 25,000 claimed condition, almost 20,000 of them are miscellaneous: Arthritis, back pain, headaches, erectile dysfunction, foot fungus. We get all those kinds of claims. That takes up our time, and part of that is because on your website you tell veterans to file a claim for everything they've got, and that's what they're doing, even though they're not at all associated.

**MS. FRESHWATER:** Which website?

**MR. FLOHR:** On the (indiscernible).

**MR. PARTAIN:** Where do we actually say to file a claim for everything on there?

**MR. FLOHR:** It was on there when -- originally when it came out I saw it on there. But I don't know if it's still on there.

**MR. PARTAIN:** I don't know, 'cause since I got involved in 2007 I don't recall that being on there.

**MR. FLOHR:** I remember seeing it.

**MR. PARTAIN:** But going back with the claims, you've got 99 male breast cancer claims; is that correct?

**MR. FLOHR:** Yes.
MR. PARTAIN: And of that 99 --

MR. FLOHR: Now, that's --

MR. PARTAIN: -- those are all --

MR. FLOHR: -- that's, again, that 99 may not be actual breast cancer. That's people who have either identified as breast cancer or they had gynecomastia or breast nodes, and those are all 'cause of the way we capture that --

MR. PARTAIN: Okay, I understand.

MR. FLOHR: -- data. It may not actually -- 'cause remember, there was only 43 --

MR. ENSMINGER: How the hell do you keep track of this?

MR. PARTAIN: Okay. But going with the veterans, you asked the question, or posed a quandary, of why there's so few veterans have filed and stuff. You know, we -- there's, you know, notification's a big issue. I mean, I get emails on a daily basis. Jerry gets emails on a daily basis. There are people here today that are just finding out about this. And so knowledge is -- knowledge is one thing, and I don't want to steal too much time, but one of the reasons why we're here today versus Atlanta is to get these meetings out to the community so the community can be aware of it. And
I'd like to see this continue. But you know, notification's a big thing, Brad, so --

**MR. FLOHR:** I have a hard time understanding that. I mean, the Navy sent, what, 200,000 letters to the Marines they could identify. And you and Jerry have been on documentaries, on TV, on 60 Minutes and all kinds of programs. It's not like, like it should be something that people don't know about.

**MR. PARTAIN:** We've done a lot of --

**MR. FLOHR:** You've done your part in getting the word out. And I don't know why it's not out there more.

**MR. ORRIS:** Well, Brad, I can probably identify a little bit of that. The Department of the Navy refuses to communicate with any of the children born at Camp Lejeune, at all. It doesn't matter their age. And I've asked Melissa multiple times why the Department of the Navy will not communicate with the children born at Camp Lejeune. And they simply state that they've sent the letters to the parents, even though they're all adults.

**MS. CORAZZA:** Yeah, my mom got four letters, one for herself and the three of us that were born at Camp Lejeune, to her home address when I haven't
lived there for 17 years.

MR. TEMPLETON: Is there any way that the miscellaneous conditions can be maybe broken out a little bit? 'Cause I mean, if we take the 15 -- let's say -- let me elaborate just for a moment on that. But if we take the 15 that we've got in there, but then now we've got 19,000 miscellaneous conditions. There's more conditions other than the 15 that we've been talking about here, and in studies and so forth. I'm curious how many of the miscellaneous conditions fall into the other diseases that have been identified outside of the 15 that's -- I mean, lumping them like that, you know, I think that deserves a little bit more visibility on those, especially since it's such a large group.

MR. FLOHR: Yeah, I think we can get some information on that. But like I said, there are really things like arthritis, things that are not really...

MR. TEMPLETON: Well, I have a comment on that, too, 'cause I do feel like that in some cases they are related, because there are some things, like let's say for example if you happen to have chemotherapy. When you have chemotherapy, then you also have --
MR. FLOHR: Absolutely, yes.

MR. TEMPLETON: -- other conditions.

MR. FLOHR: Yes.

MR. TEMPLETON: And so those conditions are related to what, what got you there in the first place.

MR. FLOHR: Well, that's -- one of them I mentioned, erectile dysfunction. If someone is service-connected for prostate cancer, which is, as you can see, we've granted 14 percent, and they have surgery, and they have erectile dysfunction based on that, that would be service-connected as well. So it's -- but whereas granted for a thing all by itself without any cause, then that's the kind of thing that --

DR. BREYSSE: And Brad, I mean, it would also be interesting to have those broken out 'cause it's conceivable that there could be other conditions, other clusters associated with this combination of exposures that haven't been discovered yet. But if there did appear to be some unusual number of some rare condition, it might be worth exploring it in more detail, if we had some greater resolution of what this last category is.

MR. FLOHR: It could be quite lengthy, and I
don't know how that works in our data, but I'll take that back when we go. At least I can get some information for next time on what they all are.

DR. BREYSSE: Appreciate it, great. Yes.

MR. HODORE: I don't know if y'all are aware that the VA have changed the regulations on filing claims called the intent to file process. And most veterans now have to go on e-benefits to even file a claim. And if they don't get this 21-90, I think, 66 form, for the intent to file form, then the VA's not even going to move forward on file -- even doing anything about the claim.

MR. FLOHR: You know, I know something about that, and I have not been involved in drafting regulations on that. The purpose was because we're all going totally electronic in the claims process. We have like 96 percent of all of our claims are now done electronically.

MR. HODORE: Okay.

MR. FLOHR: And so we came up with the idea, okay, let's put a form out there that a veteran can access through e-benefits.

MR. HODORE: Okay.

MR. FLOHR: You can complete it online, submit it online, and it goes right into an electronic
file. No more claims folders and it's easier for them to work with and to move around. Like if someone files an appeal, we just transmit their electronic form for the appeal, instead of sending in a claims file and all that. So it's much quicker.

So the intent to file, though, it's not requiring. We recommend that people file through e-benefits, and I know that e-benefits sometimes is not that easy to get into. But --

MR. HODORE: But I have a concern --

MR. FLOHR: -- it's not necessary. You can also call and they will mail you a form.

MR. HODORE: Okay.

MR. FLOHR: Contact them and they'll mail you the form and you can submit it.

MR. HODORE: Well, one of the veterans brought it to my attention that, if you did file with the intent to file process, that the VA wasn't going to be working on the claim until you file the 21-5-26EZ. So it's -- they're not going to even work on a claim until they get the intent to file process. What happened with all those veterans who have filed the claim prior to this new law on March 24th?
MR. FLOHR: They're still in the system. What is going to happen is those are all going to one of our scanning facilities, and an electronic file is going to be created, and the documents will then go away.

MR. HODORE: Okay. Thank you.

MR. FLOHR: But again, you don't have to file through e-benefits. We want you to because it's going to make it easier, quicker, for everyone. But if you contact VA and say, I can't file through e-benefits and I've got a computer -- lot of people don't access computers still.

MR. HODORE: Okay.

MR. FLOHR: We will send you a form, a 5 or 6EZ, and you can mail that.

DR. BREYSSE: Thank you. Any more questions for Brad? I know he's got to run.

MS. FRESHWATER: Just going back to the website, Brad, the -- that website that you're referring to is not the official website for the Community Assistance Panel.

MR. FLOHR: I'm sorry, which website?

MS. FRESHWATER: The website that you said, said to file -- everybody should just file for anything including toe fungus. So this, starting
now, again, in the spirit of going forward, the Community Assistance Panel actually does have an official website, and so I'll send you a link to it. And you can certainly give us information to post that you feel like it would be helpful to get to the veterans, like please don't file for toe fungus.

So I mean, we'd be happy -- again, we would be happy to go back and forth and help you inform veterans, and then also, you know, there might be things on there that you could help us with as well. There is an official -- you know, and it's, it's not verified with a little checkmark but it's one that we all can use. We have a Twitter account and a Facebook account that we're all a part of now. That's one -- because there's so many groups, we wanted to have one place.

**MR. FLOHR:** I appreciate that, Lori. I do.

**MR. PARTAIN:** And if you would, Brad, you know, I don't recall that part on the website, but I will deal with the administrator, if that is on there, take it down. It may have been on a bulletin board that someone posted on there.

**MR. FLOHR:** May have been, may have been.

**MR. PARTAIN:** But I know that didn't come from Jerry and I, 'cause we don't -- you know, we don't
ask people to file frivolous claims.

MR. FLOHR: I don't remember where it was or who posted it. I do remember it said, file a claim for everything 'cause you never know when they'll be presumptive.

MR. PARTAIN: That sounds like someone posting on a board.

MR. FLOHR: It very well could be.

MR. PARTAIN: 'Cause we don't encourage that. I mean, 'cause we've seen claims, like for example, we have a veteran with kidney cancer who was denied kidney cancer but was awarded hypertension, which we don't understand, and I can -- one of the male breast cancer guys was actually awarded male breast cancer -- or having to do with Vietnam and Agent Orange, which was -- he had to go back and correct that. So I mean, it's going both ways. So --

MR. FLOHR: You know you've contacted me in the past about specific claims, and I've done what I can to --

MR. PARTAIN: I know. But if there's something on the website specifically, please send me a copy of it, you've got my email, I'd like to see it.

MR. FLOHR: I'll do that. Thank you.

MS. FRESHWATER: We have a phone call that
Kevin wanted to get in, from a veteran, before Brad leaves.

**MS. STEVENS:** I got something on that. So when we do the CAP updates, we will -- the line'll be open for the one that Kevin has mentioned, so -- but I do have a presentation that Brady needs to do still.

**MS. FRESHWATER:** So we can't get that in --

**MR. PARTAIN:** They got to go. They have ten minutes.

**MS. FRESHWATER:** We can't get that in before Brad leaves.

**MS. STEVENS:** I would prefer to do that during CAP updates. Thank you.

**MS. FRESHWATER:** I'll do a little email, a narrative of it.

**MR. FLOHR:** Okay, great.

**DR. BREYSSE:** And also while we're switching to Brady's presentation, I assume Dr. Heaney's not on the line anymore, and I was remiss when we took a break. I wanted to thank her. If you can relate back to her and thank her for calling in. We appreciate her being here and making herself available. I was remiss in mentioning that before we broke for lunch.
Brady, you want to come up or are you going to
do it from there?

MR. WHITE: Probably from here.

DR. BREYSSE: Okay. Thank you, Brad.

MR. WHITE: Okay. So my name is Brady White, and I am with the Camp Lejeune Founding Members
Program. Just within the past couple weeks my role
is evolving a little bit more to also involve
veteran healthcare, so I might be going over both
aspects of the healthcare side of the program.

And somebody mentioned earlier, Lori, I think
it was you, about the -- some of the confusion that
might be out there regarding healthcare versus
compensation, and I think that's very true, and I've
even seen it here in some of the questions that were
asked. So maybe next time we can definitely help
resolve some of that and then focus a little bit
more on that aspect of it.

MS. FRESHWATER: I appreciate that. I think it
would be helpful. I mean, it's hard for me to
understand, you know, 'cause I've never gone through
the system at all, and so I guess I'm a good test
case as to somebody who's trying to figure it out
from the outside.

MR. WHITE: Yeah, yeah. I think that'd be a
great idea.

**MS. FRESHWATER:** Could I ask you, would we be able to get a digital copy of this PowerPoint?

**MR. WHITE:** I don't see why not.

**MS. FRESHWATER:** That'd be great. I'd just like to put it on our website so people can see it who aren't here today.

**MR. WHITE:** Okay.

**MS. FRESHWATER:** Thank you.

**MR. WHITE:** So this is just the recap of what the law covered, and it's basically all these cancers you see and the other conditions: Female infertility, miscarriage, neural behavioral effects, renal toxicity and scleroderma.

Now, let's talk a little bit about veteran eligibility, because I saw even in the last CAP meeting there was a little confusion about when a veteran's covered and when a -- again, I'm just talking for healthcare, not for compensation. So to be eligible for healthcare they must have served at Camp Lejeune on active duty status during the covered time frame, and that's from August 1 of '53 through the end of 1987, and that he had -- he or she has to have been there for 30 or more days, and it doesn't have to be consecutive days but just
a total of 30 days.

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

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

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

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

MR. WHITE: It would. They are eventually
going to be -- are you familiar with the priority groups? So a Camp Lejeune veteran is going to be Priority Group 6. So if they were Priority Group 8 before, because of their income and not receiving the benefits, now they can be.

So they do not pay copayments for third-party billing for any of the 15 covered illnesses, and as an enrolled veteran, they may receive any care provided in the medical benefits package, but may pay a copayment or have third-party billing for care not related to the 15 conditions.

MR. TEMPLETON: Brady, I've seen quite a few people say that they have been placed into Priority Group 8 temporarily, and that eventually they were supposed to be possibly moved to 6 but they haven't been.

MR. WHITE: Yes, sir. That's due to a limitation of the system. So right now there's an effort underway to update the system so that they will be put into the proper priority group.

MR. TEMPLETON: So is there a time frame on that?

MR. WHITE: I believe there is. From what I recall, and again, I'm new to the veteran side of things, I believe it's going to be by the end of
this calendar year they're hoping to have that in place.

MR. TEMPLETON: Thank you.

MS. CORAZZA: Brady, can I just ask, and maybe you can clarify, so even if you are -- the new VA has now thrown out that you don't have to claim your assets, just your actual income. I think that's a valuable point. And with the copayments, the max per day for healthcare is $50 a day copayments and $8 for prescriptions; am I correct?

MR. WHITE: That's a good follow-up question. I'm going to have to get back with you on that.

MS. CORAZZA: Yeah, it's a -- it's a valid point only because if you have to see more than one specialist, because you're sick, even if you don't meet the 15 criteria, if you stack your appointments, $50 a day is a lot cheaper and/or $8 per 90-day prescription, than going to see a civilian provider. So I was thinking maybe the audience might like to be aware of that fact.

MR. WHITE: Okay. Thank you for bringing that up. And I forgot to mention this at the beginning. I'm deaf in my right ear and my left ear is not so good. That's why I was unable to actually serve in the military. So it's hard for me to tell direction
of sound, so if I don't -- I mean, if you just start asking me a question, I might not immediately tell where you are.

**MS. CORAZZA:** Thank you.

**MR. WHITE:** So where was I? Okay, next point is veterans do not need to have service-connected disability to be eligible for receipt of healthcare benefits. Okay, I want to make sure everyone understands that.

And I just went over this thing about the copayments and again about the Priority Group 6. So any questions on veteran eligibility for healthcare?

**MR. ORRIS:** Is there ever any intention of supplying reservists and National Guard with the same benefits as the active duty?

**MR. WHITE:** Excellent question. We have to forward a proposal in order to cover the reservists, and it's now with our Office of General Counsel. Okay, for family members to be administratively eligible, remember I said there were three criteria: You have to have a dependent relationship with a veteran during the covered time frame; you have -- the family member has to have resided in Camp Lejeune or been in utero during that covered time frame for 30 or more days; and the thing I’m missing
up here, that the veteran also has to be in Camp Lejeune during that covered time frame.

Then in order to actually start receiving the reimbursement for the healthcare, they have to have been approved for one of the 15 conditions.

**MR. ORRIS:** I need some clarification. Why does the veteran have to be there if the child is in utero on the base at that time?

**MR. WHITE:** Why does the veteran have to be?

**MR. ORRIS:** You just said that if a child, even if they were exposed in utero, the veteran had to have been there for that 30-day period as well.

**MR. WHITE:** That's just one of the stipulations in the law, that the veteran has to be stationed at Camp Lejeune for the family member to have been there with them.

**MR. ORRIS:** Well, what if he was deployed?

**MR. WHITE:** What?

**MR. ORRIS:** What if he was deployed?

**MR. WHITE:** As long as he was stationed at Camp Lejeune. Doesn't have to physically be there.

**MR. ORRIS:** Thank you.

**MR. WHITE:** Good question.

**MS. FRESHWATER:** Brady? I have a woman who just wrote me, and she says her son was carried five
months on base in utero. Is he considered a
civilian? She goes on to give more details. And
she was exposed on base, Building HP-902. So then
that would mean that her son would be considered
eligible in utero.

MR. WHITE: Well, without knowing all the
specifics --

MS. FRESHWATER: Right. Obviously, I'm not,
I'm not saying that, you know, you're approving her
claim or anything, but I'm, just as a hypothetical,
I'm using this.

MR. WHITE: Sure, sure. They have to have
resided on base, right, if they -- unfortunately the
way the law is written, if they did not reside on
base, this, this law would not cover them.

MS. FRESHWATER: Five months on base is what
she's saying.

MR. WHITE: Okay, yeah. Some people think that
they resided on base when maybe they actually lived
off base and maybe they worked on base, so that's
different.

MS. FRESHWATER: Okay. Thank you.

MR. WHITE: So for the veteran program, as soon
as the President signed it into law on August 6th,
veterans were starting to be seen in the VA
healthcare system. And the regulations, the final regulations, were published in September of 2014.

And then some statistics here. We’ve provided healthcare to over 3,600 veterans to-date, and 1,700 of those have been treated for specific, one of the 15 conditions under Camp Lejeune. And but 16,000, a little over 16,000, are actually eligible for the Camp Lejeune program. So one of the outreach efforts that I'm going to do, 'cause I just saw this stat not too long ago, is follow up with those other veterans and find out, number 1, why aren't you using the VA's healthcare; and number 2, if they have a family member, have they applied?

MR. ORRIS: Quick question for you. What is your VA estimate on the number of veterans who will eventually apply, and also the same numbers for family members?

MR. WHITE: I'm going to have to get the veteran side back. So did you have a follow-up question for that? On the family members the initial estimates were -- we figured there might be about 1,133 family members made eligible each year.

MR. ORRIS: For how many years?

MR. WHITE: I don't know.

MR. ORRIS: Over a ten-year period of time
we're talking about 11,000 people who were made eligible for this program. That's less than the number of children that we know were born on the base.

MR. WHITE: Again, I'm not aware of all the exact readings for the epidemiology that went into it. But this -- they figured out that, of the total percentage of family members potentially eligible, maybe 25 percent of those would potentially become part of the Camp Lejeune family member program.

MR. ORRIS: And it's still your recommendation that every person who might be eligible should become administratively eligible as soon as possible?

MR. WHITE: Well, and after you asked that, I thought about it for a while, and I think it would be probably a good idea to encourage that. The flip side of it is, as mentioned earlier, the VBA is, you know, you know, I guess they've had a lot of claims for toe fungus and whatever else, so it kind of jams up their staff for doing stuff that is just not going to fly. But I think the benefit of getting people onboard and getting them enrolled sooner rather than later would probably outweigh the risk of the system or us being overloaded with claims,
and then creating this huge backlog. For family members that may actually have one of these illnesses, it just takes them longer to get to it now because there are a lot of people in the system.

**MR. ORRIS:** We're not talking about people with health claims, sir; we're talking about people being determined administratively eligible. That would be a different piece, wouldn’t it?

**MR. WHITE:** Well, no, it's all part of the same process. You have to go through the process for somebody to be eligible. So if somebody doesn't have a condition and they apply, then we have to go through the same process for determining their eligibility and if it’s favorably, then we would -- somebody with one of the conditions.

**MR. ORRIS:** Sure, so it's determine as many people administratively eligible as soon as possible. That way you can focus on people with health conditions as they appear.

**MR. WHITE:** Maybe we can have a sidebar conversation.

**MR. WILKINS:** Brady? My name is Kevin Wilkins. That 1,731, I'd like to find out if I'm included in that number. I've been treated for three of the conditions at the VA hospitals.
MR. WHITE: Do you remember if you told them you were at Camp Lejeune?

MR. WILKINS: Oh, yeah. Oh, yeah.

MR. WHITE: Okay. Then chances are that you are, but give me your information after this and I'll follow up.

And then here at the bottom is the phone number to call for people that -- for veterans that want to enroll in the Camp Lejeune program.

MR. ORRIS: One, one final question for you. Looking at this number totaling 16,000 veterans in four years since the law has been passed, would you deem that as a success or as a failure?

MR. WHITE: I have no idea.

MR. ORRIS: What would you deem a success or failures, the numbers? What would you --

MR. WHITE: Again, Christopher, I'm new to the veteran side. So I don't know what would constitute successful numbers.

MR. ORRIS: I mean, we know potentially a million people were exposed. And we’re talking between the two programs, less than 18,000 people in two and a half years going through your system. I think if I -- anybody could make the logical assumption that something's not working correctly.
MR. PARTAIN: But in fairness to the VA, Chris -- this is Mike -- it is not a success or failure for the VA's part. Their job is not to get the word out, per se. I mean, they can assist us in doing that. But that's where the Marine Corps and the Department of the Navy have got to get the rest of the families notified and what have you. Their job is to administer the care and track that -- track those numbers and everything.

So yeah, I agree with you, the numbers are low, and, you know, there needs to be more attention to it, but like I said, judging by just what we get in from the families and people finding out, I mean, it is not uncommon to get several emails, bang, bang, bang, from people who are just finding out. I mean, Lori was asked a question while we were talking here, and I’m getting questions and emails and stuff.

But the problem is we are fractured. We are scattered across this country, and internationally, because we have veterans from Camp Lejeune overseas in the Philippines, Thailand, Germany, Italy, all over the place. And we have, as a community, no direct way to speak to these people, and that is a major problem. You know, I cannot reach out and
send an email out to the family members and the
veterans saying, hey, this is what's going on or
even that we’d like to have a meeting. Trying to
get information out to these meetings, and we have
to rely upon surrogates such as the Department of
the Navy, the Marine Corps/Navy and the VA. And
that's something that -- you know, I know Jerry and
I have brought up to ATSDR, the registry part of
ATSDR.

We've got to find a better way to communicate
to the community. It's not out there. I mean,
there's -- I mean, the fact that we got people here
today and people asking questions, and the things
that I heard last night from the community shows
that the community really does not understand what's
happened at Camp Lejeune. And that's part of the
reason why this meeting took place in North
Carolina, and in the short future, I hope we have
one in Florida, where we got about 20,000 people
registered in the Marine Corps. So I'd like to --
and I don't know what the answer to that is, because
like I mentioned last night, we have a registry of
235,000-plus people with the Marine Corps.

So people are out there. Now, whether they're
going to show up on the VA's doorstep's another
issue, because there's a lot of different things involved in that. But the VA's -- you've got your registry of people coming in. Whether you call it a registry or not, you've got data of people coming in. ATSDR has some data. And we need to find a way to get these government agencies to work together so that there's one message being put out to the families and the veterans, so they can understand what's out there, what they need to do, what benefits are available to them and how to get those benefits.

MR. ORRIS: Thanks, Mike.

MR. WHITE: Coming back to the veteran side for a second. One thing we're doing to help, and I mean, this is a bit different than the compensation side, where the veteran, all he has to do, or she has to do, is claim that they were at Camp Lejeune during the covered time frame, and they will be enrolled in the system. Okay? So I wanted to point that out.

For the family member side, we launched in October, last year, so a little over half a year now, we've been operating. And the key component of this aspect of the program is we basically reimburse the healthcare for one of the 15 conditions, and
only those 15 conditions, or associated conditions, you know, if one of those 15 conditions caused another illness or the treatment caused another illness, we would also reimburse for that. And the reimbursement is as the last payer. So if somebody has other health insurance, we would pay after that other health insurance pays.

MR. ORRIS: I have another question for you, Brady. Do you hold the same level of what we've seen that the veterans have to go through for approval for a condition that they have -- does the family member have to go through that same process where you argue about whether they smoked a cigarette and got cancer? Is that the same exact process that you require?

MR. WHITE: Good question. And it's different -- it is different. And this is where some confusion might come into play. Where we're talking about healthcare and providing healthcare, for veterans, once they're made eligible as a Camp Lejeune veteran, they can receive healthcare at a medical center for any other condition, it doesn't have to be for one of those 15 conditions. They just don't pay any copayments.

On the family member side, what we've done, in
order to be as program-friendly as we can, because
again, we know that there's a lack of records for
determining administrative eligibility and showing
that a family member was actually onsite. So let me
tackle your -- the health thing first. So
for instance --

DR. BREYSSE: Brady, I think we need to speed
this up. If there are some questions, Chris, I
think that you have, maybe we can handle that by
e-mail or something that's in detail that...

MR. ORRIS: I'm asking some of these questions
so that the people watching can know what they need
to do. I mean, I'm looking at the numbers and we
were talking last night and our people have thought
-- and he's seeking them in answering these
questions --

MR. WHITE: Maybe I can speed things along.

MS. STEVENS: Yeah, I think one of our problems
is we've got folks that leave around 3:00, 3:30, so
we need to move forward with our agenda.

DR. BREYSSE: Go ahead. Maybe you can speed
up --

MR. WHITE: Okay, so on the family member side,
what we've done is if a family member has cancer,
one of those eight or nine cancers, we're making the
assumption that it was caused by the exposures. One of the other conditions, that's where on the form, the treating physician form, we ask for other medical documents, and the reason we do that, I know you had questions about that, the reason we do that up front is we want to make sure we try to speed the process up. Rather than, you know, getting the application and going back to the family member and asking for the documents, if we can get those up front, then our folks that we partner with over in -- under Dr. Erickson, make that connection.

But you're right. So we've had 77 determined eligible for both administrative and clinical, and it's a pretty low number, out of the 700 or so that we've received, 716, that we've received. A lot of those are administratively eligible; they just haven't supplied the medical docs to show that they've got one of the 15 conditions.

And then this is a new number. We have a call center that's dedicated to Camp Lejeune family members, that if they call, they should be able to get their questions answered. And we also have a website that, when we rolled out in October, one of my fears was it could turn into the Affordable Care Act, and how that was rolled out. And thank God,
everything worked. So we're continuously trying to improve it.

The reason for bill denials, this is kind of in descending order. The main reason is it was previously paid by their other health insurance, and they did not have any responsibility for charges. That’s the number one reason for denials. Or they did not submit OHI explanation of benefits that showed that -- we know they had other health insurance, but for whatever reason, they didn't submit the bill showing what their other health insurance paid. And then maybe wrong diagnostic code on there, that it was not for one of the 15 covered conditions, maybe it was a duplicate bill or it was outside of the service dates.

Communications, we've spent a lot of time on this but we've tried. I know OPH has tried on their side, and we tried on our side as well as far as doing some outreach. Mike, you mentioned, and it's not -- we need to do a better job of coordinating that. I know we have used the Marine Corps' database, and sent out letters. And I added my name to it to make sure it was done, to let them know our program is up and running.

And then we've also reached out to the VSOs,
but I don't think there's much traction with that, for some reason. You know, the VA has got an official VSO representative, and I know that they've reached out through that means. And maybe if you guys could help me put some pressure on them to help get the word out, that'd be great.

And this is just some enhancements that we've done. I won't spend a lot of time on these in the interest of time but -- and you guys will have access to this afterwards.

And some of the accomplishments. One of the key things here is the second bullet from the bottom. We didn't anticipate that this was going to be a really large program, initially. But one of the things we knew would help family members would be if we can have this pharmacy benefits manager, which basically -- especially if we're first payer, like if they don't have other health insurance, they go through a pharmacy to get the drugs for, you know, whatever, and some of these cancer drugs can be pretty expensive. Until we get this pharmacy benefits manager in place they have to pay for that up front, and then submit a bill that -- as soon as we get this in place, and it should be any day now, they can go through the pharmacy, show them their
card, and then have us pay for those drugs up front. So that's going to be a great benefit. So any questions?

**MS. FRESHWATER:** I have a question that someone just wrote and asked me to ask you. If a person is eligible both as a veteran, and then later as a military dependent living on base, they would be fully eligible under both categories. And you're saying they get VH care at the local clinic; however, they live 84 miles one way from the nearest oncologist, so they go to a civilian doctor. They've earned both benefits. So I think the question in there is how do you apply for both benefits? Is there -- you know, can you just kind of shed some light on that?

**MR. WHITE:** Yeah. We haven't actually encountered that yet. And again, I'm kind of new to the veteran side of the house. But I believe that they would be covered under maybe the Choice Act. You guys are familiar with the Choice Act? If they do not live within 40 miles of a VA medical center -- it used to be as the crow flies but they recently changed that -- or with more than a 30-day wait, then they can go see a whatever, a private physician. And there's a lot more criteria for
that.

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

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

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

MR. WHITE: Yeah.

MS. FRESHWATER: That's good to know.

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

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

Just so you know, last night and right now as we're speaking, this is being broadcast live on our
website. We had 167 hits last night of people watching in so that was -- that's good news.

**MR. WHITE:** Yeah, and if you guys want to invite me back, I've got money in my budget. I put it in there to come back each quarter if you need me to.

**MS. FRESHWATER:** I would like to officially invite you.

**DR. BREYSSE:** There's not a charge for an official invitation.

**MR. WHITE:** I think you were too nice, only at first. But next time I'll be prepared.

**DR. BREYSSE:** All right, if no further questions, again, I want to thank the VA folks for coming.

And the last segment, part of the agenda is the CAP updates and feedback. So we'll turn the floor over to the CAP.

**CAP UPDATES AND CONCERNS**

**MR. PARTAIN:** Well, what about audience questions? Do we have time for that too? Does anyone in the audience have questions?

**MS. FRESHWATER:** There are a few people.

**MS. STEVENS:** It's dependent on your CAP updates.
MR. PARTAIN: Okay. I think we covered -- I know I covered what I had during the meeting so I'm good.

DR. CLAPP: I'd like to, if I could, just take a minute and comment on Dr. Heaney. I know she's not on the phone, but the methodology that she was describing is inconceivable to me.

I used to teach students that were getting their master's in public health to become doctors like her, and we never taught anything like what the system was that she was describing. It seems totally subjective to me. So I didn't get a chance to say that earlier today, but I was sort of shocked by what I heard.

DR. BREYSSE: Ken?

DR. CANTOR: Yeah, it's a -- it's ancillary to this topic, and that is that Lori raised the question about how the SMEs are selected, or who selects the SMEs. I wonder if we could also see the criteria that these selections are -- that the selections are based on, because a certain amount of training and expertise of course is required for this, and it would be good to have that transparency, so I feel it’s worth asking for.

MR. ORRIS: I would also like to get an update
from the Department of the Navy regarding Building 133. I want to hear at the next meeting whether you have abated the vapor intrusion that is ongoing at that building and also what kind of notification you gave, because it's my understanding that that is a school. And I want to make sure you have notified each of the people who might have attended class or worked at that building.

**MS. FRESHWATER:** Sheila, are you involved in helping Kevin get Willie on the phone?

**MS. STEVENS:** Yeah. Well, the thing is we just have to -- is there anybody on the phone right now? Willie, are you on the phone?

**MR. WILKINS:** You might want to ask him to go ahead and call in, Sheila.

**MS. STEVENS:** Can you call him? I don't have his phone number.

**MS. FRESHWATER:** No. Willie, call, call in. Well, he's in a nursing home and this is a story that needs to be heard. He's --

**MS. STEVENS:** I mean, I don't have his -- you'll have to call him because --

**DR. BREYSSE:** No, he can hear you.

**MS. STEVENS:** Oh, he can hear us?

**MS. FRESHWATER:** So Willie, call.
MR. WILKINS: Does he need to put that PC in for passcode or just the number?

MS. STEVENS: Yeah, he needs to put the PC in.

MR. WILKINS: Well, tell him. Tell him how to call you.

MS. STEVENS: Willie, if you're on, if you can hear us right now, if you call the phone number you get, and then you'll have an operator call in and says to provide a passcode. You put the passcode in and just shout out and say you're on the line.

MS. FRESHWATER: So I would like to have audience questions. I don't have any more -- anything else to say.

MR. WHITE: While we're waiting for him, there was a question that was handed to me I neglected to answer. Does the income guidelines for VA healthcare also pertain to those veterans with a link to medical condition respective to Camp Lejeune? So that gets to the Priority 6 group. So based on income, if you're a Priority 8 group, now you would get knocked up to the Priority 6 group.

DR. BREYSSE: There's some microphones being passed around to the back while we're waiting for Willie.

MS. HOUK: My name is Sharon Houk. And I spoke
last night, but I'm a Marine. I have a question for the VA first. If you are -- you go and you get established as a Camp Lejeune-exposed veteran, then it takes a while, and then they'll come back and say you have a primary care doctor. You go see that doctor.

Well, I've been waiting almost two years and mine still says nonservice-connected on every document that I get from the VA. And so the statistics that they had of the affected Marines who are taking advantage of it, am I included in there, since I'm not service-connected or are there thousands of people still in limbo? Is there anybody still from the VA?

DR. BREYSSE: Unfortunately I think Brad probably was the person to answer that.

MS. HOUK: And also is there anything that can be done on us, as we're alive or after we're deceased, that can show -- is there any evidence, epidemiology or an autopsy, is there anything that can ever positively show that you were exposed and that that caused it? 'Cause, I mean, we're all basing it on water modeling and what happened 30 years ago. Is there no evidence at Camp Lejeune, no skin tissues or biopsies --
MS. FRESHWATER: Let me just tell you, with the VA question, since Brad isn't here, you can email the CAP gmail account, and I'll pass it along and get an answer.

MS. HOUK: Well, that was really for the scientists.

MS. FRESHWATER: No, I'm saying the first question. I just want to clear about that, okay? I'll follow up.

MS. HOUK: Okay.

DR. CANTOR: Yeah, the answer, the answer's no. It's clear, it's just in rare types of environmental exposures, and you mentioned asbestos people, that would be one where there might be evidence, either late in life or under autopsy, that that exposure had occurred. Even in the case of arsenic, for example, which we know causes a number of different cancers, there's no evidence other than the epidemiologic evidence, which is powerful, overpowering, that something -- that that caused the disease. But in the case of these solvents that metabolize very quickly, the damages occur, and the damage is what the evidence is, basically.

MS. HOUK: That's why it's so hard when you try to prove your case -- and I guess my other
question's for the VA also, but that people do the research and provide that research that they submit their time as much as you can possibly have, provide that so there aren't as many questions on the other end.

DR. BREYSSE: Yes.

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

The second statement that I share with you, as a dependent I have been trying to register with the family member program. I have found that to be a
fairly good process. I've probably been at it for about 90 days. I actually went online and registered. I got a letter back within 30 days telling me that they needed some additional information, which I have since sent. I have just recently sent some more information, but I have found the people to be very nice. When you call them a real live person answers the phone. You don't have to push any buttons. You don't have to be on hold for 30 minutes. They answer the phone. They pull up your case on a computer. They can talk to you; they know what you're doing. So I know the VA's been getting sort of a bad rap but that program looks to me like it's working.

**DR. BREYSSE:** Fantastic.

**MS. WELLS:** My name is Denise Wells. I live here in Greensboro now.

**DR. BREYSSE:** Thank you. And I think we have somebody on the line now.

**MR. WHITE:** Thank you for sharing that. I appreciate it.

**DR. BREYSSE:** We have somebody on the line, Sheila? Are you there, Willie?

**MS. STEVENS:** Willie, can you say something?

**MR. COPELAND:** Yes, I'm here.
DR. BREYSSE: All right. Willie, we can hear you. Go ahead and tell us what you have to say, please.

MR. COPELAND: My name is Willie Copeland. I was stationed at Lejeune from March of '83 to September of '85. After the Marine Corps I started working in law enforcement.

In 2003 I had to quit work from kidney failure. My kidneys \* M \* My teeth started to rot and fall out, and I just got progressively worse. And in December of 2011, the VA amputated both my legs above the knee, and never told me anything about Camp Lejeune and the water. I asked about living in a nursing home, a VA nursing home. They said I wasn't eligible.

Eventually I'm a total care patient, bed-ridden. \^ I'm going to need dialysis soon, or a kidney transplant. But I'm bed-ridden at a nursing home, and with no help from the VA and not anyone at the government VA, when I told them about Camp Lejeune, they looked like they don't know what I'm talking about. And I mean, I'm just -- nothing. And you know this stuff that's going on. When I asked -- I was 47 when my legs amputated. And the government VA did all of my medical work and they
told me nothing about the contaminated water at Camp Lejeune. And so now I'm in a private nursing home. You know, I just would like for somebody to tell me why the government VA didn't say something about Camp Lejeune or give me any kind of information.

**DR. BREYSSE:** Okay, thank you very much. So is there something you can ask, you know, from the VA, concerning -- as I understood it was serious health concerns, a veteran with service experience, and nobody at the VA connected the Camp Lejeune with his possible health conditions.

**MR. DEVINE:** If somebody can help me with his personal information, I can try and track that down --

**MS. FRESHWATER:** And is he saying he was denied -- he's trying to get it. Since then he's been denied.

**MR. WILKINS:** He tried to get into a VA nursing home, and he's in a county home.

**MR. ENSMINGER:** Well, he's also -- had filed for service connection, and he's been denied.

**DR. BREYSSE:** So Willie, there's a representative from the VA here who asked for your name and --

**MR. ENSMINGER:** Contact information.
DR. BREYSSE: -- and contact information. We'll get that to him and he'll be reaching out to you.

MR. WHITE: Could you make sure I get that also? The State home program is actually under our directorate. So it sounds like he needed some help getting to --

DR. BREYSSE: So Lori, can you make sure they get the name and contact information?

MS. FRESHWATER: Yeah. We'll follow up on all that. Sorry Willie, go ahead.

MR. COPELAND: Would you like the information now?

MS. FRESHWATER: No. Don't say it now because it's being broadcast so --

DR. BREYSSE: You can tell the whole world how to get in contact.

MS. FRESHWATER: You'll probably be getting a lot of fan mail.

MR. ENSMINGER: He'd probably be glad to have it.

MS. FRESHWATER: But Willie, I just want to say that all of us on the CAP have been really greatly affected by your story, and really appreciate your service, and we're going to work to do everything we
can to help you out.

MR. COPELAND: I really appreciate it. I'm glad that I met someone that you know, put in the nursing home and forgotten about.

MS. FRESHWATER: We have one more over here.

MR. KAISS: Yes, my name is Joseph Kaiss. I'm from Augusta, Georgia. While this wasn't going to be part of my initial question, in regards to Willie, and God bless him, when I went to the VA to initially file my claim, it wasn't specifically a VA representative, but it was someone who must have been contracted. They're on the second floor of the VA hospital, I believe it was veteran services, the woman told me that she didn't know how to file my claim, that I would have to check the other Marines that I knew from Camp Lejeune over 20-plus years ago to find out whether or not I had or they had like and kind diseases as myself. So we had to file on our own. I mean, that was pretty much ridiculous.

But my actual question that I wanted to state was that, I guess it goes back to the first question, the lady that asked the first question. You stated that there's nothing that can be done. I think she was --
towards a postmortem thing. I have, when I filed my claim, and like I said last night, I was denied last August 8th. I have a nexus letter from my board-certified oncologist, and from what I heard today from the SME, understanding the perspective of some of the board members here regarding her statements and her perspective, her position, it seemed like they were almost irrelevant to the system because the oncologist diagnosed and treats me, and the SME's perspective was, well, they're not qualified to determine anything beyond that. They have their area of expertise; we have our area of expertise, and they don't crisscross. I'm sure my oncologist would love to have a conversation with that woman.

But my question is, is there a specific field, if I am financially able to do so, if I have to pay a few thousand dollars out of my own pocket, which I think is ridiculous, but is there a specific doctor or a field of study that I need to go to that will establish a credible link that will satisfy what we -- from what we heard today, what the VA is looking for? If nothing else, my cancers were colorectal cancer, and I'm in Stage IV cirrhosis, of which I was denied on both. The only thing the VA
accepted was the fact that, yeah, they contaminated me. If I have to be that first person to establish a link, so be it. But who is it that I need to go to, from what we heard today, to get some kind of credible evidence that it sounds like the VA is going to accept? 'Cause obviously my oncologist didn't work.

**DR. BREYSSE:** Well, I think what we talked about last night and this morning, Dr. Heaney is board certified in occupational environmental medicine. The clinics we talked about this morning, the -- I can't remember the --

**DR. CLAPP:** The occupational environmental health clinics?

**DR. BREYSSE:** Yeah, the AOEC -- If you go to AOEC -- I'm searching on the web to see occupational environmental health clinics. I think if you got a work up by one of those doctors, they'd at least have the same credential that Dr. Heaney has. So in terms of having a physician that -- you know, if the argument is that an oncologist isn't prepared to make an association between an environmental risk factor and a disease, you know, that may or may not be true, but certainly a physician who is similarly board certified as one of the experts that the VA's
using, might be the kind of evidence that you're
going to need to help with that claim.

MR. KAISS: All right. Thank you.

MR. PARTAIN: And if you do reach out to
someone like that, let us know what happened, and
also --

MR. KAISS: I'll let the world know.

MR. PARTAIN: And if there's any fees that they
charge, I'd like to know the cost of those fees too.

MR. KAISS: I'll let the world know that too.

DR. BREYSSE: I have a question for the general
public. How did you hear about this meeting? We
had a nice turnout last night. If we have a meeting
in Florida, it'd be nice to get a sense for what was
effective in reaching you and how'd you find out
about it and what brought you up here, so that we
know we can do a better job next time and build on
what worked. There's a microphone coming around.
Just raise your hand.

UNIDENTIFIED SPEAKER: I got an email from the
Marine Corps.

DR. BREYSSE: Okay.

UNIDENTIFIED SPEAKER: My brother received an
email, I believe, from your organization, and he’s
on a registry that you have. And I didn't, and I am
on the registry for the Marine Corps.

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

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

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

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

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

UNIDENTIFIED SPEAKER: I am just lucky to know someone on the CAP, Lori Freshwater. I did not see either an email or internet or articles, anything else. She invited me on Facebook to the event, and
I spoke around; I’ve got a couple of my buddies watching on the live stream. But otherwise I had no idea about today.

**DR. BREYSSE:** Great.

**MR. PARTAIN:** With that note, the notification part of it, you mentioned the Marine Corps and what have you. In 2009 we had the NRC report and the Marine Corps distributed that report, basically saying there's nothing here, move along, you know, we can't prove anything, to all the families and members on their registry.

And, you know, I'm hearing some people didn't get emails from the Marine Corps; some people did. We were told that the Marine Corps sent out notifications. I'm not going to debate that there but, you know, I would like to see, as a member of CAP, for ATSDR to request custodianship of that registry and to set up a formal registry so there is no bias or no -- I mean, in the past it's been used as a tool to disseminate the Marine Corps' point of view to the families and to the Marines. And I'd rather see it in a more objective venue and custodialship.

**DR. BREYSSE:** So as Frank said that's not -- that's more of a mailing list than a registry. We
would need something different from that.

    MR. PARTAIN: Well, let's create one, give
people a place to go. That's what we need. I mean,
I've said it several times during the meeting today.

    MS. STEVENS: So with that, I'm going to
just -- Lori asked me to let people know how to
contact CAP members. There's three different ways
if you want to get a hold of everybody in the CAP,
and the first one is an email and it's the
 samplejeunecn@gmail.com.

    DR. BREYSSE: And no spaces, just three words.

    MS. STEVENS: Yeah. samplejeunecn@gmail.com.
The next one is a Twitter account, and it's
basically @amplejeune, @amplejeune. And then if
you go to Facebook, you can find, just search for
Camp Lejeune and it'll be right there.

    MS. FRESHWATER: No, Camp Lejeune CAP.

    MS. STEVENS: CAP. Sorry, Camp Lejeune CAP.

    MS. FRESHWATER: And the icon is a Newsweek
cover with the Marine.

    MR. PARTAIN: Toxic Marine.

    MS. STEVENS: The toxic Marine.

    MS. FRESHWATER: And I just want to say that I
know a lot of the people on Facebook who can't
travel, who are in the groups, did a lot to get
people watching online. And I just wanted to thank them, because they do -- they work hard too. They just can't make it to the meeting.

DR. BREYSSE: Great. So we're at 15 minutes past. Morris?

MR. MASLIA: I've done a fair amount of Facebook notification for my cycling, okay, and one of the things, and I don't know if we're doing this, but you can actually proactively advertise on Facebook. You can spend $5 a day or whatever, and just the -- give you an example, for my cycling group, we had an event. I put $5 a day for three days, and it went -- and I can tell them what area of the country I want to do it. Within 24 hours they had already notified over 1,500 people, where it had reached over 1,500 people. So that is, rather than just passively seeing who your friends are, we may want to look at actually actively promoting the event through a dollar amount or so many days before the meeting.

MS. FRESHWATER: Morris, did that translate into real life? Because I paid 20 bucks out of my pocket to boost one of the posts about the meeting for Camp Lejeune, for a CAP account. And it said that we had reached thousands of people but I don't
know if that really translated to --

MR. MASLIA: Well, we got a number of people actually contacting me about this particular event.

MS. STEVENS: Okay. What we'll do is as we get close, like we did last time, we'll have a committee talking about ways to do outreach. Thank you.

MR. MASLIA: It was just a suggestion.

MS. STEVENS: Well, you're on the committee, Morris.

MR. MASLIA: Well, you'll have to put up with my cycling and food pictures.

WRAP UP/ADJOURN

DR. BREYSSE: So since we're passed time, we have a number of action items that we would normally review. I want to propose this. We'll summarize them and send them around, and have everybody comment. The purpose of doing that is to make sure we didn't miss anything or everybody was onboard with that. To be honest, in the past that has not been a big problem. So we'll summarize and send those around, and if you think something was missed, respond and we'll try and get a clean final list for all the participants to react to the next time we get together in August. And again, our next meeting is August --
MS. STEVENS: 27.

DR. BREYSSE: -- 27th in Atlanta?

MS. STEVENS: August 27th in Atlanta. We'll have it on our website. Some of you got little cards. It'll be on the website. Because it's in Atlanta, it's on a federal -- on federal property, you are required to register. The only purpose of the registration is to give your name. I'll give it to our security guards to make sure that you can get on our installation. So that's August 27th.

DR. BREYSSE: All right, and so with that I'd like to again thank all the CAP members for helping us out with this important work. Thank the VA, and I think we heard some pretty encouraging new steps that the ATSDR and VA can take with respect to some of the issues we have dealt with. And again, I'm looking forward to moving those forward.

I'd like to thank the Marines, the Department of Defense for being here as well, and thank the public and I'd like to thank everybody who was listening in. It's a great CAP meeting, and we'll see you at the end of August.

MS. FRESHWATER: Thank you and thank Sheila.

MR. PARTAIN: And we would like to actually see the Marine Corps here.
(Whereupon the meeting was adjourned at 2:48 p.m.)
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