

Exhibit 511

Expert Report of Lisa A. Bailey, Ph.D.

In the Case of: Cometto Davis v. United States

Prepared by



Lisa A. Bailey, Ph.D.

Prepared for
United States Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530

April 8, 2025



GRADIENT

www.gradientcorp.com

One Beacon Street, 17th Floor
Boston, MA 02108
617-395-5000

Table of Contents

	<u>Page</u>
1	Qualifications 1
2	Introduction and Executive Summary 2
2.1	Executive Summary..... 2
3	Methodology..... 9
3.1	General Methodology..... 9
3.2	Introduction to Toxicology..... 10
3.3	Introduction to Human Health Risk Assessment..... 10
3.3.1	Dose-Response Assessment 11
3.3.1.1	Derivation of Cancer Toxicity Criteria..... 11
3.3.2	Exposure Assessment 13
3.3.2.1	Calculations for the Mess Hall Duty Inhalation Exposure Pathway 15
3.3.3	Risk Characterization for Cancer Health Effects 15
3.3.3.1	Cancer Toxicity Criteria Are Used to Estimate the Excess Lifetime Cancer Risk (ELCR) in a Population 16
3.3.3.2	Cancer Risk Calculations 16
3.4	The "Linear No-Threshold" Model and the Concept of "No Safe Dose" for Carcinogens..... 18
3.5	Regulatory Toxicology and Risk Assessment vs. Risk Evaluation to Assess Potential Causation 20
3.6	Margin of Exposure Estimates 21
4	Brief History of the US Marine Corps Base Camp Lejeune Site 23
4.1	Site Description and History 23
4.2	Investigations of Groundwater Contamination..... 23
5	Hazard Assessments and Toxicity Criteria 25
5.1	Hazard Assessments 25
5.1.1	Trichloroethylene (TCE) 25
5.1.2	Tetrachloroethylene (PCE)..... 25
5.1.3	Benzene..... 26
5.1.4	Vinyl Chloride..... 26
5.1.5	<i>trans</i> -1,2-Dichloroethylene (1,2-tDCE) 27
5.2	Toxicity Criteria 27
5.2.1	Trichloroethylene (TCE) 27

5.2.2	Tetrachloroethylene (PCE)	29
5.2.3	Benzene.....	30
5.2.4	Vinyl Chloride	30
5.2.5	<i>trans</i> -1,2-Dichloroethylene (1,2-tDCE)	32
6	Plaintiff-Specific Regulatory Risk Evaluation	33
6.1	Plaintiff Background.....	33
6.2	Plaintiff Exposure Estimates	33
6.3	Regulatory Risk Calculations	35
6.4	Risk Evaluation Conclusion	38
7	Plaintiff-Specific Margins of Exposure	40
8	Consideration of Epidemiology and Animal Studies Relevant to NHL	41
8.1	TCE	41
8.2	PCE	42
8.3	Benzene.....	42
8.4	Vinyl Chloride.....	43
8.5	1,2-tDCE	43
8.6	Conclusions from Epidemiology and Toxicology Studies.....	44
9	Rebuttal of the Plaintiff's Experts' Reports.....	45
9.1	Dr. Reynolds	45
9.2	Dr. Hoppe	46
10	Conclusion and Summary of Opinions.....	48
	References	49
Appendix A	<i>Curriculum Vitae</i> Lisa A. Bailey, Ph.D.	
Appendix B	Testimony Experience of Lisa A. Bailey, Ph.D.	
Appendix C	Materials Considered	
Appendix D	Plaintiff Risk Calculations	
Appendix E	Point of Departure (POD) Derivations for Trichloroethylene (TCE) and Vinyl Chloride	

List of Tables

Table 5.1	US EPA TCE Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])
Table 5.2	US EPA TCE Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])
Table 5.3	TCE Toxicity Criteria Applied in the Risk Calculations
Table 5.4	US EPA PCE Oral Cancer Toxicity Value (Cancer Slope Factor [CSF])
Table 5.5	US EPA PCE Inhalation Cancer Toxicity Value (Inhalation Unit Risk [IUR])
Table 5.6	PCE Toxicity Criteria Applied in the Risk Calculations
Table 5.7	US EPA Benzene Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])
Table 5.8	US EPA Benzene Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])
Table 5.9	Benzene Toxicity Criteria Applied in the Risk Calculations
Table 5.10	US EPA Vinyl Chloride Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])
Table 5.11	US EPA Vinyl Chloride Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])
Table 5.12	Vinyl Chloride Toxicity Criteria Applied in the Risk Calculations
Table 6.1	Excess Lifetime Cancer Risks (ELCRs) by Exposure Pathway for the Plaintiff
Table 6.2	Excess Lifetime Cancer Risks (ELCRs) for Benzene, Tetrachloroethylene (PCE), and Trichloroethylene (TCE)

List of Figures

- Figure 3.1 Dose-Response Curve
- Figure 3.2 Approach for Cancer Slope Factor (CSF) or Inhalation Unit Risk (IUR) Development
- Figure 3.3 Linear No-Threshold (LNT) vs. Threshold Models
- Figure 3.4 Linear No-Threshold (LNT) vs. Threshold Model Extrapolations from the Point of Departure (POD)

Abbreviations

$\mu\text{g}/\text{m}^3$	Micrograms per Cubic Meter of Air
$(\mu\text{g}/\text{m}^3)^{-1}$	Per Micrograms per Cubic Meter of Air
1,2-cDCE	<i>cis</i> -1,2-Dichloroethylene
1,2-tDCE	<i>trans</i> -1,2-Dichloroethylene
ACS	American Cancer Society
ADAF	Age-Dependent Adjustment Factor
AT	Averaging Time
ATSDR	Agency for Toxic Substances and Disease Registry
BMD	Benchmark Dose
BMDL	Lower Confidence Limit on the Benchmark Dose
CLL	Chronic Lymphocytic Leukemia
CSF	Cancer Slope Factor
CTE	Central Tendency Exposure
DEC	Daily Exposure Concentration
DED	Daily Exposure Dose
ED	Exposure Duration
EF	Exposure Frequency
ELCR	Excess Lifetime Cancer Risk
ET	Exposure Time
EV	Events During Exposure Duration
HB	Holcomb Boulevard
HP	Hadnot Point
IARC	International Agency for Research on Cancer
IUR	Inhalation Unit Risk
L	Liter
LADD	Lifetime Average Daily Dose
LADE	Lifetime Average Daily Exposure
LED	Lower Confidence Limit of the Exposure Dose
LNT	Linear No Threshold
MCL	Maximum Contaminant Level
MoE	Margin of Exposure
$\text{mg}/\text{kg}\text{-day}$	Milligrams per Kilogram Body Weight per Day
$(\text{mg}/\text{kg}\text{-day})^{-1}$	Per Milligrams per Kilogram Body Weight per Day
NHL	Non-Hodgkin's Lymphoma
NRC	National Research Council
NTP	National Toxicology Program
PBPK	Physiologically Based Pharmacokinetic
PCE	Tetrachloroethylene/Perchloroethylene
POD	Point of Departure
ppb	Parts per Billion
ppm	Parts per Million
RAGS	Risk Assessment Guidance for Superfund
RME	Reasonable Maximum Exposure

SD	Standard Deviation
SDWA	Safe Drinking Water Act
TCE	Trichloroethylene
TSCA	Toxic Substances Control Act
TT	Tarawa Terrace
US DOJ	United States Department of Justice
US EPA	United States Environmental Protection Agency
WoE	Weight of Evidence
WTP	Water Treatment Plant

1 Qualifications

I am a Principal at Gradient, an environmental and risk sciences consulting firm that specializes in toxicology, epidemiology, risk assessment, and other disciplines. I have more than 25 years of experience in toxicology and human health risk assessment. I received my Ph.D. in biochemistry from the Massachusetts Institute of Technology in 1996, and I was a post-doctoral fellow at the Harvard School of Public Health from 1996 to 1999. I have expertise in toxicology, molecular biology, genetic toxicology and mutagenesis, mechanisms of carcinogenesis, weight-of-evidence (WoE) evaluations and systematic review, and risk communication.

My expertise in WoE evaluations includes systematic review and in-depth evaluation and integration of all data relevant to a particular chemical and its potential association with human disease (*i.e.*, toxicokinetics data, animal toxicity data, epidemiology data, mechanistic data, and human exposure data). I have conducted in-depth WoE evaluations of many chemicals and have published several papers describing the results of my analyses.

I also have expertise in conducting human health risk assessments for environmental, consumer product, and occupational exposures. In order to assess whether exposure (*via* inhalation, dermal contact, or ingestion) to a particular substance may be associated with potential human health risk, both hazard and exposure (including the level, duration, and frequency of exposure) need to be considered, and only when the two combined are sufficient to cause disease in humans is there cause for concern. Therefore, my expertise in human health risk assessment consistently involves in-depth evaluation of the potential hazards of chemicals in addition to consideration of the extent to which humans are exposed to the chemicals of concern in the environment, consumer products, or the workplace.

I have authored many peer-reviewed articles and book chapters in the field of human health risk and toxicology and have presented my scientific findings and analyses at conferences, to community groups, and to regulatory agencies. I am also a full member of the Society of Toxicology and the Society for Risk Analysis.

Gradient is currently being compensated at the rate of \$595 per hour for my work in this matter. My *curriculum vitae* is attached as Appendix A. My testimony experience is attached as Appendix B. Appendix C lists all the materials I considered in the preparation of this report.

2 Introduction and Executive Summary

This report was prepared at the request of the United States Department of Justice (US DOJ). As part of my engagement in this case, I have been asked to review materials relevant to the case *Cometto Davis v. United States* and to develop opinions related to whether there is scientific support for the plaintiff's claim that exposure to chemicals in tap water (trichloroethylene [TCE], tetrachloroethylene [also known as perchloroethylene (PCE)], vinyl chloride, benzene, and *trans*-1,2-dichloroethylene [1,2-tDCE]) while employed and residing at Camp Lejeune is causally associated with the plaintiff's non-Hodgkin's lymphoma (NHL) diagnosis.

My report includes:

- An executive summary (Section 2.1);
- An overview of the general risk assessment methodology I applied to evaluate risk for the plaintiff (Section 3);
- A brief discussion of the history of the Marine Corps Base Camp Lejeune Site (Section 4);
- Hazard evaluation summaries (based on the expert report by Dr. Julie Goodman [2025]) and summaries of the regulatory toxicity criteria used to calculate risks for TCE, PCE, vinyl chloride, benzene, and 1,2-tDCE (Section 5);
- A plaintiff-specific risk evaluation, based on exposure information provided in the expert report by Dr. Judy LaKind (2025) (Section 6);
- A comparison of the estimated exposures for the plaintiff to exposures from the animal or human studies that are the basis of the chemical-specific toxicity criteria (Section 7);
- A comparison of the estimated exposures for the plaintiff to exposure information from relevant epidemiology or animal studies (Section 8);
- A rebuttal of the plaintiff's experts' reports (Section 9); and
- A summary of my opinions related to the plaintiff's claim that exposures to chemicals in tap water while employed/residing at Camp Lejeune are related to the plaintiff's diagnosis (Section 10).

2.1 Executive Summary

Section 3 of this report provides a discussion of the general approach to toxicology and risk assessment and regulatory risk assessment guidelines.

- Toxicology is the study of health effects resulting from exposure to chemical, biological, or physical agents. One of the most fundamental concepts in the field of toxicology is the dose-response relationship; dose is the amount of a chemical to which an organism is exposed, and a response is the effect on the organism resulting from the chemical exposure. A dose-response relationship occurs when the chemical exposure and the effect are correlated, and the effect (response) increases directly with increased exposure (dose). For most chemicals, biological effects (with a dose-response relationship) occur only when the dose exceeds a certain exposure level for a sufficient period of time. It is common for dose-response data from toxicology

investigations to be used in risk assessment, which is a tool used to predict adverse health effects based on knowledge of the effects of chemicals and exposures.

- Human health risk assessment is the systematic process of characterizing potential adverse human health effects resulting from exposure to environmental chemicals. Risk assessment generally involves four steps:
 - **Hazard Identification:** Identify the potential hazard (*i.e.*, determine whether a particular chemical is causally linked to any health effects).
 - **Dose-Response Assessment:** Determine the relationship between the nature and magnitude of exposure to the hazard and the probability of a health effect occurring.
 - **Exposure Assessment:** Estimate the level of human exposure to the hazard.
 - **Risk Characterization:** Compare the estimated human exposure level of concern to the dose-response assessment for the chemical and characterize the comparison as a risk estimate, then assess the magnitude of uncertainty in the risk estimate.
- The United States Environmental Protection Agency (US EPA) has derived toxicity criteria for many chemicals based on its **hazard and dose-response assessments** of those chemicals.
 - Toxicity criteria are quantitative estimates of risk of the adverse health effects associated with a given chemical exposure level. Toxicity criteria are typically derived from observations of chemical exposures and health effects reported in epidemiology or animal studies, and are conservatively based on the most sensitive endpoint reported in the health effect studies (*i.e.*, the health effect occurring at the lowest exposure level). They are also designed to be protective of the most sensitive populations (*e.g.*, children and the elderly). Therefore, US EPA's toxicity criteria reflect conservative estimates of the relationship between exposures and health effects (*i.e.*, overly protective assumptions about exposures and health effects), particularly for short exposure durations for healthy individuals in a population.
 - The cancer toxicity criteria derived by US EPA are referred to as the cancer slope factor (CSF), which is used to characterize risk from oral and dermal exposures, and the inhalation unit risk (IUR), which is used to characterize risk from inhalation exposure. These criteria are derived based on the most sensitive cancer endpoint evaluated in the available studies. CSFs are described as risks per milligrams per kilogram body weight per day (or $[\text{mg/kg-day}]^{-1}$). IURs are described as risks per microgram per cubic meter of air (or $[\mu\text{g/m}^3]^{-1}$). For example:
 - ▶ A CSF of $0.01 (\text{mg/kg-day})^{-1}$ is equivalent to a risk of 1 in 100 or 1% (1 cancer case in 100 people exposed) from exposure to 1 milligram per kilogram body weight per day (mg/kg-day) of a chemical over a lifetime (70 years) of oral or dermal exposure.
 - ▶ An IUR of $0.01 (\mu\text{g/m}^3)^{-1}$ is equivalent to a risk of 1 in 100 or 1% (1 cancer case in 100 people exposed) from continuous exposure to 1 microgram per cubic meter of air ($\mu\text{g/m}^3$) of a chemical over a lifetime (70 years) of inhalation exposure.
- In the **exposure assessment** step in the risk assessment, daily oral or dermal doses of a chemical taken into the body, averaged over the appropriate exposure period, and expressed in units of mg/kg-day are estimated for an individual. Similarly, inhalation exposure concentrations, averaged over the appropriate exposure period, and expressed in units of $\mu\text{g/m}^3$ are estimated for an individual.
- In her expert report (LaKind, 2025), Dr. LaKind describes the daily exposure doses (DEDs) for oral and dermal exposures and daily exposure concentrations (DECs) for inhalation exposures calculated for the plaintiff for each chemical. Using the plaintiff-specific DED and DEC estimates from Dr. LaKind (2025), the exposure frequency (how often exposure occurs, in terms of days per

year), and exposure duration (how long the exposure was, in terms of years), for the plaintiff, and an averaging time (the period over which the exposure is averaged) of 70 years, or 25,550 days (consistent with US EPA regulatory guidelines for cancer risk estimates), I calculated the plaintiff's lifetime average daily doses (LADDs) for oral and dermal chemical exposures and the lifetime average daily exposures (LADEs) for inhalation chemical exposures for the plaintiff.

- I calculated the plaintiff's LADDs as follows:

- ▶ $LADD = (DED \times EF \times ED) \div AT$, where:

LADD = Lifetime Average Daily Dose (mg/kg-day)

DED = Daily Exposure Dose (mg/kg-day)

EF = Exposure Frequency (days/year)

ED = Exposure Duration (years)

AT = Averaging Time (25,550 days)

- I calculated the plaintiff's LADEs as follows:

- ▶ $LADE = (DEC \times EF \times ED) \div AT$, where:

LADE = Lifetime Average Daily Exposure ($\mu\text{g}/\text{m}^3$)

DEC = Daily Exposure Concentration ($\mu\text{g}/\text{m}^3$)

EF = Exposure Frequency (days/year)

ED = Exposure Duration (years)

AT = Averaging Time (25,550 days)

- In the **risk characterization** step in the risk assessment, the estimated human exposure levels of concern (LADD or LADE, as described above) are combined with the dose-response assessment (toxicity criteria [CSF or IUR]) for each chemical to calculate risk estimates for each chemical and exposure pathway (*i.e.*, ingestion, dermal contact, or inhalation).
- Cancer toxicity criteria are used in regulatory risk evaluations to estimate the incremental risk of developing cancer following a specific chemical exposure, beyond the background cancer risk. US EPA refers to this risk as the excess lifetime cancer risk (ELCR), which is expressed as a unitless probability (*e.g.*, 1 cancer case in 1 million people exposed, or 1×10^{-6}).
 - ▶ US EPA has established a target ELCR range of 1×10^{-6} (1 cancer case in 1,000,000 people exposed) to 1×10^{-4} (1 cancer case in 10,000 people exposed); an exposure that may result in an ELCR that falls within this range, that is calculated using conservative assumptions, is considered acceptable by US EPA (1990, 1991).
 - ▶ To provide perspective on what a target ELCR of 1 in 10,000 or 1 in 1,000,000 means, it is helpful to understand how these risks compare to the overall lifetime probability of being diagnosed with cancer. According to the American Cancer Society (ACS), the lifetime probability of developing any cancer (*i.e.*, background lifetime cancer risk for all cancers combined) is approximately 40% on average across the population (ACS, 2024). Individual risk will vary and is based on a number of different factors, including age, sex, race, lifestyle (*e.g.*, diet, exercise), and family history.
 - ▶ US EPA's acceptable ELCR range of 1×10^{-6} (1 cancer case in 1 million people exposed, or 0.0001% probability) to 1×10^{-4} (1 cancer case in 10,000 people exposed, or 0.01% probability) is well below the background lifetime probability of developing cancer (*i.e.*, ~40% overall in the population) – the equivalent of a total cancer risk range of 40.0001-

40.01%. Therefore, any exceedance of the regulatory cancer risk target should be interpreted carefully, and not be taken to mean that health effects are expected to occur for any particular individual as a result of that exceedance.

- Cancer risk (ELCR) from oral or dermal exposures to a chemical is calculated by multiplying the lifetime oral or dermal dose of that chemical (LADD) by the chemical-specific CSF, as follows:
 - ▶ $\text{ELCR from Oral or Dermal Exposure} = \text{LADD (mg/kg-day)} \times \text{CSF ([mg/kg-day]}^{-1})$
- Similarly, cancer risk (ELCR) from inhalation exposure to a chemical is calculated by multiplying the lifetime inhalation exposure concentration of that chemical (LADE) by the chemical-specific IUR, as follows:
 - ▶ $\text{ELCR from Inhalation Exposure} = \text{LADE } (\mu\text{g/m}^3) \times \text{IUR } ([\mu\text{g/m}^3]^{-1})$
- As an example risk calculation, applying a CSF of $0.01 \text{ (mg/kg-day)}^{-1}$ to an LADD of 0.005 mg/kg-day would result in the following risk calculation: $0.005 \text{ mg/kg-day} \times 0.01 \text{ (mg/kg-day)}^{-1} = \text{an excess risk (ELCR) of } 0.00005 \text{ (or 5 cancer cases in 100,000 people exposed, or } 5 \times 10^{-5}, \text{ or 0.005\%)}$. This ELCR falls within US EPA's target risk range and is considered acceptable by US EPA.

Section 4 briefly describes the history of the Marine Corps Base Camp Lejeune Site. Operations at Camp Lejeune started in late 1941. Multiple water treatment plants (WTPs)¹ have serviced the Camp Lejeune base, including Hadnot Point (HP), Tarawa Terrace (TT), and Holcomb Boulevard (HB). The HP WTP was the first plant to come online in 1942, and serviced the base until the TT and HB WTPs came online in 1952 and in the summer of 1972, respectively (Hennet, 2024). In the early 1980s, the groundwater sources for two of the WTPs that serviced the Camp Lejeune base (HP and TT) were found to be contaminated with volatile organic compounds. Although the groundwater source for the HB WTP was not contaminated, the HB water system was contaminated when its drinking water was supplied by the HP WTP in the spring and summer months from 1972 through 1985 (ATSDR, 2017a). The contaminants identified in the drinking water at the HP WTP were TCE, PCE, vinyl chloride, 1,2-tDCE, and refined petroleum products (including benzene) (ATSDR, 2017a). The contaminants identified in the drinking water at the TT WTP were TCE, PCE, vinyl chloride, and 1,2-tDCE (ATSDR, 2017a).

As summarized in the hazard assessment in Section 5, the Agency for Toxic Substances and Disease Registry (ATSDR), in its "Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune" ATSDR (2017b), concluded that there was "sufficient evidence for causation" for benzene exposure and NHL, "sufficient evidence for causation" for TCE exposure and NHL, and "equipoise and above evidence for causation" for PCE exposure and NHL. ATSDR (2017b) provided no comment on whether there is a causal association between 1,2-tDCE or vinyl chloride exposure and NHL. Overall, as discussed in Section 5, the US EPA, International Agency for Research on Cancer (IARC), and National Toxicology Program (NTP) have concluded that there is suggestive evidence of an association between TCE exposure and NHL, and suggestive but weak evidence of an association between PCE exposure and NHL. Although ATSDR and US EPA generally did not make conclusions regarding the potential association between benzene exposure and NHL, IARC concluded that there is "limited evidence" that benzene exposure causes NHL (see Section 5). Dr. Goodman (2025) concluded that, while there is some evidence for a positive association based on epidemiology studies, the scientific evidence, overall, does not

¹ Hadnot Point (HP), Tarawa Terrace (TT), and Holcomb Boulevard (HB) supplied drinking water to residences and workplaces at Camp Lejeune (see Hennet, 2024). Additional Camp Lejeune water-distribution systems which were not contaminated include: Marine Corps Air Station New River, Onslow Beach, Courthouse Bay, Camp Geiger, Rifle Range, and Montford Point/Camp Johnson (Hennet, 2024).

support a causal association between TCE exposure and NHL. Dr. Goodman also concluded that, overall, the scientific evidence does not provide support for causal associations between exposure to PCE, benzene, vinyl chloride, or 1,2-tDCE and NHL.

Section 5 also summarizes the US EPA toxicity criteria used in the cancer risk evaluation for the plaintiff. The TCE toxicity criteria are based on NHL as one of the most sensitive endpoints. The benzene toxicity criteria are based on leukemia as the most sensitive endpoint, and therefore are overly protective for NHL. Because the scientific evidence does not support, or only provides weak support for, an association between NHL and exposure to PCE or vinyl chloride,² the cancer toxicity criteria for these chemicals are also not based on NHL. Therefore, cancer risk calculations for benzene, PCE, and vinyl chloride are not predictive of, and are overly conservative for, NHL risk from exposure to these chemicals. However, I conservatively apply the criteria for these chemicals to estimate the plaintiff's overall excess lifetime cancer risk.

In Section 6, I calculate cancer risks based on exposure estimates for Mr. Davis. Mr. Davis was stationed at Camp Lejeune from February 1979 through September 1982, and again from December 1982 through June 1985. Mr. Davis lived in the HP barracks from February 1979 through March 1980, and then in Tarawa Terrace residential housing from April 1980 through June 1985 when not deployed overseas (Davis, 2024; McGowan, Hood, Felder, & Phillips, LLC, 2024). In total, Mr. Davis lived in the HP barracks for approximately 1.2 years and at the Tarawa Terrace residences for approximately 5.1 years. Mr. Davis worked as a radio operator, communications chief, and recruiter, but also testified to participating in field training. With respect to water consumption, Mr. Davis testified to consuming between 3.8 to 5.7 liters (L) of water per day. Mr. Davis also testified to showering twice a day, though he did not provide information on the duration of his showers. In addition, Mr. Davis testified that he was assigned to two 30-day rotations of mess hall duty (Davis, 2024).

For my risk calculations, I used TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE exposure estimates for Mr. Davis from tap water (*via* ingestion of drinking water, and *via* dermal and inhalation exposure to shower vapor) calculated by Dr. LaKind (2025) (DED and DEC estimates, as discussed earlier) for the two main areas of concern for groundwater contamination at Camp Lejeune (HP and TT). I combined this information with the regulatory toxicity criteria summarized in Section 5, to conduct a conservative regulatory risk evaluation for Mr. Davis. Risks were calculated for the following exposure pathways and scenarios for the exposure period of concern (6.3 years) for Mr. Davis:

▪ **Baseline Exposure Pathways:**

- Drinking Water Ingestion – For this exposure pathway, because it is not clear that the plaintiff's water ingestion came from only one WTP, I evaluated three scenarios for both the HP and TT WTPs: (1) central tendency exposure (CTE), which assumes ingestion of 1.3 L of tap water per day; (2) reasonable maximum exposure (RME), which assumes ingestion of 3.3 L of tap water per day; and (3) a custom military high-end exposure, which assumes ingestion of 4.7 L per day based on the high-end ingestion rate that Mr. Davis claims.³
- Dermal and Inhalation Exposures from Showering – For these exposure pathways, I calculated risks based on the CTE (50th percentile) and RME (95th percentile) dermal dose and inhalation concentration outputs from both a communal showering facility exposure model and a

² Note that, as discussed in Section 5, US EPA does not consider *trans*-1,2-dichloroethylene (1,2-tDCE) to be carcinogenic. Therefore, there are no cancer toxicity criteria available for 1,2-tDCE.

³ As discussed in Section 6.1, Mr. Davis originally testified to drinking two to three gallons of water per day when in the field, equivalent to an average of 9.5L/day (Davis, 2024). Although, when further questioned about how many times he filled his canteen in the field, Mr. Davis testified that he filled it between eight to ten times after confirming that his canteen held approximately 16 ounces of water (Davis, 2024), for a range of ingestion rates between 3.8L/day and 4.7L/day. Therefore, I considered 4.7L/day as a military high-end ingestion rate.

residential exposure model (ATSDR, 2024a), and based on the plaintiff's locations of residence during his time at Camp Lejeune (HP and TT WTPs for Mr. Davis). The inhalation concentrations from the shower model were provided by Dr. LaKind and are discussed further in her report (LaKind, 2025). Note that the residential shower model accounts for additional household water uses, including appliances, sinks and toilets. The communal shower model also accounts for additional water uses, including sinks and toilets.

▪ **Additional Exposure Pathway:**

- Inhalation from Mess Hall Duty (HP WTP) – For this exposure pathway, I calculated risks based on estimated air concentrations for mess hall worker exposures provided by Dr. LaKind and discussed further in her report (LaKind, 2025). Mr. Davis testified to performing two 30-day stints of mess hall duty, but did not provide further details regarding the specific timing of these assignments, the location(s) of the mess hall(s), or his specific duties in the mess hall. I calculated mess hall duty risks based on water concentrations from the HP WTP and assumed an exposure time of 8 hours per day spent in the dishwashing area and 8 hours per day spent in the pre-rinse area.

▪ **Exposure Scenarios Evaluated for Mr. Davis:**

- The CTE exposure scenario, which includes the following exposure pathways: CTE drinking water ingestion (TT and HP WTPs), CTE dermal and inhalation exposures from showering (HP and TT WTPs), and inhalation exposures from mess hall duty (HP WTP).
- The RME exposure scenario, which includes the following exposure pathways: RME drinking water ingestion (TT and HP WTPs), RME dermal and inhalation exposures from showering (HP and TT WTPs), and inhalation exposures from mess hall duty (HP WTP).
- The custom military high-end exposure scenario, which includes the following exposure pathways: custom military high-end drinking water ingestion (TT and HP WTPs), RME high-end dermal and inhalation exposures from showering (HP WTP), and inhalation exposures from mess hall duty (HP WTP).

Based on standard risk assessment methodology, which includes overly health-protective assumptions about exposure and risk, the maximum risk estimate calculated for Mr. Davis's estimated exposures is 4×10^{-4} (or 4 cancer cases in 10,000 exposed people, or 0.04% increased risk) for all the exposure scenarios and all chemicals evaluated. However, a major driver of the estimated cancer risks for Mr. Davis is the inhalation exposure pathway from mess hall duty, which has an ELCR of 2×10^{-4} and is based on overly conservative assumptions (*e.g.*, using the month with the maximum contaminant concentrations in water to model air concentrations, and assumptions of 7 days per week and 16-hour duty shifts over two 30-day periods). If Mr. Davis's mess hall duty occurred during months when the contaminant concentrations were closer to the average (or median), then his estimated mess hall cancer risks would be nearly halved to 1×10^{-4} , which does not exceed US EPA's target cancer risk range. If Mr. Davis worked at the mess hall for 5 days per week (instead of 7), which is likely, then his mess hall cancer risks using the average contaminant water concentrations would be even lower, at 8×10^{-5} . When only considering the chemicals (TCE, PCE, and benzene) for which ATSDR concludes there is some evidence of a causal association with NHL, Mr. Davis's cancer risks from drinking water and showering range from 2×10^{-5} (CTE) to 5×10^{-5} (custom military high-end), and his ELCRs from mess hall duty (assuming exposure to average chemical concentrations in water for 5 days per week) would be 7×10^{-5} , resulting in total ELCRs ranging from 9×10^{-5} (CTE) to 1×10^{-4} (RME and military high-end), which do not exceed US EPA's target risk range. It should be noted that the PCE and benzene cancer toxicity criteria are overly protective for NHL because the values are based on the more sensitive liver cancer and leukemia endpoints, respectively, and not NHL.

Therefore, the calculated ELCRs for PCE and benzene are not predictive, and overly conservative, for estimating NHL risk.

In Section 7, I compare the plaintiff-specific doses and exposure concentrations to the doses or exposure concentrations that are the basis of the toxicity criteria (predicted to be associated with no, or a very low, response from animal or human studies) before linear extrapolation to derive the toxicity criteria. These comparisons are called margins of exposure (MoEs) and are equal to the doses or exposure concentrations that are the basis of the toxicity criteria divided by the plaintiff-specific doses or exposure concentrations. MoEs above 1 provide support that adverse health effects would not be expected for the individual. Based on these comparisons for Mr. Davis's exposures, the MoEs range from 52 to 54,000,000, all of which are well above 1, providing additional support that Mr. Davis's exposures would not have been expected to lead to his NHL.

Further, in Section 8, I consider comparisons of the plaintiff's exposure estimates to exposures in relevant epidemiology and animal studies. As discussed, Mr. Davis's exposure estimates are orders of magnitude below the concentrations in these studies, providing additional support that Mr. Davis's exposures would not have been expected to lead to his NHL.

Based on the results of my analysis described above, it is my opinion, to a reasonable degree of scientific certainty, that there is insufficient evidence to conclude that Mr. Davis's exposures to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE from tap water during the 6.3 years that he was stationed at Camp Lejeune were causally associated with his NHL.

I reserve the right to amend my opinion in the future should new information become available to me.

3 Methodology

3.1 General Methodology

The opinions herein are based on my training and experience in toxicology and risk assessment, and on a review of documents available to me as of the date of this report. Specific documents I have reviewed are presented in the references section of this report. In addition, there are many documents that I have reviewed in my professional history that supported my understanding of this case but are not cited specifically in this report. The types of information I relied upon for my analyses include the following:

- Case-specific documents, including:
 - Expert report of Dr. Goodman (2025), which addresses general causation information regarding exposures to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE;
 - Expert report of Dr. LaKind (2025) regarding exposure information for the plaintiff;
 - Expert reports of Drs. Hennet (2024) and Spiliotopoulos (2024) regarding groundwater modeling for Camp Lejeune;
 - Expert reports submitted on behalf of the plaintiff by Drs. Reynolds (2025a) and Hoppe (2025);
 - Plaintiff's deposition; and
 - Other Plaintiff materials, if available, as cited within (*e.g.*, declaration, military or employment records).
- Camp Lejeune evaluations conducted by ATSDR related to potential health effects from exposure to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE in groundwater.
- General toxicology and risk assessment guidance documents authored by agencies such as US EPA and ATSDR.
- Publicly available environmental and regulatory documents that are not case specific, but provide data and information relevant to my analyses. Such documents include chemical-specific toxicity criteria and toxicological reviews.
- Scientific literature specifically related to chemicals (TCE, PCE, vinyl chloride, benzene, and 1,2-tDCE) and exposures associated with the Camp Lejeune litigation.

The specific analyses I performed for my evaluation are briefly stated below.

- Reviewed the plaintiff's deposition and other relevant plaintiff materials (*e.g.*, military records);
- Reviewed information related to possible associations between exposures to TCE, PCE, vinyl chloride, benzene, and 1,2-tDCE in tap water and the health effects alleged by the plaintiff, based on information provided in the expert report prepared by Dr. Goodman (2025);
- Applied standard risk assessment methodology to conduct a risk evaluation for the plaintiff using plaintiff-specific doses calculated and supplied to me by Dr. LaKind (2025), based on Dr. LaKind's and my agreement on exposure assumptions appropriate for the plaintiff;

- Conducted a margin of exposure (MoE) analysis, comparing the estimated exposures for the plaintiff to exposures from the animal or human studies that are the basis of the chemical-specific toxicity criteria; and
- Compared the estimated exposures for the plaintiff to exposure information from relevant epidemiology or animal studies.

The following sections provide more information about methodologies for toxicology, human health risk assessment, and regulatory risk evaluation.

3.2 Introduction to Toxicology

Toxicology is the study of health effects resulting from exposure to chemical, biological, or physical agents. An understanding of the scientific principles in the field of toxicology is necessary for evaluating the potential for a causal relationship between exposure to chemicals and health effects. One of the most fundamental concepts in the field of toxicology is the dose-response relationship; dose is the amount of a chemical to which an organism is exposed, and a response is the effect on the organism resulting from the chemical exposure. A dose-response relationship occurs when the chemical exposure and the effect are correlated, and the effect (response) increases directly with increased exposure (dose). However, for most chemicals, biological effects (with a dose-response relationship) occur only when the dose exceeds a threshold level for a certain period of time. At doses ranging between zero and the threshold, biochemical or physiological mechanisms can negate a chemical's effects, thereby preventing any adverse effects from occurring. As the magnitude and duration of exposure begin to exceed the threshold, these protective mechanisms can become less effective. Consequently, at exposure levels higher than the threshold for a given chemical, the effect begins to appear in a manner that corresponds to the increase in dose. It is common for dose-response data from toxicology investigations to be used in risk assessment, which is a tool used to predict adverse health effects based on knowledge of the effects of chemicals and exposures.

3.3 Introduction to Human Health Risk Assessment

Human health risk assessment is the systematic process of characterizing potential adverse human health effects resulting from exposure to environmental hazards (NRC, 1983). Risk assessment generally involves four steps that were first presented by the National Academy of Sciences in 1983 (NRC, 1983).

1. **Hazard Identification:** Identify the potential hazard (*i.e.*, determine whether a particular chemical is causally linked to any health effects).
2. **Dose-Response Assessment:** Determine the relationship between the nature and magnitude of exposure to the hazard and the probability of a health effect occurring.
3. **Exposure Assessment:** Estimate the level of human exposure to the hazard.
4. **Risk Characterization:** Compare the estimated human exposure level of concern to the dose-response assessment for the chemical and characterize the comparison as a risk estimate, then assess the magnitude of uncertainty in the risk estimate.

The hazard identification steps for TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE are described in more detail in Dr. Goodman's expert report (Goodman, 2025), and are summarized in Section 5 of my report. The exposure assessment for the plaintiff is introduced below and described in more detail in Dr. LaKind's expert report (LaKind, 2025) and in Section 6 of my report.

Below, I provide more detail on the general approach for the dose-response assessment and risk characterization steps of a risk assessment, including discussion of US EPA's hazard and dose-response approach for the derivation of regulatory toxicity criteria. Because NHL is the health effect of concern for this plaintiff, in this section, I have focused the dose-response and risk characterization methodology discussions on cancer risk evaluations.

3.3.1 Dose-Response Assessment

A dose-response assessment characterizes the relationship between the nature and magnitude of exposure to a chemical of concern and the probability that one or more adverse health effects may result from that exposure. Regulatory agencies rely on dose-response assessments to derive chemical-specific toxicity criteria for use in evaluating potential cancer risks from oral, dermal, or inhalation exposures of concern (see Section 3.3.2).

The following section describes the derivation of cancer toxicity criteria used in regulatory risk assessments.

3.3.1.1 Derivation of Cancer Toxicity Criteria

Regulatory toxicity criteria for cancer and noncancer effects, such as those established by US EPA and ATSDR, are typically derived from observations of chemical exposures and health effects reported in epidemiology or animal studies, and are conservatively based on the most sensitive endpoint reported in the health effect studies (*i.e.*, the health effect occurring at the lowest exposure level). They are designed to be protective of the most sensitive populations (*e.g.*, children and the elderly). Therefore, toxicity criteria reflect conservative estimates of the relationship between exposures and health effects (*i.e.*, overly protective assumptions about exposures and health effects), particularly for short exposure durations for healthy individuals in a population.

US EPA and ATSDR apply standard risk assessment methodologies to estimate the dose-response relationship between chemical exposures and health effects in epidemiology or animal studies. Then, based on that relationship and an understanding of the mechanism of action for a particular chemical (if known) and the associated health effect, these regulatory agencies derive an exposure concentration or dose that is predicted to be associated with no (or a very low) response. This exposure concentration or dose is referred to as the point of departure (POD) (US EPA, 2021), from which cancer and noncancer toxicity criteria are typically derived. Because the plaintiff was diagnosed with NHL, the process for deriving regulatory cancer toxicity criteria is described below.

The cancer toxicity criteria derived by US EPA are referred to as the cancer slope factor (CSF), which is used to characterize risk from oral and dermal exposures, and the inhalation unit risk (IUR), which is used to characterize risk from inhalation exposure. Dose-response information from studies used to derive toxicity criteria can be plotted graphically as the relationship between the magnitude of the response (*i.e.*, health effect) observed at each evaluated chemical dose (referred to as a "dose-response curve"). See Figure 3.1 for an example of a dose-response curve. CSF and IUR values are typically derived by drawing a line from the POD (the dose associated with no, or a very low, response in animal or human studies) on the dose-response curve down to the point of origin (or zero-response).

US EPA often uses a benchmark dose (BMD) modeling approach (US EPA, 2012a) to develop dose-response curves and PODs for the derivation of toxicity criteria. US EPA uses the 95% upper bound on the dose-response curves for these derivations, stating that "[t]he use of upper bounds generally is considered to be a health-protective approach for covering the risk to susceptible individuals" (US EPA, 2005). Using

the upper bound on the response results in a lower POD, called the lower confidence limit on the benchmark dose (BMDL). See Figure 3.2 for an example of linear extrapolation from a POD, based on a BMD/BMDL, for the derivation of toxicity criteria (*e.g.*, CSF or IUR). Depending on how the POD is derived, it can sometimes be referred to as a lower confidence limit of the exposure dose (LED). For cancer toxicity criteria, both the BMDL and LED values are typically associated with a cancer risk in the range of 1-10%.

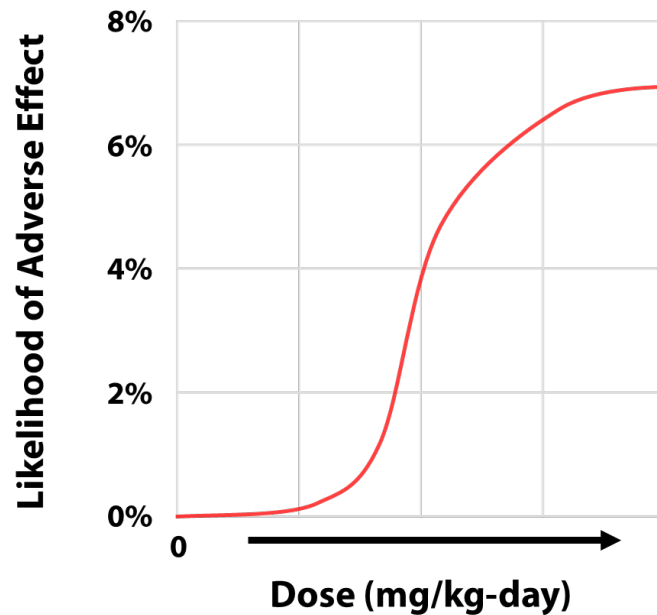


Figure 3.1 Dose-Response Curve

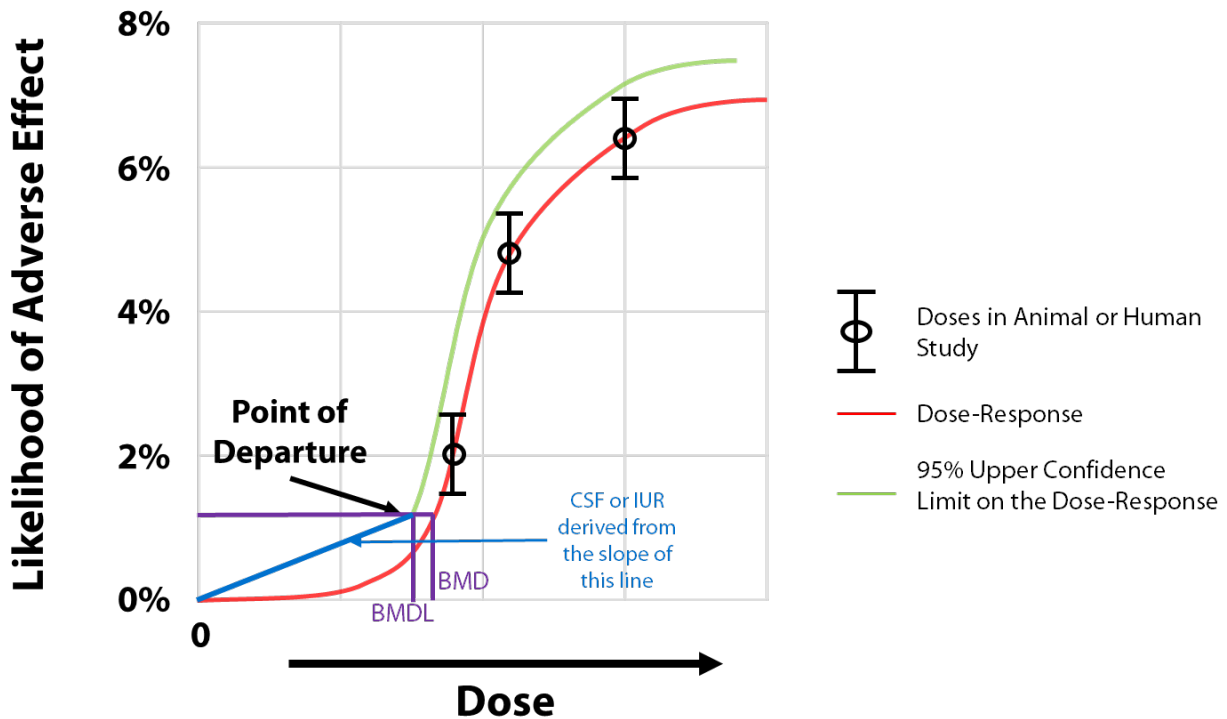


Figure 3.2 Approach for Cancer Slope Factor (CSF) or Inhalation Unit Risk (IUR) Development.
 BMD = Benchmark Dose; BMDL = Lower Confidence Limit on the Benchmark Dose.

CSFs are used to estimate the probability of an individual developing cancer as a result of a lifetime of oral or dermal exposure to a particular amount of a potential carcinogen, described as risks per mg/kg-day (*i.e.*, $[\text{mg/kg-day}]^{-1}$). For example, a CSF of $0.01 (\text{mg/kg-day})^{-1}$ is equal to a risk of 1 in 100 or 1% from exposure to 1 mg/kg-day of a substance over a lifetime. Similarly, US EPA defines the IUR as the probability of an individual developing cancer from continuous exposure to a particular amount of a potential carcinogen in air, described as risks per $\mu\text{g}/\text{m}^3$ (or $[\mu\text{g}/\text{m}^3]^{-1}$). For example, an IUR of $0.01 (\mu\text{g}/\text{m}^3)^{-1}$ is equal to a risk of 1 in 100 or 1% from continuous exposure to 1 $\mu\text{g}/\text{m}^3$ of a substance in air over a lifetime.

Further, for some chemicals for which there is only reliable observational information (*i.e.*, a human or animal study) to derive either a CSF or an IUR, US EPA might conduct what is called a "route-to-route extrapolation" and derive an IUR from a CSF, or *vice versa*, using information about a chemical's absorption, distribution, metabolism, and excretion for the two exposure pathways, as well as assumptions about human and animal body weights and inhalation rates.

3.3.2 Exposure Assessment

Oral or dermal exposure estimates represent the daily dose of a chemical taken into the body, averaged over the appropriate exposure period and expressed in the units of milligram of chemical per kilogram of human body weight per day (mg/kg-day). Inhalation exposure estimates represent the daily exposure concentration of a chemical taken into the body, averaged over the appropriate exposure period and expressed in the units of microgram of a chemical per cubic meter of air ($\mu\text{g}/\text{m}^3$). The primary source for the exposure equations used in human health risk assessment is US EPA's "Risk Assessment Guidance for Superfund" (RAGS) (US EPA, 1989).

My risk calculations for the plaintiff, which are described in Section 6, start with Dr. LaKind's plaintiff-specific daily doses and daily inhalation exposure concentrations, which I have termed daily exposure doses (DEDs) and daily exposure concentrations (DECs), respectively. Dr. LaKind provides a detailed discussion of the plaintiff's DED and DEC estimates in her report (LaKind, 2025), including discussion of the dermal and shower inhalation exposure models applied and the exposure parameters used in those models. As described in her report, Dr. LaKind calculated plaintiff-specific daily dose and daily inhalation exposure concentration estimates from exposure point concentrations of chemicals in tap water at Camp Lejeune (LaKind, 2025).

The plaintiff's exposure frequency (EF, how often exposure to chemicals occurred) and exposure duration (ED, how long the exposure to chemicals was) are also considered in the risk calculations. A daily exposure frequency of 365 days per year is typically applied for tap water use (ingestion and showering). Exposure duration generally corresponds to the time period that the plaintiff lived or worked at Camp Lejeune. Finally, consistent with US EPA guidance (US EPA, 2014), an averaging time (the period over which the chemical exposures are averaged) was applied to derive the risk estimates. The averaging time that US EPA recommends using to calculate exposure estimates for cancer risk calculations is a 70-year lifetime (*i.e.*, 25,550 days), because the cancer toxicity criteria are based on a lifetime of exposure (US EPA, 2014).

For evaluating oral and dermal exposures for cancer risk estimates, the relevant dose metric is the lifetime average daily dose (LADD), which is defined as the amount of a chemical taken into the body *via* oral or dermal exposure during the exposure period, averaged over a 70-year life lifetime (*i.e.*, 25,550 days). Using the DED estimates from Dr. LaKind, I calculate LADDs for oral and dermal exposures to the chemicals of interest as follows:

$$\text{LADD} = \frac{\text{DED} \times \text{EF} \times \text{ED}}{\text{AT}}$$

where:

LADD = Lifetime Average Daily Dose (mg/kg-day)
 DED = Daily Exposure Dose (mg/kg-day)
 EF = Exposure Frequency (days/year)
 ED = Exposure Duration (years)
 AT = Averaging Time (25,550 days)

For evaluating inhalation exposures for cancer risk estimates, the relevant dose metric is the lifetime average daily exposure (LADE), which is defined as the amount of chemical that someone is exposed to *via* inhalation during the exposure period, averaged over a 70-year lifetime (*i.e.*, 25,550 days). Using the DEC estimates from Dr. LaKind, I calculate LADEs for inhalation exposures to the chemicals of interest as follows:

$$\text{LADE} = \frac{\text{DEC} \times \text{EF} \times \text{ED}}{\text{AT}}$$

where:

LADE = Lifetime Average Exposure Concentration ($\mu\text{g}/\text{m}^3$)
 DEC = Daily Exposure Concentration ($\mu\text{g}/\text{m}^3$)
 EF = Exposure Frequency (days/year)
 ED = Exposure Duration (years)
 AT = Averaging Time (25,550 days)

See Appendix D for more details on these calculations.

3.3.2.1 Calculations for the Mess Hall Duty Inhalation Exposure Pathway

As described in Dr. LaKind's expert report (LaKind, 2025), a mess hall duty inhalation exposure pathway was also evaluated for the plaintiff. As discussed by Dr. LaKind, and consistent with the ATSDR "Public Health Assessment for Camp Lejeune Drinking Water" (ATSDR, 2017a), only the inhalation exposure pathway is considered for the mess hall duty exposure pathway. For this exposure pathway, Dr. LaKind provided an indoor air concentration (AC) for each chemical for exposures during pre-rinsing dishes, while using the steam table, and in the dishwashing area. I calculated a daily exposure concentration (DEC) from the AC values, based on the following equation:

$$DEC = \frac{(AC_{dish} \times ET_{dish}) + (AC_{rinse} \times ET_{rinse}) + (AC_{steam} \times ET_{steam})}{24 \text{ hours/day}}$$

where:

DEC	=	Daily Exposure Concentration ($\mu\text{g}/\text{m}^3$)
AC _{dish}	=	Air Concentration in Mess Hall Dishwashing Area ($\mu\text{g}/\text{m}^3$)
AC _{rinse}	=	Air Concentration in Mess Hall Pre-Rinse Area ($\mu\text{g}/\text{m}^3$)
AC _{steam}	=	Air Concentration in Mess Hall Steam Table Area ($\mu\text{g}/\text{m}^3$)
ET _{dish}	=	Exposure Time in Mess Hall Dishwashing Area (hours/day)
ET _{rinse}	=	Exposure Time in Mess Hall Pre-Rinse Area (hours/day)
ET _{steam}	=	Exposure Time in Mess Hall Steam Table Area (hours/day)

The lifetime average daily exposure (LADE) for the mess hall inhalation exposure pathway is then calculated as follows (slightly modified from the LADE equation discussed earlier to reflect the total number of events that occurred during the exposure duration):

$$LADE = \frac{DEC \times EF \times EV}{AT}$$

where:

LADE	=	Lifetime Average Exposure Concentration ($\mu\text{g}/\text{m}^3$)
DEC	=	Daily Exposure Concentration ($\mu\text{g}/\text{m}^3$)
EF	=	Exposure Frequency (days/event)
EV	=	Events During Exposure Duration (number of events)
AT	=	Averaging Time (25,550 days)

See Appendix D for details on this calculation.

3.3.3 Risk Characterization for Cancer Health Effects

In the risk characterization step of the risk assessment, the estimated human exposure levels of concern (LADD or LADE, as described above) are combined with the dose-response assessment (chemical-specific toxicity criteria [CSF or IUR]) for each chemical to calculate risk estimates for each chemical and exposure pathway.

3.3.3.1 Cancer Toxicity Criteria Are Used to Estimate the Excess Lifetime Cancer Risk (ELCR) in a Population

Cancer risks are characterized as the incremental probability that an individual will develop cancer during their lifetime due to exposure to a chemical under the specific exposure scenarios evaluated. All individuals have a background risk of developing cancer at some point in their lifetimes. According to the American Cancer Society (ACS), the lifetime probability of developing any cancer (*i.e.*, background cancer risk for all cancers combined) is slightly less than 1 in 2 (41.6%) for men and slightly more than 1 in 3 (39.6%) for women (ACS, 2024). As described by ACS (2024), the lifetime probability of developing NHL is 2.3% for men and 1.9% for women, in the population overall. Background cancer risk is based on cancer incidence within the population and does not mean that all individuals are at 40% risk of developing cancer. Individual risk (background or above background) will vary and is based on a number of different factors, including age, sex, race, lifestyle (*e.g.*, diet, exercise), and family history (ACS, 2024; Mayo Clinic, 2024).

Cancer toxicity criteria are used in regulatory risk evaluations to estimate the incremental risk of developing cancer as a result of a specific chemical exposure, beyond the background cancer risk. This risk is termed the excess lifetime cancer risk (ELCR), which is expressed as a unitless probability (*e.g.*, 1 cancer case in 1 million people exposed, or 1×10^{-6}). US EPA has established a target ELCR range of 1×10^{-6} (1 cancer case in 1,000,000 people exposed) to 1×10^{-4} (1 cancer case in 10,000 people exposed); an exposure that may result in an ELCR that falls within this range, that is calculated using conservative assumptions, is considered acceptable (US EPA, 1990, 1991). To provide perspective on what a target ELCR of 1 in 10,000 or 1 in 1,000,000 means, it is helpful to understand how these risks compare to the overall lifetime probability of being diagnosed with cancer. A risk of 1 in 1,000,000 is equivalent to a cancer risk of 0.000001, or an ELCR of 0.0001%. A risk of 1 in 10,000 is equivalent to a cancer risk of 0.0001, or an ELCR of 0.01%. Adding these risks to the background risk of developing any cancer over a lifetime (~40%, or about 400,000 cancer cases in a population of 1,000,000) results in total cancer risks of 40.0001-40.01%. Another way to think about these risks is as follows.

- A 40% background cancer risk is the same as 400,000 cancer cases occurring in a population of 1,000,000. Compare that to:
 - 400,001 cancer cases in a population of 1,000,000 (the same as a risk of 40.0001%, or a 1×10^{-6} ELCR), and
 - 400,100 cancer cases in a population of 1,000,000 (the same as a risk of 40.01%, or a 1×10^{-4} ELCR).

Therefore, US EPA's target ELCRs are well below the overall lifetime risk of getting cancer (including NHL) and represent only very slight increases above the background risk of cancer, based on conservative assumptions of exposure and toxicity.

3.3.3.2 Cancer Risk Calculations

Per US EPA (1989) guidance, the ELCR for oral or dermal exposure to a chemical is calculated by multiplying the lifetime average daily oral or dermal dose (LADD) of that chemical by the chemical-specific CSF, as follows:

$$\text{ELCR from Oral or Dermal Exposure} = \text{LADD (mg/kg-day)} \times \text{CSF } ([\text{mg/kg-day}]^{-1})$$

Similarly, per US EPA (1989), the ELCR from inhalation exposure to a chemical is calculated by multiplying the lifetime average daily inhalation exposure concentration (LADE) of that chemical by the chemical-specific IUR, as follows:

$$\text{ELCR from Inhalation Exposure} = \text{LADE } (\mu\text{g}/\text{m}^3) \times \text{IUR } ([\mu\text{g}/\text{m}^3]^{-1})$$

US EPA does not derive toxicity criteria based specifically on dermal exposure toxicity studies. Instead, risk from dermal exposure to chemicals is assessed based on oral toxicity criteria, under the assumption that once a chemical is absorbed into the blood stream, the health effects caused by that chemical are similar regardless of whether the route of exposure was oral or dermal. Because oral toxicity criteria are based on the amount of a chemical *administered* per unit of time and body weight (*i.e.*, the chemical intake), and not the amount absorbed systemically from the gastrointestinal tract, and because dermal exposures are expressed as absorbed intake levels, the oral criteria need to be adjusted to be applicable to *absorbed* doses before they can be used to assess risk from dermal exposure (US EPA, 1989, 1992, 2004).

This adjustment is made using the chemical's oral absorption efficiency (*i.e.*, the systemic absorption of the chemical following oral exposure). If a chemical's systemic absorption following oral exposure is very high (almost 100%), then the absorbed dose is virtually the same as the administered dose, and no adjustment of the oral toxicity factor is necessary for dermal risk calculations. If a chemical's systemic absorption following oral exposure is very low (*e.g.*, 5%), the chemical's oral toxicity criterion must be adjusted to account for the fact that the absorbed dose is much smaller than the administered dose before the criterion can be used to assess risk from dermal exposure to that chemical. US EPA recommends adjusting a chemical's oral toxicity criterion for use in evaluating dermal exposure and risks only when the systemic absorption of that chemical following oral exposure is less than 50%, to "obviate the need to make comparatively small adjustments in the toxicity value that would otherwise impart on the process a level of accuracy that is not supported by the scientific literature" (US EPA, 2004). Because the oral absorption efficiencies of TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE are not less than 50%, their oral toxicity criteria can be used to assess risks posed by dermal exposure to these chemicals without any adjustment (US EPA, 2004).

For some chemicals that US EPA considers to be carcinogenic *via* a mutagenic mode of action (chemicals considered to react with DNA and lead to permanent changes in DNA, *i.e.*, mutations), such as TCE (for kidney cancer), US EPA (2011a) recommends applying age-dependent adjustment factors (ADAFs) to the cancer toxicity criteria to derive values protective of children in various age ranges. The current ADAFs are 10 for <2-year-olds (*i.e.*, an increase in the ELCR estimate by 10-fold is recommended for this age group), 3 for 2- to <16-year-olds (*i.e.*, an increase in the ELCR estimate by 3-fold is recommended for this age group), and 1 for ≥16-year-olds (no increase to the ELCR estimate is recommended for this age group) (US EPA, 2011a). US EPA recommends multiplying the CSF and IUR by the 10- and 3-fold ADAFs as part of the cancer risk calculations. US EPA does not recommend such adjustments when deriving cancer toxicity criteria for PCE or benzene because the agency does not consider PCE or benzene to cause cancer by a mutagenic mode of action. As discussed in Section 5, US EPA has derived vinyl chloride cancer toxicity values for continuous lifetime exposure from birth that should be applied for early-life (from-birth) scenarios.

After calculating cancer risks from exposure to chemicals *via* each relevant exposure pathway, the ELCR is derived by summing the risks across chemicals and exposure pathways. If the ELCR falls within US EPA's acceptable risk range of 1×10^{-4} to 1×10^{-6} (or 1 additional cancer case in 10,000 people exposed to 1 additional cancer case in 1,000,000 people exposed), there is no need for further evaluation. If the ELCR is calculated to be greater than 1 in 10,000, the *potential* cancer risk from the evaluated chemical exposures requires further evaluation. However, because of the overly conservative nature of regulatory

toxicity criteria, as discussed above, the exceedance of an estimated ELCR of 1×10^{-4} does not mean that adverse health effects will occur or are even likely to occur in any one individual.

3.4 The "Linear No-Threshold" Model and the Concept of "No Safe Dose" for Carcinogens

Carcinogenic compounds are often incorrectly described as having "no safe dose." The "no safe dose" concept can be described as meaning that any level of exposure to a carcinogen will lead to some level of increased cancer risk. This concept comes from the linear no-threshold (LNT) or "nonthreshold" mechanism of carcinogenesis that is often conservatively assumed to apply in regulatory cancer risk evaluations. As described by US EPA (and other regulatory agencies), the LNT mechanism of action is applied when there is no known "threshold" dose below which exposure to a carcinogen is not expected to lead to some level of risk, even if it is very low. CSFs and IURs that are derived by extrapolating from the lowest doses in an animal or human study (or POD) down to a response of zero (as discussed above), are derived by applying the LNT approach. In contrast, a threshold model for deriving toxicity criteria is based on the concept that there is some dose below which no adverse effects are expected.

Figure 3.3 depicts a threshold (often the BMDL derived from the animal or human study) and a LNT dose-response model that could be applied to a POD. Figure 3.4 provides a comparison of the LNT and threshold model extrapolations from the PODs. As shown, for a threshold model, US EPA typically applies uncertainty factors (*e.g.*, for sensitive subpopulations, or for the use of an animal study) to the POD to derive a toxicity value, at or below which adverse health effects are not expected. Non-cancer toxicity values are typically derived using a threshold approach.

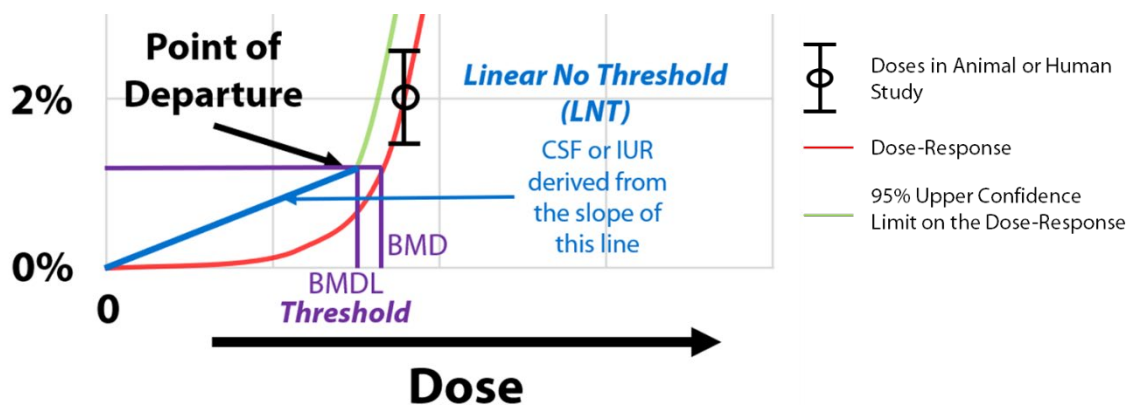


Figure 3.3 Linear No-Threshold (LNT) vs. Threshold Models. CSF = Cancer Slope Factor; IUR = Inhalation Unit Risk.

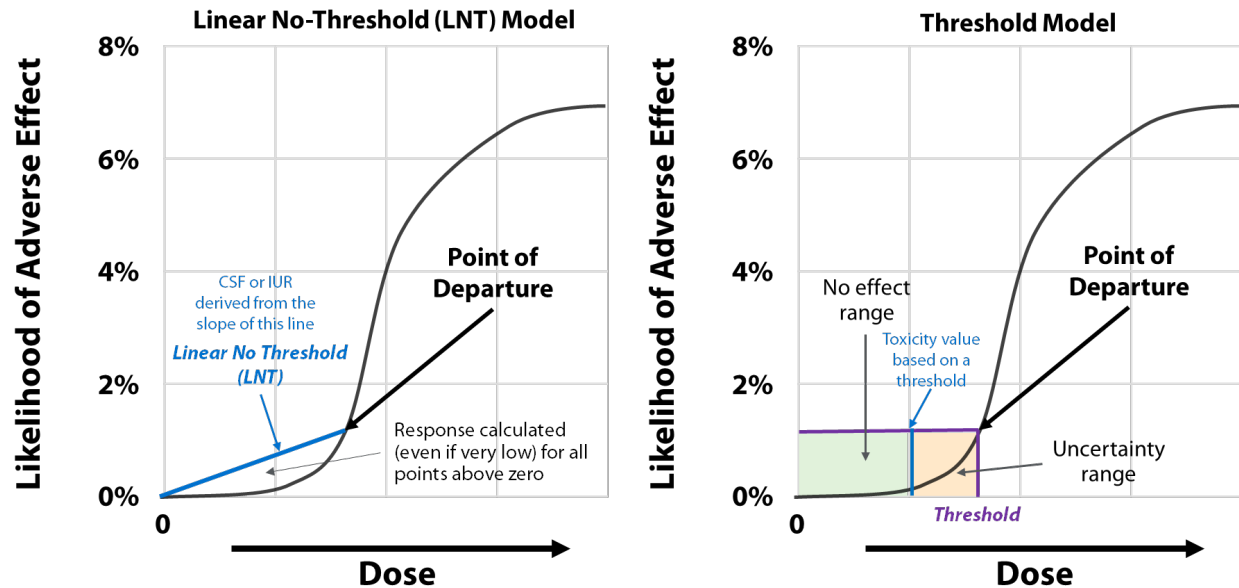


Figure 3.4 Linear No-Threshold (LNT) vs. Threshold Model Extrapolations from the Point of Departure (POD)

Regulatory agencies often consider a nonthreshold approach to be the mechanism of carcinogenesis for genotoxic carcinogens (*i.e.*, carcinogens that directly interact with DNA), even when there is no reliable evidence of genotoxicity for these chemicals at low doses. Therefore, for chemicals that have been observed to be genotoxic only at high doses, a nonthreshold approach may be very conservative. Some carcinogens have been found to cause cancer through mechanisms that are not directly genotoxic. For example, some chemicals can cause cytotoxicity (cell death) at certain doses (usually high doses); cytotoxic conditions can result in oxidative stress that can result in the generation of toxic substances (*i.e.*, oxygen radicals) that can react with DNA and cause mutations and cancer. These carcinogens are considered to have a "threshold."

A nonthreshold mechanism of carcinogenesis implies that any level of exposure, even as low as a single molecule of a substance in a cell, potentially presents some level of response because of the possibility that (in theory) one molecule of the substance could react with DNA in a critical gene, and the consequent DNA damage could result in a mutation in that gene (permanent change in DNA) that could then result in carcinogenesis. However, this theoretical carcinogenic mechanism is not biologically plausible, even for carcinogens that are known to react directly with DNA. Several scientific reviews on this topic (*e.g.*, Cardarelli and Ulsh, 2018; Golden *et al.*, 2019; Calabrese, 2023) describe that there is no scientific consensus regarding the use of the nonthreshold approach for estimating cancer risk. Although a nonthreshold approach is reasonable to consider on a theoretical basis, the probability that it will occur in humans (*i.e.*, is it biologically plausible?) needs to be considered in the context of the high levels of DNA damage that human cells experience and efficiently repair on a daily basis.

DNA damage occurs daily in every cell in the human body as a result of normal daily living, and the body readily repairs that damage on a regular basis (Ames *et al.*, 1995). DNA damage from endogenous processes (*i.e.*, processes that naturally occur in the human body) are thought to result in a steady-state (*i.e.*, continuous, or any point in time) background level of about 50,000 damaged DNA bases in every human cell (Swenberg *et al.*, 2011). Although carcinogens have the potential to damage DNA either directly or indirectly, possibly resulting in mutations that may contribute to the development of cancer, these processes are more likely to happen when the body's normal cellular and molecular defense and repair mechanisms

are damaged or overwhelmed by high concentrations of a mutagen or carcinogen. The body's normal defense mechanisms can efficiently eliminate low concentrations of a mutagenic or carcinogenic substance and repair DNA damage that exposure to the substance may have caused. Therefore, exposures to low levels of genotoxic carcinogens would be unlikely to lead to increases in genotoxicity, mutations, and carcinogenesis beyond what would be considered background levels. Therefore, the current scientific evidence supports a threshold mode of action even for substances that interact directly with DNA, as long as the exposure levels are low enough to not significantly overwhelm cells' normal defense mechanisms.

The National Research Council (NRC) report "Science and Decisions: Advancing Risk Assessment" described the need for an improved framework for dose-response analysis (NRC, 2009). The authors of this report discuss the nonthreshold (LNT) approach and address some of the points I have raised here. The authors state the following regarding the nonthreshold dose-response approach (referred to by NRC as the "low-dose linear" approach):

Low-dose linear individual and population dose-response. For this conceptual model, both individual risk and population risk have no threshold and are linear at low doses.... Note that low-dose linear means that at low doses "added risk" (above background) increases linearly with increasing dose; **it does not mean that the dose-response relationship is linear throughout the dose range between zero dose and high doses.** (NRC, 2009 [emphasis added])

The NRC goes on to illustrate that the linear dose-response approach is based on an assumption of linearity above background from the hypothetical average of a number of different nonlinear (or threshold) dose-response curves in the population, showing that for a given individual, the dose-response is not linear throughout the dose range between zero and high doses. That is, for every individual, there is an exposure level, even for genotoxic substances, below which DNA damage and mutagenesis would not be expected to occur because of cellular defense mechanisms that are able to fully function at low exposures to exogenous (*i.e.*, environmental) substances. However, in the absence of information about the shape of the population dose-response curve in the low dose background range, regulators often conservatively assume the relationship is linear below the background level.

Therefore, the concept that there is "no safe dose" for carcinogens, or that there is no threshold below which increased cancer risk is unlikely, is not biologically plausible. Although US EPA and other regulatory agencies often apply the nonthreshold model (the basis of the "no safe dose" concept) to derive cancer toxicity criteria, the scientific evidence supports the conclusion that this approach is overly conservative when evaluating low exposures to genotoxic and mutagenic carcinogens in the population, and likely even more conservative when evaluating these exposures on an individual basis.

Further, based on the conservative derivations of cancer toxicity values using a nonthreshold approach, cancer risks calculated using these toxicity values are overly conservative, particularly at low doses; *i.e.*, for low exposures that typically occur in the population, a threshold approach is likely to be more scientifically appropriate.

3.5 Regulatory Toxicology and Risk Assessment vs. Risk Evaluation to Assess Potential Causation

There are substantial differences between how toxicological data are used in a regulatory framework to protect public health *vs.* how they are used to evaluate the potential for causation between an individual's chemical exposures and health effects (Aleksunes and Eaton, 2019). The approach to regulatory decision-making is, in part, directed by policy. As practitioners of public health, regulatory toxicologists are more

concerned with avoiding adverse health effects than with estimating the likelihood of health effects actually occurring in a population or an individual (Rodricks and Rieth, 1998; ATSDR, 2018a,b). This difference in perspective is important, because, as discussed above, regulators often use high-end estimates of exposure and toxicity (which can result in overprediction of potential health risks) to be protective of human health. The aim of US EPA and other public health agencies is not to precisely define which effects are expected to occur at any given exposure level, but to define the level at which health effects are *unlikely* to occur (US EPA, 1993; ATSDR, 2018a,b). Thus, regulatory criteria are designed to "protect the health of everyone in general and no one in particular" (Rodricks and Rieth, 1998). As such, guidelines developed by US EPA and other agencies for deriving regulatory toxicity criteria state that such criteria are designed to be applicable to "susceptible groups," or sensitive subpopulations, which include life stages (*e.g.*, developing fetus) and other factors that may predispose certain individuals to experience a greater response to a given exposure (US EPA, 2002; ATSDR, 2018a,b). Thus, a regulatory risk assessment is designed to be protective of the population overall, and should not be the sole method used to evaluate risks on an individual basis. However, because of the conservative nature of regulatory toxicity criteria, if individual exposures are at or below those criteria, it can be concluded that the individual exposures do not pose concern for potential adverse health effects.

In contrast to risk assessments performed for regulatory or guidance purposes, assessing the likelihood of a chemical exposure causing health effects for an individual requires a risk evaluation specifically for that individual, based on an individual exposure assessment, dose characterization, and an understanding of the potential health effects that the chemical of interest may have on humans at the exposure levels relevant to the individual (Olsen *et al.*, 2014). This type of evaluation can include a risk calculation, using regulatory toxicity criteria, based on the individual's exposure information, as a screening-level conservative first step in a causation analysis. However, as discussed above, it is important to consider the conservative nature of these regulatory criteria, and the fact that they often reflect exposure levels that are much lower than the exposure levels in the animal or human studies at which effects were reported. Therefore, application of regulatory risk calculations for an individual causation analysis is overly conservative and should not be used by itself in a causation analysis. However, if the conservative regulatory risk estimates fall at or below US EPA's acceptable risk range, those results provide strong support for the conclusion that the exposures of concern are not likely to be causally associated with the health effect of concern.

Further, given the conservative nature of the regulatory risk calculations, even if there is an exceedance of US EPA's risk target, that does not mean that health effects are likely to occur. Therefore, for a causation analysis, it is also useful to evaluate potential causal relationships by comparing the estimated doses for the individual to doses or exposure information from the health effect studies (animal or human) that are the basis of the toxicity criteria. These relationships are called margins of exposure (MoEs), as discussed in the next section.

In some cases, it is also helpful to compare plaintiff-specific exposure information to exposure information from reliable epidemiology studies that evaluated the potential relationships between exposures to the chemicals of concern and the disease of concern.

3.6 Margin of Exposure Estimates

As discussed above, the exposure levels at which health effects are predicted to be associated with no (or very low) responses in animal or human studies are the starting points (*i.e.*, PODs) used to derive regulatory toxicity criteria. PODs are the doses from which linear extrapolation is conducted to lower doses for the derivation of cancer toxicity criteria. I describe the PODs for TCE, PCE, benzene, and vinyl chloride in Section 5 of this report. In Section 7, I compare the plaintiff's exposure estimates for these chemicals to the appropriate POD. These types of comparisons provide what is called margins of exposure (MoE)

between the exposure predicted for an individual and the lowest exposure levels at which health effects have been observed (or exposure levels at which no effects have been observed, for some chemicals) in human or animal studies. In comparison to the conservative regulatory risk calculations that are designed to assess risk for the most sensitive individual in a population, and for any concentration above zero (for carcinogens), MoEs provide a comparison of individual exposure estimates to concentrations much closer to those at which health effects have been reported in human studies (or extrapolated to humans from animal studies). The equation used to calculate MoEs is as follows:

$$\text{MoE} = \frac{\text{POD for the Cancer Toxicity Value}}{\text{Individual LADD or LADE}}$$

If the MoE is greater than 1, that indicates that the POD (*i.e.*, estimated to reflect exposures related to no or very low responses) is higher than exposures estimated for the individual, providing support that adverse health effects would not be expected for the individual.

These MoE calculations, in addition to comparisons of individual exposure information to exposure information from other relevant epidemiology studies, are important for causation analyses because they provide a more useful comparison of the plaintiff's exposures to exposures where health effects have been observed in people. If the plaintiff's exposures are well below exposures where effects have been observed in epidemiology or toxicology studies, even if there is a risk calculation greater than US EPA's targets, these results provide support that the individual exposures are not likely to be associated with the health effect of concern.

4 Brief History of the US Marine Corps Base Camp Lejeune Site

4.1 Site Description and History

In the early 1940s, the United States Marine Corps developed a water-distribution system at its Camp Lejeune base, which is located in Onslow County, North Carolina, approximately 70 miles northeast of Wilmington, North Carolina (ATSDR, 2013a). The sole source of drinking water at Camp Lejeune is groundwater wells that pump water from the Castle Hayne aquifer system (ATSDR, 2013a).

Operations at Camp Lejeune started in late 1941. Multiple water treatment plants (WTPs)⁴ have serviced Camp Lejeune, including Hadnot Point (HP), Tarawa Terrace (TT), and Holcomb Boulevard (HB) (the three at issue in this litigation). The HP WTP was the first plant to come online, in 1942 (Hennet, 2024). The HP WTP serviced the base until the TT and HB WTPs came online in 1952 and in the summer of 1972, respectively (Hennet, 2024). Because the WTPs were connected to many more groundwater wells than were needed to supply drinking water to the base, the wells' service was rotated and water from different wells was sometimes mixed at the WTPs before being delivered to Camp Lejeune residences and facilities as tap water (ATSDR, 2013a).

4.2 Investigations of Groundwater Contamination

In 1974, the Safe Drinking Water Act (SDWA) was established to protect the quality of drinking water in the United States (US Congress, 1974). Under the SDWA, US EPA developed national drinking water regulations that included the derivation of maximum contaminant levels (MCLs), *i.e.*, the highest level of a contaminant that is allowed in drinking water.

In the early 1980s, the groundwater sources for two of the WTPs that serviced Camp Lejeune (HP and TT) were found to be contaminated with volatile organic compounds. Although the groundwater source for the HB WTP was not contaminated, the HB WTP was contaminated when HB drinking water was supplied by the HP WTP in the spring and summer months from 1972 through 1985 (ATSDR, 2017a). The contaminants identified in the drinking water at the HP WTP were TCE, PCE, vinyl chloride, and refined petroleum products (including benzene) (ATSDR, 2017a). The HP contamination is believed to have been related to historical base operations and disposal practices (ATSDR, 2017a). TCE was the primary contaminant identified at the HP WTP. Groundwater modeling conducted by ATSDR estimated that the maximum mean monthly reconstructed level of TCE was 783 parts per billion (ppb), in November 1983 (ATSDR, 2017a). The maximum reconstructed mean monthly concentrations of benzene and PCE were 12 ppb (in April 1984) and 39 ppb (in November 1983), respectively (ATSDR, 2017a). The maximum reconstructed mean monthly concentration of vinyl chloride was 67 ppb, in November 1983 (Maslia *et al.*,

⁴ Hadnot Point (HP), Tarawa Terrace (TT), and Holcomb Boulevard (HB) supplied drinking water to residences and workplaces at Camp Lejeune (see Hennet, 2024). Additional Camp Lejeune water-distribution systems which were not contaminated include: Marine Corps Air Station New River, Onslow Beach, Courthouse Bay, Camp Geiger, Rifle Range, and Montford Point/Camp Johnson (Hennet, 2024).

2016; ATSDR, 2017a). The maximum reconstructed mean monthly concentration of 1,2-tDCE was 435 ppb, in November 1983 (ATSDR, 2017a).⁵

Contamination of the TT WTP supply wells was found to be due to an off-site dry cleaner (Bove *et al.*, 2014), with PCE identified as the primary contaminant. TCE, vinyl chloride, and 1,2-tDCE were also detected at this WTP as PCE degradation products (ATSDR, 2017a; Bove *et al.*, 2014).⁶ Groundwater modeling conducted by ATSDR, including a multispecies degradation model of PCE, estimated that the maximum reconstructed mean monthly concentration of PCE in the TT WTP was 158 ppb, in June 1984 (ATSDR, 2017a). Applying the same model, ATSDR estimated maximum reconstructed mean monthly concentrations of TCE and vinyl chloride of 7 and 12 ppb, respectively (ATSDR, 2017a). The maximum reconstructed mean monthly concentration of 1,2-tDCE was 22 ppb (ATSDR, 2017a).⁷

The wells directly serving the other Camp Lejeune water-distribution systems – Holcomb Boulevard (HB), Marine Corps Air Station New River, Onslow Beach, Courthouse Bay, Camp Geiger, Rifle Range, and Montford Point/Camp Johnson – were not contaminated with solvents (Hennet, 2024). As stated previously, the HB WTP was largely uncontaminated except when HB drinking water was supplied by the HP WTP (ATSDR, 2017a).

By February 1985, the most highly contaminated wells servicing the HP and TT WTPs had been removed from service (ATSDR, 2017b).

⁵ Drs. Hennet and Spiliotopoulos explain in their expert reports that ATSDR's modeled groundwater concentrations are unreliable and likely biased high as a result of several conservative assumptions used in ATSDR's modeling (Hennet, 2024; Spiliotopoulos, 2024).

⁶ Refined petroleum products were not contaminants of the TT WTP; therefore, benzene was not identified as a contaminant of concern at the TT WTP, and ATSDR did not model groundwater concentrations for benzene for the TT WTP (ATSDR, 2013b; Hennet, 2024).

⁷ Drs. Hennet and Spiliotopoulos explain in their expert reports that ATSDR's modeled groundwater concentrations are unreliable and likely biased high as a result of several conservative assumptions used in ATSDR's modeling (Hennet, 2024; Spiliotopoulos, 2024).

5 Hazard Assessments and Toxicity Criteria

This section summarizes the TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE hazard assessments that have been conducted by regulatory agencies, and the hazard evaluations conducted by Dr. Goodman (2025) that are specifically focused on exposure to each of these chemicals and NHL. In addition, I summarize the US EPA cancer toxicity criteria for TCE, PCE, benzene, and vinyl chloride that are applied in the plaintiff-specific risk evaluation (Section 6). Note that US EPA has not derived oral or inhalation toxicity criteria for 1,2-tDCE, because US EPA concluded that there was inadequate evidence with which to assess the carcinogenic potential of 1,2-tDCE (US EPA, 2010a,b).

5.1 Hazard Assessments

5.1.1 Trichloroethylene (TCE)

To understand the potential association between TCE exposure and NHL, I reviewed the NHL general causation report prepared by Dr. Goodman (2025). In addition, I reviewed the conclusions from several regulatory agency TCE toxicological reports. US EPA (2011a, 2020a), ATSDR (2019a), and IARC (2014) conclude that the epidemiologic studies suggest a causal relationship between TCE exposure and NHL. In its assessment of the evidence regarding drinking water contaminants at Camp Lejeune, ATSDR (2017b) concluded that there was "sufficient evidence for causation" for TCE and NHL, stating that the basis for its conclusion was a meta-analysis of the NHL subtypes and "mechanistic evidence that TCE causes immunosuppression which is a risk factor for NHL."

Based on the available epidemiology studies and agency reviews that evaluated TCE exposure and NHL, Dr. Goodman concluded that, "Given that associations between TCE and NHL or NHL subtypes are generally weak, the methodological limitations of most epidemiology studies (particularly the high likelihood of exposure measurement error), and the changing classification of NHL over time, I conclude that the epidemiology evidence does not support a causal association between TCE exposure and NHL" (Goodman, 2025). Dr. Goodman also concluded that "There is no animal evidence indicating TCE can cause lymphoma, or any proposed MoA for NHL with sufficient scientific support" (Goodman, 2025). In summary, Dr. Goodman's review of the epidemiology and toxicology studies that have evaluated potential associations between TCE exposure and NHL concluded that overall, "while there is some evidence for a positive association in epidemiology studies, the scientific evidence as a whole does not support a causal association between TCE and NHL" (Goodman, 2025).

5.1.2 Tetrachloroethylene (PCE)

To understand the potential association between PCE exposure and NHL, I reviewed the NHL general causation report prepared by Dr. Goodman (2025). In addition, I reviewed the conclusions from several regulatory agency PCE toxicological reports (ATSDR, 2019b; US EPA, 2012b, 2020b) and IARC (2014). Overall, these agencies concluded that there is suggestive but weak evidence of an association between PCE exposure and NHL. In its assessment of the evidence regarding drinking water contaminants at Camp Lejeune, ATSDR (2017b) concluded that there is "equipoise evidence and above for causation" for PCE and NHL based on epidemiological evidence.

Based on the available epidemiology studies and agency reviews that evaluated PCE exposure and NHL, Dr. Goodman concluded that, "Given that most analyses in epidemiology studies do not provide evidence of associations between PCE exposure and NHL or NHL subtypes, the methodological limitations of these studies (particularly the high likelihood of exposure measurement error), and the changing NHL classification over time, I conclude that the epidemiology evidence does not support a causal association between PCE exposure and NHL" (Goodman, 2025). Dr. Goodman also concluded that "chronic PCE oral and inhalation animal studies do not provide evidence of increased lymphoma incidence" (Goodman, 2025). In summary, Dr. Goodman's review of the epidemiology and toxicology studies that have evaluated potential associations between PCE exposure and NHL concluded that overall, "the scientific evidence does not support a causal association between PCE and NHL" (Goodman, 2025).

5.1.3 Benzene

To understand the potential association between benzene exposure and NHL, I reviewed the NHL general causation report prepared by Dr. Goodman (2025). In addition, I reviewed the conclusions from several regulatory agency benzene toxicological reports. Although ATSDR (2007a, 2015) and US EPA (2003a) generally did not make conclusions regarding the potential association between benzene exposure and NHL, IARC (2018) concluded that there is "limited evidence" that benzene exposure causes NHL. In its assessment of the evidence regarding drinking water contaminants at Camp Lejeune, ATSDR (2017b) concluded that there is "sufficient evidence for causation" for exposure to benzene and NHL, stating that its conclusion is based on epidemiological evidence and mechanistic evidence in animals.

Based on the available epidemiology studies and agency reviews that evaluated benzene exposure and NHL, Dr. Goodman concluded that, "Given that most epidemiology analyses do not provide evidence of associations between benzene and NHL or any NHL subtype, and the methodological limitations of most epidemiology studies, particularly the high likelihood of exposure and outcome measurement error, I conclude that the epidemiology evidence does not support a causal association between benzene exposure and NHL or any NHL subtype" (Goodman, 2025). Dr. Goodman also concluded that "animal bioassays do not provide evidence that benzene can cause lymphoma across species" (Goodman, 2025). In summary, Dr. Goodman's review of the epidemiology and toxicology studies that have evaluated potential associations between benzene exposure and NHL concluded that "scientific evidence does not provide support for a causal association between benzene exposure and NHL" (Goodman, 2025).

5.1.4 Vinyl Chloride

To understand the potential association between vinyl chloride exposure and NHL, I reviewed the NHL general causation report prepared by Dr. Goodman (2025). In addition, I reviewed the conclusions from regulatory agency vinyl chloride toxicological reports. Overall, ATSDR (2024b) and US EPA (2003b) did not conclude that vinyl chloride exposure is a known cause of NHL in humans. In its assessment of the evidence regarding drinking water contaminants at Camp Lejeune, ATSDR (2017b) did not comment on evidence for an association between vinyl chloride exposure and NHL.

Based on the available epidemiology studies and agency reviews that evaluated vinyl chloride exposure and NHL, Dr. Goodman concluded that "the epidemiology studies do not provide evidence of a causal association between vinyl chloride and NHL" (Goodman, 2025). Dr. Goodman also concluded that for vinyl chloride "animal carcinogenicity studies do not provide evidence of causation in humans" (Goodman, 2025). In summary, Dr. Goodman's review of the epidemiology and toxicology studies that have evaluated potential associations between vinyl chloride exposure and NHL concluded that overall, the "scientific evidence does not support a causal association between vinyl chloride and NHL" (Goodman, 2025).

5.1.5 *trans*-1,2-Dichloroethylene (1,2-tDCE)

To understand the potential association between 1,2-tDCE exposure and NHL, I reviewed the expert report prepared by Dr. Goodman (2025). In addition, I reviewed the conclusions from regulatory agency 1,2-tDCE toxicological reports. Dr. Goodman concluded that currently available scientific evidence is too limited to address whether there is a causal association between 1,2-tDCE and NHL (Goodman, 2025). Overall, US EPA (2010a,b) and ATSDR (2023) have not concluded that 1,2-tDCE is associated with increased NHL risk in humans. In its assessment of the evidence regarding drinking water contaminants at Camp Lejeune, ATSDR (2017b) did not comment on whether *cis*-1,2-dichloroethylene (1,2-cDCE), 1,2-tDCE, or their mixtures are carcinogenic.

5.2 Toxicity Criteria

This section summarizes the cancer toxicity criteria that US EPA derived for TCE, PCE, benzene, and vinyl chloride based on the methodology described in Section 3, and US EPA's hazard assessment of these chemicals as described in the documents cited below.

5.2.1 Trichloroethylene (TCE)

Table 5.1 summarizes the cancer types, points of departure (PODs), and oral cancer toxicity criteria (cancer slope factors [CSFs]) that US EPA derived for TCE (US EPA, 2011b). Table 5.2 summarizes the cancer types, PODs, and inhalation cancer toxicity criteria (inhalation unit risks [IURs]) that US EPA derived for TCE (US EPA, 2011b). Note that US EPA does not provide TCE oral PODs for renal cell carcinoma (kidney cancer), non-Hodgkin's lymphoma (NHL), or liver cancer, or TCE inhalation PODs for NHL or liver cancer. Because PODs are used in the MoE analyses in Section 7, I estimated PODs for these pathways and endpoints as described in Appendix E.

Based on its hazard assessment for TCE, US EPA first derived the TCE IURs for renal cell carcinoma, NHL, and liver cancer based on two human occupational TCE inhalation studies (Charbotel *et al.*, 2006; Raaschou-Nielsen *et al.*, 2003; US EPA, 2011b) (Table 5.2). US EPA then applied a TCE physiologically based pharmacokinetic (PBPK) model to conduct a route-to-route (inhalation-to-oral) extrapolation to derive the TCE CSFs from the IURs (US EPA, 2011b) (Table 5.1).

Table 5.3 summarizes the TCE toxicity criteria used in the risk evaluation for the plaintiff.

Table 5.1 US EPA TCE Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])

Chemical	Oral CSF ^{a,b} [(mg/kg-day) ⁻¹]	POD (mg/kg-day)	Cancer Type	Sources
TCE	4.6×10^{-2}	LED ₀₁ = 0.21 ^c	Renal cell carcinoma, NHL, and liver cancer	US EPA (2011a,b)
	9.33×10^{-3}	LED ₀₁ = 1.07 ^d	Renal cell carcinoma	
	2.16×10^{-2}	LED ₀₁ = 0.46 ^d	NHL	
	1.55×10^{-2}	LED ₀₁ = 0.65 ^d	Liver cancer	

Notes:

IUR = Inhalation Unit Risk; LED₀₁ = Lower Confidence Limit of the Exposure Dose at an Extra Risk Level of 1%; mg/kg-day = Milligrams per Kilogram Body Weight per Day; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day; NHL = Non-Hodgkin's Lymphoma; PBPK = Physiologically Based Pharmacokinetic; POD = Point of Departure; ppm = Parts per Million; (ppm)⁻¹ = Per Parts per Million; TCE = Trichloroethylene; US EPA = United States Environmental Protection Agency.

(a) Individual CSFs for the three cancers were derived by US EPA (2011a) by extrapolating from the IURs for these cancers. Each IUR was multiplied by a cancer-specific PBPK model-derived adjustment for route-to-route extrapolation (from inhalation to oral exposure) (US EPA, 2011a), as follows. Renal Cell Carcinoma: 5.49×10^{-3} (ppm)⁻¹ \times 1.7 ppm per mg/kg-day = 9.33×10^{-3} (mg/kg-day)⁻¹. NHL: 1.10×10^{-2} (ppm)⁻¹ \times 1.97 ppm per mg/kg-day = 2.16×10^{-2} (mg/kg-day)⁻¹. Liver Cancer: 5.49×10^{-3} (ppm)⁻¹ \times 2.82 ppm per mg/kg-day = 1.55×10^{-2} (mg/kg-day)⁻¹.

(b) The CSF for the three cancer types combined was derived by US EPA (2011a) as follows: $(5.49 \times 10^{-3} \text{ [ppm]}^{-1} \times 1.7 \text{ ppm per mg/kg-day}) \times 5 = 4.6 \times 10^{-2} \text{ (mg/kg-day)}^{-1}$. The factor of 5 is equal to the total risks summed across all three endpoints ($4.6 \times 10^{-2} \text{ [mg/kg-day]}^{-1}$) divided by the kidney cancer risk ($9.33 \times 10^{-3} \text{ [mg/kg-day]}^{-1}$).

(c) US EPA (2011a) calculated the LED₀₁ in mg/kg-day for the three cancers combined using the following equation: LED₀₁ = (kidney cancer LED₀₁ in ppm \div 1.70 ppm per mg/kg-day) \div 5 = $(1.82 \div 1.70) \div 5 = 0.21 \text{ mg/kg-day}$.

(d) See Appendix E for derivation.

Table 5.2 US EPA TCE Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])

Chemical	IUR [($\mu\text{g}/\text{m}^3$) ⁻¹ ; (ppm) ⁻¹]	POD ($\mu\text{g}/\text{m}^3$ [ppb])	Cancer Type	Sources
TCE	4.1×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 2.2×10^{-2} (ppm) ⁻¹	LEC ₀₁ = 2,445 ^a (455)	Renal cell carcinoma, NHL, and liver cancer	Charbotel <i>et al.</i> (2006); Raaschou-Nielsen <i>et al.</i> (2003); US EPA (2011a,b)
	1.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 5.5×10^{-3} (ppm) ⁻¹	LEC ₀₁ = 9,781 (1,820)	Renal cell carcinoma	
	2.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 1.1×10^{-2} (ppm) ⁻¹	LEC ₀₁ = 4,890 ^b (910)	NHL	
	1.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 5.5×10^{-3} (ppm) ⁻¹	LEC ₀₁ = 9,781 ^b (1,820)	Liver cancer	

Notes:

$\mu\text{g}/\text{m}^3$ = Micrograms per Cubic Meter; ($\mu\text{g}/\text{m}^3$)⁻¹ = Per Micrograms per Cubic Meter; LEC₀₁ = Lower Confidence Limit of the Exposure Concentration at an Extra Risk Level of 1%; POD = Point of Departure; ppb = Parts per Billion; ppm = Parts per Million; (ppm)⁻¹ = Per Parts per Million; NHL = Non-Hodgkin's Lymphoma; TCE = Trichloroethylene; US EPA = United States Environmental Protection Agency.

(a) US EPA (2011a) calculated the LEC₀₁ for all three cancers combine using the following equation and the LEC₀₁ for kidney cancer of 1.82 ppm: LEC₀₁ = kidney cancer LEC₀₁ \div 4 = $1.82 \text{ ppm} \div 4 = 0.455 \text{ ppm}$ (equivalent to 2,445 $\mu\text{g}/\text{m}^3$). The factor of 4 is equal to the total risks summed across all three endpoints ($4.1 \times 10^{-6} \text{ [}\mu\text{g}/\text{m}^3\text{]}^{-1}$) divided by the kidney cancer risk ($1.0 \times 10^{-6} \text{ [}\mu\text{g}/\text{m}^3\text{]}^{-1}$).

(b) See Appendix E for derivation.

Table 5.3 TCE Toxicity Criteria Applied in the Risk Calculations

Chemical	Criteria	Cancer Type	Value
TCE	Oral CSF	NHL	$2.16 \times 10^{-2} \text{ (mg/kg-day)}^{-1}$
	IUR	NHL	$2.0 \times 10^{-6} \text{ (}\mu\text{g}/\text{m}^3\text{)}^{-1}$

Notes:

($\mu\text{g}/\text{m}^3$)⁻¹ = Per Microgram per Cubic Meter; CSF = Cancer Slope Factor; IUR = Inhalation Unit Risk; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day; TCE = Trichloroethylene.

Source: US EPA (2011b).

5.2.2 Tetrachloroethylene (PCE)

Table 5.4 summarizes the cancer type, POD, and oral cancer toxicity criterion (CSF) that US EPA derived for PCE (US EPA, 2012b). Table 5.5 summarizes the cancer type, POD, and inhalation cancer toxicity criterion (IUR) that US EPA derived for PCE (US EPA, 2012b).

Based on its hazard assessment for PCE, US EPA (2012b) first derived a PCE IUR based on an inhalation tumor bioassay conducted in mice that reported hepatocellular adenomas and carcinomas (liver cancer) (JISA, 1993) and applying a PCE PBPK model to extrapolate from animal to human doses (Table 5.4). US EPA then applied the same PBPK model to conduct a route-to-route (inhalation-to-oral) and animal-to-human extrapolation to derive the PCE CSF from the IUR (US EPA, 2012b) (Table 5.5).

Table 5.6 summarizes the PCE toxicity criteria used in the cancer risk evaluation for the plaintiff. Because the evidence overall is suggestive but weak (based on agency reviews) for PCE exposure and NHL, increased NHL risks are not expected from PCE exposure, and PCE cancer toxicity values specific to NHL are not available. Therefore, using US EPA's PCE cancer toxicity criteria that are based on liver cancer is not predictive of NHL risk. However, I conservatively apply the criteria to estimate cancer risk for the plaintiff.

Table 5.4 US EPA PCE Oral Cancer Toxicity Value (Cancer Slope Factor [CSF])

Chemical	Oral CSF ([mg/kg-day] ⁻¹)	POD (mg/kg-day)	Cancer Type (Sex/Species)	Sources
PCE	2.1×10^{-3}	50	Hepatocellular adenomas or carcinomas (male mice)	US EPA (2012b,c)

Notes:

mg/kg-day = Milligrams per Kilogram Body Weight per Day; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day;
PCE = Tetrachloroethylene; POD = Point of Departure; US EPA = United States Environmental Protection Agency.

Table 5.5 US EPA PCE Inhalation Cancer Toxicity Value (Inhalation Unit Risk [IUR])

Chemical	IUR ([μg/m ³] ⁻¹ ; [ppm] ⁻¹)	POD (μg/m ³ [ppb])	Cancer Type (Sex/Species)	Source
PCE	2.6×10^{-7} (μg/m ³) ⁻¹ ; 1.8×10^{-3} (ppm) ⁻¹	390,000 (60,000)	Hepatocellular adenomas or carcinomas (male mice)	JISA (1993); US EPA (2012b,c)

Notes:

μg/m³ = Micrograms per Cubic Meter; (μg/m³)⁻¹ = Per Micrograms per Cubic Meter; ppb = Parts per Billion; (ppm)⁻¹ = Per Parts per Million; PCE = Tetrachloroethylene; POD = Point of Departure; US EPA = United States Environmental Protection Agency.

Table 5.6 PCE Toxicity Criteria Applied in the Risk Calculations

Chemical	Criteria	Cancer Type (Sex/Species)	Value
PCE	Oral CSF	Hepatocellular adenomas or carcinomas (male mice)	2.1×10^{-3} (mg/kg-day) ⁻¹
	IUR		2.6×10^{-7} (μg/m ³) ⁻¹

Notes:

(μg/m³)⁻¹ = Per Micrograms per Cubic Meter; CSF = Cancer Slope Factor; IUR = Inhalation Unit Risk; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day; PCE = Tetrachloroethylene.

Source: US EPA (2012b).

5.2.3 Benzene

Table 5.7 summarizes the cancer type, POD, and oral cancer toxicity criterion (CSF) that US EPA derived for benzene (US EPA, 2003a). Table 5.8 summarizes the cancer type, POD, and inhalation cancer toxicity criterion (IUR) that US EPA derived for benzene (US EPA, 2003a).

Based on its hazard assessment for benzene, US EPA (2003a) first derived a benzene IUR based on two sets of benzene exposure estimates derived from the Rinsky *et al.* (1981, 1987) Pliofilm rubber worker cohort studies that evaluated leukemia: (1) exposure estimates from Paustenbach *et al.* (1992), and (2) exposure estimates from Crump and Allen (1984) (Table 5.7). US EPA then conducted route-to-route (inhalation-to-oral) extrapolation to derive the benzene CSF from the IUR (US EPA, 2003a) (Table 5.8).

Table 5.9 summarizes the benzene toxicity criteria used in the risk evaluation for the plaintiff. I chose to use the higher end of the range of benzene CSFs and IURs provided by US EPA (2003a) in my risk calculations.

Table 5.7 US EPA Benzene Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])

Chemical	Oral CSF [(mg/kg-day) ⁻¹]	POD (mg/kg-day)	Cancer Type	Sources
Benzene	1.5×10^{-2} to 5.5×10^{-2}	0.055	Leukemia	Rinsky <i>et al.</i> (1981, 1987); US EPA (1999, 2003a)

Notes:

mg/kg-day = Milligrams per Kilogram Body Weight per Day; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day;
POD = Point of Departure; US EPA = United States Environmental Protection Agency.

Table 5.8 US EPA Benzene Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])

Chemical	IUR [($\mu\text{g}/\text{m}^3$) ⁻¹ ; (ppm) ⁻¹]	POD ($\mu\text{g}/\text{m}^3$ [ppb])	Cancer Type	Sources
Benzene	2.2×10^{-6} to 7.8×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 7.1×10^{-3} to 2.5×10^{-2} (ppm) ⁻¹	383 (120)	Leukemia	Rinsky <i>et al.</i> (1981, 1987); US EPA (1998, 2003a)

Notes:

$\mu\text{g}/\text{m}^3$ = Micrograms per Cubic Meter; ($\mu\text{g}/\text{m}^3$)⁻¹ = Per Micrograms per Cubic Meter; POD = Point of Departure; ppb = Parts per Billion; (ppm)⁻¹ = Per Parts per Million; US EPA = United States Environmental Protection Agency.

Table 5.9 Benzene Toxicity Criteria Applied in the Risk Calculations

Chemical	Criteria	Cancer Type	Value
Benzene	Oral CSF	Leukemia	5.5×10^{-2} (mg/kg-day) ⁻¹
	IUR		7.8×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹

Notes:

($\mu\text{g}/\text{m}^3$)⁻¹ = Per Micrograms per Cubic Meter; CSF = Cancer Slope Factor; IUR = Inhalation Unit Risk; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day.

Source: US EPA (2003a).

5.2.4 Vinyl Chloride

Table 5.10 summarizes the cancer type, PODs, and oral cancer toxicity criteria (CSFs) that US EPA derived for vinyl chloride (US EPA, 2000, 2003b). Table 5.11 summarizes the cancer type and inhalation cancer toxicity criteria (IURs) that US EPA derived for vinyl chloride (US EPA, 2003b). Note that US EPA does not provide vinyl chloride oral or inhalation PODs. Because PODs are used in the MoE analyses in Section 7, I estimated PODs for these pathways as described in Appendix E.

Based on its hazard assessment for vinyl chloride, US EPA (2000, 2003b) derived a vinyl chloride CSF for continuous lifetime exposure during adulthood based on an increased incidence of liver angiosarcoma, hepatocellular carcinoma, and neoplastic nodules in female rats in the oral study by Feron *et al.* (1981) and applying a vinyl chloride PBPK model to extrapolate from animal to human doses. US EPA derived two very similar CSFs using two extrapolation methods and they recommend using the lower of the two values for risk calculations (US EPA, 2000, 2003b). US EPA (2000, 2003b) also recommends a two-fold higher CSF to account for continuous lifetime exposure from birth. Values are summarized in Table 5.10.

US EPA (2000, 2003b) derived a vinyl chloride IUR for continuous lifetime exposure during adulthood based on an increased incidence of liver angiosarcomas, angiomas, hepatomas, and neoplastic nodules in female rats in the inhalation studies by Popper *et al.* (1981) and Maltoni *et al.* (1984) and applying a vinyl chloride PBPK model to extrapolate from animal to human doses. US EPA (2000, 2003b) also recommends a two-fold higher CSF to account for continuous lifetime exposure from birth. Values are summarized in Table 5.11

Table 5.12 summarizes the vinyl chloride toxicity criteria used in the risk evaluation for the plaintiff. Because no agency has concluded that vinyl chloride exposure is associated with NHL, vinyl chloride cancer toxicity values specific to NHL are not available. Therefore, using US EPA's vinyl chloride cancer toxicity criteria that are based on liver cancer is not predictive of NHL risk. However, I conservatively apply the criteria to estimate cancer risk for the plaintiff.

Table 5.10 US EPA Vinyl Chloride Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs])

Chemical	Oral CSF [(mg/kg-day) ⁻¹]	POD ^a (mg/kg-day)	Cancer Type (Sex/Species)	Sources
Vinyl Chloride	Continuous Lifetime Exposure During Adulthood			
	7.2 × 10 ⁻¹ ; 7.5 × 10 ⁻¹	LED ₁₀ = 0.133	Liver angiosarcomas, hepatocellular carcinomas, and neoplastic liver nodules (female rat)	Feron <i>et al.</i> (1981); US EPA (2000, 2003b)
	Continuous Lifetime Exposure from Birth			
	1.4; 1.5	LED ₁₀ = 0.067	Liver angiosarcomas, hepatocellular carcinomas, and neoplastic liver nodules (female rat)	Feron <i>et al.</i> (1981); US EPA (2000, 2003b)

Notes:

LED₁₀ = Lower Confidence Limit of the Exposure Dose at an Extra Risk Level of 10%; mg/kg-day = Milligrams per Kilogram Body Weight per Day; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day; POD = Point of Departure; US EPA = United States Environmental Protection Agency.

(a) See Appendix E for derivation.

Table 5.11 US EPA Vinyl Chloride Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs])

Chemical	IUR ($[\mu\text{g}/\text{m}^3]^{-1}$)	POD ^a ($\mu\text{g}/\text{m}^3$ [ppb])	Cancer Type (Sex/Species)	Sources
Vinyl Chloride	Continuous Lifetime Exposure During Adulthood			
	4.4×10^{-6}	LEC ₁₀ = 22,727 (8,900)	Liver angiosarcomas, angiomas, hepatomas, and neoplastic liver nodules (female rat)	Popper <i>et al.</i> (1981); Maltoni <i>et al.</i> (1984); US EPA (2000, 2003b)
	Continuous Lifetime Exposure from Birth			
	8.8×10^{-6}	LEC ₁₀ = 11,364 (4,445)	Liver angiosarcomas, angiomas, hepatomas, and neoplastic liver nodules (female rat)	Popper <i>et al.</i> (1981); Maltoni <i>et al.</i> (1984); US EPA (2000, 2003b)

Notes:

$\mu\text{g}/\text{m}^3$ = Micrograms per Cubic Meter; $(\mu\text{g}/\text{m}^3)^{-1}$ = Per Micrograms per Cubic Meter; LEC₁₀ = Lower Confidence Limit of the Exposure Concentration at an Extra Risk Level of 10%; ppb = Parts per Billion; POD = Point of Departure; US EPA = United States Environmental Protection Agency.

(a) See Appendix E for derivation.

Table 5.12 Vinyl Chloride Toxicity Criteria Applied in the Risk Calculations

Chemical	Criteria	Cancer Type	Value
Vinyl Chloride	Oral CSF	Liver angiosarcomas, angiomas, hepatomas, and neoplastic liver nodules (female rat)	$7.2 \times 10^{-1} (\text{mg}/\text{kg}\cdot\text{day})^{-1}$ (adult continuous)
	IUR		$4.4 \times 10^{-6} (\mu\text{g}/\text{m}^3)^{-1}$ (adult continuous)

Notes:

$(\mu\text{g}/\text{m}^3)^{-1}$ = Per Microgram per Cubic Meter; CSF = Cancer Slope Factor; IUR = Inhalation Unit Risk; $(\text{mg}/\text{kg}\cdot\text{day})^{-1}$ = Per Milligrams per Kilogram Body Weight per Day.

Source: US EPA (2003b).

5.2.5 *trans*-1,2-Dichloroethylene (1,2-tDCE)

US EPA (2010a,b) concluded that there was inadequate evidence from which to assess the carcinogenic potential of 1,2-cDCE, 1,2-tDCE, or their mixtures. Therefore, US EPA has not derived a CSF or IUR for 1,2-cDCE, 1,2-tDCE, or their mixtures. ATSDR (2017a) did not evaluate cancer risk from exposure to 1,2-tDCE.

6 Plaintiff-Specific Regulatory Risk Evaluation

This section summarizes the plaintiff's residential and employment history, including the duration of time the plaintiff was stationed at Camp Lejeune, and a risk evaluation for the plaintiff based on the plaintiff's estimated exposures. I perform regulatory risk calculations based on exposure estimates for the plaintiff from the expert report of Dr. LaKind (2025), plaintiff-specific information about exposure duration (*i.e.*, time spent on base), information about exposure frequency for the activities evaluated (*e.g.*, number of times per week), and US EPA's toxicity criteria for the chemicals of interest (when available), as summarized in Section 5, and applying standard risk assessment methodology as summarized in Section 3.

6.1 Plaintiff Background

As discussed in Mr. Davis's deposition (Davis, 2024), he was stationed at Camp Lejeune from February 1979 through September 1982, and again from December 1982 through June 1985, with an overseas deployment in the interim,⁸ for a total of approximately 6.3 years. Mr. Davis testified in his deposition that he first lived in Hadnot Point (HP) in the North Street barracks in February 1979, and then moved to the French Creek barracks (also in Hadnot Point) in November 1979 (Davis, 2024). Housing records indicate that Mr. Davis began living at Tarawa Terrace [TT] starting in April 1980, first at 2262 Tarawa Boulevard followed by 3412 Haggard Drive from September 1981 until he left Camp Lejeune in June 1985 (Davis, 2024; McGowan, Hood, Felder, & Phillips, LLC, 2024). In total, Mr. Davis lived in the HP barracks for approximately 1.2 years and at the Tarawa Terrace residences for approximately 5.1 years. While stationed at Camp Lejeune, Mr. Davis had multiple military occupational specialties including radio operator, radio chief, communications chief, and recruiter (Davis, 2024). According to Mr. Davis, he spent about 32 weeks in the field during his first year on base (Davis, 2024). In his deposition, Mr. Davis testified to consuming between 1 and 1.5 gallons of water per day (or about 3.8-5.7 L, for an average of 4.7 L) when he was not in the field, and 2-3 gallons of water per day (or about 7.6-11.4 L, for an average of 9.5 L) or more when he was in the field (Davis, 2024). However, he later clarified that he would fill up his 16-ounce canteen between eight to ten times per day when he was in the field (Davis, 2024), which is equivalent to 3.8-4.7 L. Mr. Davis stated that he showered twice a day while he lived at the barracks and later at his residences in Tarawa Terrace, but he did not specify the duration of these showers (Davis, 2024). In addition, Mr. Davis stated that during the time period when he was a radio operator (from an unspecified "end of training" date through 1985, the year he left Camp Lejeune), he was assigned to two 30-day rotations of mess hall duty, but did not provide any more details (Davis, 2024).

Mr. Davis is claiming that his exposure to the water at Camp Lejeune is the cause of his Non-Hodgkin's Lymphoma (NHL), which he states he was diagnosed with on December 16, 2021 (Davis, 2024).

6.2 Plaintiff Exposure Estimates

Exposure estimates for the plaintiff were calculated based on the average of the monthly average concentrations of TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE over the duration of the plaintiff's exposure period from modeled treatment plant finished water concentrations for both the HP and TT WTPs,

⁸ Mr. Davis was deployed overseas between September 23, 1982, and December 30, 1982 (Davis, 2024). Consistent with Dr. LaKind's report (2025), October and November 1982 are therefore excluded from the exposure and risk analysis.

which are available in ATSDR's "Public Health Assessment for Camp Lejeune Drinking Water" (ATSDR, 2017a), as described in Dr. LaKind's report (LaKind, 2025). Exposures from drinking water were evaluated for both the HP and TT WTPs for the entire time Mr. Davis was on base (6.3 years), while dermal and inhalation exposures from showering were evaluated only for the WTP that supplied water to the plaintiff's place of residence during his time on base. Because Mr. Davis stated that he lived in the HP Barracks (*i.e.*, the main part of Camp Lejeune served by the Hadnot Point water system) and Tarawa Terrace, I evaluated shower exposures for Mr. Davis from the HP WTP for 1.2 years and the TT WTP for 5.1 years. In addition, I evaluated inhalation exposure from mess hall duty from the HP WTP. Plaintiff-specific TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE daily tap water exposure estimates, from drinking water (ingestion exposure pathway), showering (dermal and inhalation exposure pathways), and mess hall duty (inhalation exposure pathway) are described in more detail in Dr. LaKind's expert report (LaKind, 2025). Risks were calculated for the following baseline exposure pathways and scenarios for the exposure period of concern for the plaintiff:

- Drinking Water Ingestion – For this exposure pathway, because it is not clear that the plaintiff's water ingestion came from only one of the two water treatment systems, I evaluated three scenarios for both the HP and TT WTPs: (1) central tendency exposure (CTE), which assumes ingestion of 1.3 L of tap water per day; (2) reasonable maximum exposure (RME), which assumes ingestion of 3.3 L of tap water per day; and (3) a custom military high-end exposure, which assumes ingestion of 4.7 L per day based on the high-end ingestion rate that Mr. Davis claims.⁹
 - As discussed above, Mr. Davis's claimed tap water ingestion rates are most consistent with the RME and custom military high-end exposure scenarios. Although the upper end of Mr. Davis's claimed tap water ingestion rate of 9.5 L/day is likely overly conservative, I did consider the 4.7 L/day ingestion rate in my risk calculations below.
- Dermal and Inhalation Exposures from Showering – For these exposure pathways, I calculated risks based on the CTE (50th percentile) and RME (95th percentile) dermal dose and inhalation concentration outputs from both a communal showering facility exposure model and a residential exposure model (ATSDR, 2024a), and based on the plaintiff's locations of residence during his time at Camp Lejeune (HP and TT WTPs for Mr. Davis). The inhalation concentrations from the shower model were provided by Dr. LaKind and are discussed further in her report (LaKind, 2025).
 - Communal Facility Shower Model (HP WTP) – Both the CTE and RME exposures from the communal shower facility model are estimated based on a mean daily shower duration of 20 minutes, with a standard deviation (SD) of 5.3 minutes (the SD is the model's default value) (LaKind, 2025). As described in Dr. LaKind's report (LaKind, 2025), using these inputs to the communal shower model results in a 95th percentile shower duration of 30 minutes. Note that the communal shower model accounts for additional water uses, including sinks and toilets.
 - Residential Shower Model (TT WTP) – This model estimates average daily dermal and inhalation exposures from showering, assuming a two-person household. Two scenarios were modeled: (1) CTE, which assumes both residents take consecutive 7-minute showers in the morning, and (2) RME, which assumes both residents take consecutive 20-minute showers in the morning. Note that the residential shower model accounts for additional household water uses, including appliances, sinks, and toilets.

⁹ As discussed in Section 6.1, Mr. Davis originally testified to drinking two to three gallons of water per day when in the field, equivalent to an average of 9.5 L/day (Davis, 2024). Although, when further questioned about how many times he filled his canteen in the field, Mr. Davis testified that he filled it between eight to ten times after confirming that his canteen held approximately 16 ounces of water (Davis, 2024), for a range of ingestion rates between 3.8 L/day and 4.7 L/day. Therefore, I considered 4.7 L/day as a military high-end ingestion rate that is representative of Mr. Davis's time in the field.

- As discussed above, Mr. Davis did not provide information on the duration of his showers. However, as discussed in Dr. LaKind's report (LaKind, 2025), the RME assumption of 20-minute showers is higher than averages reported in literature, and therefore Mr. Davis's shower exposures are likely to be captured by the outputs of these models.

In addition to the baseline exposure pathways outlined above, Dr. LaKind's expert report also includes a summary of air exposure concentrations relevant to the mess hall duty exposure pathway that was evaluated for Mr. Davis (LaKind, 2025). As discussed in the ATSDR "Public Health Assessment for Camp Lejeune Drinking Water," the main exposure pathway for mess hall duty is the inhalation pathway, with potential exposures from other pathways (*e.g.*, dermal pathway) being very minor and contributing little to the overall risk estimate (ATSDR, 2017a). Based on Mr. Davis's deposition, he served on mess hall duty twice, each time for 30 days, but he did not specify where on base or specifically when he conducted mess hall duty (Davis, 2024). Therefore, Dr. LaKind conservatively estimated exposures from the one month with the highest concentrations for the chemicals of interest and assumed an exposure time of 16 hours to account for the 12 hours the mess hall operates and 2 hours before and after it opens to the public. Consequently, I calculated mess hall duty risks based on water concentrations from the HP WTP and assumed an exposure time of 8 hours per day spent in the dishwashing area and 8 hours per day spent in the pre-rinse area. Additional details, including air exposure concentrations in the mess hall, can be found in Appendix D.

Based on the above exposure pathways, the following exposure scenarios are evaluated for Mr. Davis:

- The CTE exposure scenario, which includes the following exposure pathways: CTE drinking water ingestion (TT and HP WTPs), CTE dermal and inhalation exposures from showering (HP and TT WTPs), and inhalation exposures from mess hall duty (HP WTP).
- The RME exposure scenario, which includes the following exposure pathways: RME drinking water ingestion (TT and HP WTPs), RME dermal and inhalation exposures from showering (HP and TT WTPs), and inhalation exposures from mess hall duty (HP WTP).
- The military high-end exposure scenario, which includes the following exposure pathways: military high-end drinking water ingestion (TT and HP WTPs), RME high-end dermal and inhalation exposures from showering (HP WTP), and inhalation exposures from mess hall duty (HP WTP).

6.3 Regulatory Risk Calculations

Risk calculations for the plaintiff based on the estimates of oral and dermal daily exposure doses (DEDs) and daily inhalation exposure concentrations (DECs), which were based on Dr. LaKind's expert report (LaKind, 2025), considering the exposure duration for the plaintiff (approximately 6.3 years in total) and applying the toxicity values summarized in Section 5, are shown in Table 6.1. More detail on the risk calculations (including chemical- and pathway-specific calculations) is presented in Appendix D.

Table 6.1 Excess Lifetime Cancer Risks (ELCRs) by Exposure Pathway for the Plaintiff^a

Exposure Pathway	Water Source	Excess Lifetime Cancer Risks		
		Central Tendency	Reasonable Maximum	Military High-End
Baseline Exposure Pathways				
Ingestion of Drinking Water	HP WTP	5×10^{-5}	1×10^{-4}	2×10^{-4}
	TT WTP	7×10^{-6}	2×10^{-5}	3×10^{-5}
Dermal Contact from Showering in the Barracks and Residential Housing	HP+TT WTP	1×10^{-6}	1×10^{-6}	1×10^{-6}
Inhalation from Showering in the Barracks and Residential Housing	HP+TT WTP	1×10^{-6}	5×10^{-6}	5×10^{-6}
Additional Exposure Pathways				
Inhalation from Mess Hall Duty	HP WTP	2×10^{-4}	2×10^{-4}	2×10^{-4}
Total ELCRs (All Pathways)				
Assuming drinking water, barracks showering, and mess hall duty come from HP WTP, and residential showering comes from TT WTP		3×10^{-4}	4×10^{-4}	4×10^{-4}
Assuming barracks showering and mess hall duty come from HP WTP, and drinking water and residential showering comes from TT WTP		2×10^{-4}	3×10^{-4}	3×10^{-4}

Notes

ELCR = Excess Lifetime Cancer Risk; HP = Hadnot Point; TT = Tarawa Terrace; WTP = Water Treatment Plant.

(a) All ELCRs are rounded to 1 significant digit and are based on values from tables in Appendix D.

As shown in Table 6.1, the maximum ELCR calculated for Mr. Davis's estimated exposures (*i.e.*, military high-end exposure scenario at Hadnot Point [HP]) is 4×10^{-4} , or 4 cancer cases in 10,000 exposed people, or 0.04% increased risk. However, a major driver of the estimated cancer risks for Mr. Davis is the inhalation exposure pathway from mess hall duty, which has an ELCR of 2×10^{-4} and is based on overly conservative assumptions. As described in Dr. LaKind's expert report (2025), without specific information on the dates when Mr. Davis was assigned to mess hall duty, the month with the maximum concentration of contaminants, November 1983, was chosen to model mess hall exposures. In November 1983, the modeled concentration of TCE, which accounts for 80% of the mess hall ELCR, was 783 µg/L at HP WTP. This is nearly twice the average (410 µg/L) and median (427 µg/L) concentrations of TCE, and about 18 times higher than the lowest concentration of TCE (43 µg/L), at HP WTP for the entire time period when Mr. Davis was at Camp Lejeune. If Mr. Davis's mess hall duty occurred during months when the contaminant concentrations were closer to the average, then Mr. Davis's estimated mess hall cancer risks would be nearly halved, to 1×10^{-4} , which does not exceed US EPA's target cancer risk range. And lower exposure concentrations could result in risk estimates that could be as low as 14-fold lower for mess hall cancer risks (or 2×10^{-5})¹⁰. Furthermore, because the frequency of mess hall duty is not clear, I assumed that Mr. Davis worked in the mess hall every day for 30 days. It is more likely that Mr. Davis would have worked 5 days per week rather than 7 days per week. Applying an adjustment to the risk estimates to account for 5 rather than 7 days per week ($5/7 \text{ days} = 0.7$), and assuming average/median exposure concentrations, results in total mess hall risk of 8×10^{-5} , and even lower (1×10^{-5}) if exposures occurred during months with the lowest exposure concentrations for 5 days per week. It is worth noting that it is possible that mess hall duty did not consist of 16-hour days; however, because this is my current understanding of possible mess hall duty hours, I am assuming 16-hour days for my calculations. Fewer hours per day would result in lower risks.

¹⁰ The 14-fold ratio is based on an average of the lowest TCE water concentrations (43 and 71 µg/L) during the time Mr. Davis was at Camp Lejeune, in comparison to 783 µg/L.

Further, the cancer risk estimate is for all cancer types for all chemical exposures evaluated and is driven predominantly by vinyl chloride and TCE in drinking water and TCE in air from mess hall duty (see Appendix D, Table D.3). As discussed in Section 5, none of the regulatory agency documents concluded vinyl chloride exposures are known causes of NHL in humans. Therefore, the calculated vinyl chloride risk estimate (based on liver cancer) is not predictive, and is overly protective, of NHL. Although inconsistent with Dr. Goodman's conclusions (Goodman, 2025), as discussed in Section 5, ATSDR concluded that there is "sufficient evidence" for causation for TCE or benzene exposure and NHL, and "equipoise and above evidence" for causation for PCE exposure and NHL.

The following bullets break down what the ingestion and shower risks would be for Mr. Davis just from TCE, PCE, and benzene. As shown in Appendix D, for Mr. Davis:

- The estimated ingestion and shower cancer risks for TCE (which are based on NHL) area within US EPA's acceptable range with a maximum ELCR of 5×10^{-5} , or 5 NHL cases in 100,000 exposed people, or 0.005% increased risk of NHL from all exposure scenarios at HP and TT.
- The estimated ingestion and shower cancer risks for PCE are within US EPA's target risk range, with a maximum ELCR of 2×10^{-6} , or approximately 2 cancer cases in 1,000,000 exposed people, or a 0.0002% increased cancer risk from the overly conservative military high-end exposure scenario. In addition, as discussed in Section 5, US EPA's cancer toxicity criteria (that are derived to be based on the most sensitive endpoint) are based on liver cancer for PCE; therefore, the PCE risk estimate is overly protective of NHL.
- The estimated ingestion and shower cancer risks for benzene are also within US EPA's target risk range, with a maximum ELCR of 2×10^{-6} , or approximately 2 cancer cases in 1,000,000 exposed people, or a 0.0002% increased cancer risk from all exposure scenarios. In addition, as discussed in Section 5, US EPA's cancer toxicity criteria are based on leukemia for benzene; therefore, the benzene risk estimate is overly protective of NHL.
- The total maximum (conservative) cancer risk estimate from TCE, PCE, and benzene combined (the only chemicals for which ATSDR concludes there is some evidence for a causal association with NHL) from ingestion and showering is 5×10^{-5} , which is within US EPA's acceptable cancer risk range.
- Although adding the most conservative (and uncertain) mess hall risks from TCE, PCE, and benzene would result in an ELCR from all pathways that exceeds US EPA's acceptable risk range, if modified but reasonable adjustments are made to the mess hall exposure concentrations (use of average/median concentrations rather than the maximum) and frequency (5 days per week rather than 7 days per week), the total risk for TCE, PCE, and benzene combined (from ingestion, showering, and mess hall duty) is 1×10^{-4} ($7 \times 10^{-5} + 5 \times 10^{-5} = 1 \times 10^{-4}$), which does not exceed US EPA's acceptable risk range (Table 6.2). If Mr. Davis's exposures occurred during months with water concentrations less than the mean, or if he worked less than 16-hour days, his exposures would result in even lower risks.

Table 6.2 Excess Lifetime Cancer Risks (ELCRs) for Benzene, Tetrachloroethylene (PCE), and Trichloroethylene (TCE)

Exposure Scenario	Central Tendency	Reasonable Maximum	Military High-End
ELCR from drinking water and showering ^a	2×10^{-5}	4×10^{-5}	5×10^{-5}
ELCR from mess hall duty	2×10^{-4}	2×10^{-4}	2×10^{-4}
ELCR from mess hall duty using adjusted and reasonable exposure assumptions ^b	7×10^{-5}	7×10^{-5}	7×10^{-5}
Total ELCRs across exposure pathways			
Using conservative default assumptions for mess hall exposures	2×10^{-4}	2×10^{-4}	3×10^{-4}
Using adjusted and reasonable assumptions for mess hall exposures	9×10^{-5}	1×10^{-4}	1×10^{-4}

Notes

TT = Tarawa Terrace; HP = Hadnot Point; WTP = Water Treatment Plant.

(a) These risks are calculated by summing the highest cancer risk from HP or TT WTP for benzene, PCE, and TCE.

(b) These risks are calculated using average concentrations of benzene, PCE, and TCE in HP WTP water, and assuming mess hall exposures for 5 days per week. Values are calculated as follows: unadjusted risk value \times 5/7 days per week \div 2 (to account for the ratio of the maximum water concentrations compared to the average or median concentrations).

Also note that I assumed Mr. Davis ingested 4.7 L per day of water (every day) as a high-end estimate. If I assume he ingested 4.7 L per day for only the 32 weeks that he claims he was in the field and 3.3 L per day for the weeks he was not in the field, the overall ingestion rate is approximately equal to the RME exposure scenario, and risks would be equal to the RME scenario.

It is also important to keep in mind that, as discussed in Section 3, these risk estimates are protective of the whole population (including sensitive individuals). Therefore, they are based on conservative assumptions about exposures and health effects and, consequently, are likely overestimates for healthy individuals. In addition, some of the toxicity criteria that are based on inhalation studies are extrapolated to toxicity criteria that can be applied to oral and dermal exposure pathways (or *vice versa*). These extrapolations include conservative assumptions, and therefore, the toxicity values derived based on these extrapolations likely overpredict exposures and risks.

It is also important to note that there is some uncertainty in the modeled finished water concentrations of TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE from the two WTPs that are available from ATSDR (2007b, 2013b). As described in the expert reports by Dr. Hennet (2024) and Dr. Spiliotopoulos (2024), ATSDR's modeled finished water concentrations are likely biased high as a result of several conservative assumptions in the modeling. These results suggest that exposures and risks calculated based on ATSDR's modeled concentrations may be overestimated.

6.4 Risk Evaluation Conclusion

Overall, the regulatory risk calculations support the conclusion that Mr. Davis was not exposed to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE in tap water at Camp Lejeune at levels that are of concern for human health. At the highest potential exposure for Mr. Davis (including conservative, and potentially unrealistic exposure assumptions for mess hall duty), and applying conservative, health-protective assumptions for other variables in the risk equations, Mr. Davis's exposures to chemicals in the Camp Lejeune drinking water did not increase his overall cancer risk by more than 0.04% (*i.e.*, 4×10^{-4} , or 4 cancer cases in 10,000 exposed people) over his background cancer risk. However, based on the highest potential exposures for Mr. Davis for drinking water and showering and considering modified but reasonable adjustments to the exposure assumptions for Mr. Davis for his mess hall duty (*i.e.*, an average/median mess

hall concentration and an exposure frequency of 5 rather than 7 days per week for mess hall duty) – considering risks from the only chemicals for which ATSDR concludes there is "sufficient evidence" (TCE and benzene) or "equipoise and above evidence" (PCE) of an association – Mr. Davis's exposures did not increase his overall cancer risk by more than 0.01% (*i.e.*, 1×10^{-4} , or 1 cancer case in 10,000 exposed people) over his background cancer risk, and does not exceed US EPA's acceptable cancer risk range. Therefore, based on reasonable assumptions for mess hall exposures, one cannot reasonably conclude that Mr. Davis's exposures to chemicals in Camp Lejeune water are causally associated with his NHL.

Because the cancer risks presented in Table 6.1 are overestimated for healthy individuals in a population (like Mr. Davis during the time of his alleged exposure), in Section 7, I have also conducted margin of exposure (MoE) comparisons between the exposures predicted for the plaintiff and the lowest exposure levels at which health effects have been observed (or exposure levels at which no effects have been observed, for some chemicals) in the human or animal studies that are the basis of the toxicity criteria. In Section 8, I have also conducted a comparison of the plaintiff's estimated exposures to the exposures reported in epidemiology and animal studies relevant to NHL.

7 Plaintiff-Specific Margins of Exposure

As discussed in Section 3, the exposure levels at which health effects are predicted to be associated with no (or a very low) response from animal or human studies are the starting points (*i.e.*, points of departure [PODs]) used to derive regulatory toxicity criteria. PODs are the doses from which linear extrapolation is conducted to lower doses for the derivation of cancer toxicity criteria. In this section, I compare the plaintiff's exposure estimates for the chemicals evaluated in this report to the chemical-specific PODs. These types of comparisons provide what is called margins of exposure (MoEs) between the exposure predicted for an individual and the lowest exposure levels at which health effects have been observed (or exposure levels at which no effects have been observed, for some chemicals) in human or animal studies. In comparison to the conservative regulatory risk calculations (described in Section 6) that are designed to assess risk for the most sensitive individual in a population, and for any concentration above zero (for carcinogens), MoEs provide a comparison of individual exposure estimates to concentrations much closer to those at which health effects have been reported in human studies (or in animal studies used to extrapolate to humans). As discussed in Section 3, the equation used to calculate MoEs is as follows:

$$\text{MoE} = \frac{\text{POD for the Cancer Toxicity Value}}{\text{Individual LADD or LADE}}$$

If the MoE is greater than 1, that indicates that the POD (*i.e.*, estimated to reflect exposures related to no or very low responses) is higher than exposures estimated for the individual, providing support that adverse health effects would not be expected for the individual.

The PODs for the ingestion (or dermal) and inhalation pathways for each chemical assessed herein are presented in Section 5.2. The plaintiff-specific exposure levels and MoEs are presented in Appendix D. As shown in Table D.1 and D.2, the MoEs for the plaintiff range from 52 to 54,000,000. For TCE (*i.e.*, the only chemicals for which the toxicity values are based on NHL) *via* all exposure pathways, the MoEs range from 52 to 1,000,000. Therefore, the MoEs are orders of magnitude above 1, indicating that the plaintiff's estimated exposure levels to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE in tap water (*via* inhalation, ingestion, and dermal exposure) at Camp Lejeune were well below the exposure doses and concentrations used to derive the toxicity criteria for these chemicals, providing additional support that the plaintiff's exposures would not have been expected to lead to adverse health effects.

8 Consideration of Epidemiology and Animal Studies Relevant to NHL

In this section, I compare the exposure estimates for the plaintiff to exposure information I identified from epidemiology and toxicology studies summarized in Dr. Goodman's expert report that evaluated the possible association between TCE, PCE, benzene, vinyl chloride, or 1,2-tDCE exposure and NHL risk (Goodman, 2025).

Although Dr. Goodman reviewed epidemiology studies that evaluated potential correlations between chemical exposures and NHL in study participants who were stationed at Camp Lejeune, I did not consider exposure estimates from those studies because of the limitations in the studies (*e.g.*, high likelihood of exposure misclassification), as discussed by Dr. Goodman (2025). Dr. Goodman (2025) also states the following with regard to these studies:

Overall, most analyses do not provide evidence of associations between either working or living at Camp Lejeune or TCE, PCE, benzene, or vinyl chloride exposures at Camp Lejeune and NHL overall or any NHL subtype. Almost all risk estimates were less than or close to 1. The few reported statistically significant risk estimates were not consistently reported across analyses of the Camp Lejeune population, and all were <1. (Goodman, 2025).

8.1 TCE

As summarized in Section 5, ATSDR, in its "Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune" (ATSDR, 2017b), concluded that there was "sufficient evidence for causation" for TCE exposure and NHL. US EPA (2011a, 2020a), ATSDR (2019a), and IARC (2014) conclude that the epidemiology studies suggest a causal relationship between TCE exposure and NHL. Dr. Goodman concluded that "while there is some evidence for a positive association in epidemiology studies, the scientific evidence does not support a causal association between TCE and NHL" (Goodman, 2025).

For my exposure comparisons, I relied on the NHL cancer epidemiology study conducted by Raaschou-Nielsen *et al.* (2003) that is considered by US EPA to be the most reliable study from which to quantify a potential association between TCE exposure and NHL, and from which to derive TCE cancer toxicity criteria (US EPA, 2011b) (see Section 5). These cancer toxicity criteria were applied in the recent US EPA final risk management rule for TCE under its Toxic Substances Control Act (TSCA) (US EPA, 2024a). A comparison of the exposure information estimated from this study, based on US EPA's derivation of TCE toxicity criteria specific to NHL, to the plaintiff's exposure estimates is described in Section 7; *i.e.*, Mr. Davis's TCE exposure estimates (over all exposure pathways) are 52 to 53,600,000 times lower than the NHL PODs for TCE that are based on the Raaschou-Nielsen *et al.* (2003) study.

8.2 PCE

As summarized in Section 5, ATSDR concluded that there is "equipoise or above" evidence for causation for PCE exposure and NHL (ATSDR, 2017b). Overall, ATSDR (2019b), US EPA (2012b, 2020b) and IARC (2014) concluded that there is suggestive but weak evidence of an association between PCE exposure and NHL. Dr. Goodman concluded that, overall, the scientific evidence does not support a causal association between PCE and NHL (Goodman, 2025).

Based on my review of Dr. Goodman's report (Goodman, 2025), the epidemiology (occupational) studies that also reported exposure information for PCE – Talibov *et al.* (2017) (men only) and Seidler *et al.* (2007) – both reported no associations between PCE exposure and NHL. Talibov *et al.* (2017) reported no associations between chronic lymphocytic leukemia (CLL; a subtype of NHL) and PCE inhalation exposure concentrations as high as >99.8 parts per million (ppm)-years. Seidler *et al.* (2007) reported no associations between CLL or NHL and PCE inhalation exposure concentrations as high as >78.8 ppm-years. I converted the 99.8 ppm-years exposure estimate from an occupational exposure to a continuous daily exposure for a resident ($99.8 \text{ ppm-years} \times 5/7 \text{ days} \times 8/24 \text{ hours} = 23.8 \text{ ppm-years}$). This exposure estimate is orders of magnitude above (250-fold higher than) those estimated for Mr. Davis (0.095 ppm-years). I calculated Mr. Davis's cumulative PCE exposure in ppm-years by summing the maximum cumulative ppm-year exposures from showering in the barracks, showering in his residence, and from his mess hall duty.^{11,12}

Mr. Davis's oral PCE exposure estimates are well below those reported in the animal bioassays discussed by Dr. Goodman (2025). Dr. Goodman's report indicates that, overall, there are no consistent significant increases or trends in malignant lymphomas in 2-year chronic animal bioassays at PCE oral doses up to 1,072 mg/kg-d (Goodman, 2025). This dose is orders of magnitude higher than Mr. Davis's maximum estimated PCE oral LADD of 0.0052 mg/kg-day.

See Appendix D for Mr. Davis's inhalation exposure and oral dose estimates.

8.3 Benzene

As summarized in Section 5, ATSDR concluded that there is "sufficient" evidence for causation between benzene exposure and NHL. US EPA (2003a) generally did not make conclusions regarding the potential association between benzene exposure and NHL, and IARC (2018) concluded that there is "limited evidence" that benzene exposure causes NHL. Dr. Goodman concluded that the scientific evidence does not provide support for a causation association between benzene exposure and NHL (Goodman, 2025).

Based on my review of Dr. Goodman's report (Goodman, 2025), the epidemiology studies that also reported exposure information for benzene – Collins *et al.* (2003, 2015), Bassig *et al.* (2015), Talibov *et al.* (2017), Seidler *et al.* (2007), Stenehjem *et al.* (2015), Glass *et al.* (2003), Orsi *et al.* (2010), Wong *et al.* (2010),

¹¹ 1 ppm PCE = 6,780 µg/m³ (CDC, 2019a).

¹² I estimated the ppm-year concentration for shower vapor exposure for the barracks by converting the maximum daily PCE concentration from barracks shower vapor (0.98 µg/m³) to ppm (0.00014 ppm) and multiplying by the number of years Mr. Davis took showers in the barracks at Camp Lejeune (1.2 years): $0.00014 \text{ ppm} \times 1.2 \text{ years} = 0.00017 \text{ ppm-years}$. Similarly, I estimated the ppm-year concentration for shower vapor exposure from Mr. Davis's residence at TT by converting the daily PCE concentration from TT shower vapor (62 µg/m³) to ppm (0.009 ppm) and multiplying by the number of years Mr. Davis took showers at his TT residence at Camp Lejeune (5.1 years): $0.009 \text{ ppm} \times 5.1 \text{ years} = 0.047 \text{ ppm-years}$. I did the same for mess hall vapor exposures, using the daily PCE concentration (1983 µg/m³, or 0.29 ppm) and multiplying by the number of years Mr. Davis spent doing mess hall duty at Camp Lejeune (60 days ÷ 365 days/year = 0.16 years): $0.29 \text{ ppm} \times 0.16 \text{ years} = 0.048 \text{ ppm-years}$. I then summed the ppm-year cumulative exposure concentrations from showering and mess hall duty: $0.00017 \text{ ppm-years} + 0.047 \text{ ppm-years} + 0.048 \text{ ppm-years} = 0.095 \text{ ppm-years}$.

Linnet *et al.* (2020), Rushton *et al.* (2014), and Schnatter *et al.* (2012) – are all occupational inhalation studies that reported few associations, and overall suggest a no significant effect level between NHL and benzene exposure at concentrations as high as 11 ppm-years (based on Bassig *et al.* [2015]), with several studies reporting no significant risks at even higher concentrations (*i.e.*, up to 130 ppm-years). I converted the 11 ppm-years exposure estimate from an occupational exposure to a continuous daily exposure for a resident ($11 \text{ ppm-years} \times 5/7 \text{ days} \times 8/24 \text{ hours} = 2.6 \text{ ppm-years}$). This exposure estimate is well above (~100-fold higher than) those estimated for Mr. Davis (0.026 ppm-years). I calculated Mr. Davis's cumulative benzene exposure in ppm-years by summing the maximum cumulative ppm-year exposures from showering in the barracks, showering in his residence, and from his mess hall duty.^{13,14}

Mr. Davis's oral benzene exposure estimates are well below those reported in the animal bioassays discussed by Dr. Goodman (2025). Dr. Goodman's report indicates that, overall, there are no consistent significant increases or trends in malignant lymphomas in 2-year chronic animal bioassays at benzene oral doses up to 200 mg/kg-d (Goodman, 2025). This dose is orders of magnitude higher than Mr. Davis's maximum estimated benzene oral LADD of 0.00039 mg/kg-day

See Appendix D for Mr. Davis's inhalation exposure and oral dose estimates.

8.4 Vinyl Chloride

As summarized in Section 5, US EPA and ATSDR do not conclude that exposure to vinyl chloride is associated with NHL. Dr. Goodman concluded that the scientific evidence does not provide support for a causation association between vinyl chloride and NHL.

Based on my review of Dr. Goodman's report (Goodman, 2025), only one epidemiology (occupational) study is available that evaluated a potential association between vinyl chloride exposure and NHL risk, and that also reported exposure information (Mundt *et al.*, 2017). As shown in Dr. Goodman's report (Goodman 2025), the study reported a no significant effect level between NHL and vinyl chloride exposure at concentrations as high as >2,271 ppm-years. I converted the 2,271 ppm-years exposure estimate from an occupational exposure to a continuous daily exposure for a resident ($2,271 \text{ ppm-years} \times 5/7 \text{ days} \times 8/24 \text{ hours} = 541 \text{ ppm-years}$). This exposure estimate is orders of magnitude above (2,300-fold higher than) those estimated for Mr. Davis (0.23 ppm-years). I calculated Mr. Davis's cumulative vinyl chloride exposure in ppm-years by summing the maximum cumulative ppm-year exposures from showering in the barracks, showering in his residence, and from his mess hall duty.^{15,16} See Appendix D for Mr. Davis's inhalation exposure estimates.

There were no oral animal bioassays discussed in Dr. Goodman's report (Goodman, 2025) that evaluated exposures to vinyl chloride and malignant lymphoma risk.

8.5 1,2-tDCE

As summarized in Section 5, Dr. Goodman concluded that, overall, the scientific evidence (including epidemiology and toxicology studies) is too limited to address whether there is a causal association between

¹³ 1 ppm benzene = 3,190 µg/m³ (CDC, 2019b).

¹⁴ Calculations for benzene were conducted in the same manner as for PCE, but with benzene daily exposure concentrations for all three exposure pathways, as presented in Appendix D.

¹⁵ 1 ppm vinyl chloride = 2,560 µg/m³ (CDC, 2019c).

¹⁶ Calculations for vinyl chloride were conducted in the same manner as for PCE and benzene, but with vinyl chloride daily exposure concentrations for all three exposure pathways, as presented in Appendix D.

1,2-tDCE and NHL (Goodman, 2025). ATSDR (2017b) provided no comment on whether there is a causal association between 1,2-tDCE exposure and NHL. The US EPA and ATSDR do not conclude that there is an association between exposure to 1,2-tDCE and NHL (see Section 5). Therefore, exposure comparisons cannot be made for 1,2-tDCE.

8.6 Conclusions from Epidemiology and Toxicology Studies

As described above, Mr. Davis's exposures to TCE, PCE, benzene, and vinyl chloride were well below exposure levels of concern for NHL, or well below levels in animal studies that overall did not observe significant increases (or significant trends) in malignant lymphomas. Therefore, these results provide additional support that Mr. Davis's estimated exposures would not have been expected to lead to his NHL.

9 Rebuttal of the Plaintiff's Experts' Reports

I reviewed the reports of the plaintiff's experts, Dr. Kelly Reynolds (2025a), who provided exposure estimates for the plaintiff, and Dr. Richard Hoppe (2025), who provided opinions on specific causation for Mr. Davis. Below, I note the methodological flaws in their analyses, with respect to risk assessment.

9.1 Dr. Reynolds

Dr. Reynolds' report (Reynolds, 2025a) does not provide reliable estimates of TCE, PCE, vinyl chloride, and benzene exposures for Mr. Davis from which to evaluate potential adverse health effects.

Dr. Reynolds relies on ATSDR's monthly modeled concentrations (in $\mu\text{g/L}$) of TCE, PCE, vinyl chloride, and benzene to calculate total cumulative amounts (μg) of each chemical summed over time, based on plaintiff-specific drinking water ingestion rates and exposure durations for the total time the plaintiff spent at Camp Lejeune (Reynolds, 2025a). Dr. Reynolds describes that her exposure scenarios are based on military field manuals and plaintiff depositions. Dr. Reynolds provides these estimates in plaintiff-specific "exposure assessment charts" in her report (Reynolds, 2025a).

Although Dr. Reynolds' calculations are not clearly explained, it appears that she first calculates a cumulative $\mu\text{g/L}$ -month concentration for the plaintiff based on the chemical concentrations and the number of months the plaintiff was stationed at Camp Lejeune. She also calculates a total chemical mass (in μg) for each plaintiff based on the water concentration and the daily ingestion rate; these calculations were further explained in her calculation summary (Reynolds, 2025b). With respect to Dr. Reynolds' use of total amount (μg) as an oral exposure estimate – this is not a standard exposure metric used in risk assessment. As previously discussed in Section 3.3.2, oral and dermal exposure estimates are represented by the daily dose of a chemical taken into the body, averaged over the appropriate exposure period and expressed in units of milligram of chemical per kilogram of human body weight per day (mg/kg-day). Inhalation exposure estimates represent the daily exposure concentration of a chemical taken into the body, averaged over the appropriate exposure period and expressed in units of microgram of a chemical per cubic meter of air ($\mu\text{g/m}^3$). As discussed in Section 3, doses and inhalation exposure estimates can then be used to calculate excess lifetime cancer risks (ELCRs) using US EPA's chemical-specific toxicity criteria, and then the results can be compared to US EPA guidelines for acceptable ELCRs. Therefore, Dr. Reynolds' representation of exposure as the total ingested amount of a chemical (μg) cannot be used directly to evaluate potential health effects for the plaintiff. That is, the mass of ingested chemical needs to be divided by body weight for the plaintiff and averaged over the appropriate averaging time, as described in Section 3, and as presented in my report for the plaintiff (Section 6), so that the oral doses can be used to calculate ELCRs per US EPA risk assessment guidelines.

Further, total mass cannot be compared to exposure estimates in most reliable animal or epidemiology studies. Doses (mg/kg-day) or inhalation concentrations ($\mu\text{g/m}^3$) are typically used in animal bioassays for evaluating potential health effects from chemical exposures. Most reliable epidemiology studies provide cumulative exposure estimates in ppm-year (*i.e.*, inhalation exposure concentration \times number of years exposed) and ppb-month or ppb-year (*i.e.*, ingested water concentration \times number of months or years exposed). Thus, there is no risk-based comparison that can be made between total ingested mass and exposure information from relevant animal or epidemiology studies.

9.2 Dr. Hoppe

Dr. Hoppe's report (Hoppe, 2025) does not provide a reliable analysis of specific causation or risk of NHL with regard to Mr. Davis's alleged exposures. Dr. Hoppe concludes that the concentrations of TCE, PCE, and benzene in the tap water during the time that Mr. Davis was stationed at Camp Lejeune was "more likely than not, the cause of Mr. Davis's NHL" without providing a robust analysis of the best available scientific information relevant to the potential specific causal association between exposure to these chemicals and Mr. Davis's NHL. Therefore, Dr. Hoppe cannot use his evaluation to determine Mr. Davis's risks. Below I describe several serious flaws in Dr. Hoppe's analysis:

- Dr. Hoppe's risk evaluation is not consistent with US EPA's risk assessment guidelines, which consider not only exposure concentrations, but also exposure frequency and duration.
 - As discussed in Sections 3 and 5, exposure frequency and duration are critical components of US EPA's risk assessment methodology. It is only when the exposure concentrations, in combination with exposure frequencies and durations, result in doses exceeding US EPA's toxicity criteria (*i.e.*, result in a risk estimate that exceeds US EPA's acceptable targets) that there is concern for potential adverse health effects. And even with slight exceedances of US EPA's conservative risk targets, health effects are not necessarily expected (discussed in Section 3).
- Dr. Hoppe's comparison to US EPA Maximum Contaminant Levels (MCLs) for allowable chemical concentrations in drinking water is not a reliable risk evaluation method.
 - US EPA does not use MCLs to evaluate potential risks to human health.
 - MCLs are derived to be acceptable (health-protective) daily drinking water concentrations over a lifetime of exposure (~70 years) (US EPA, 2024b), which is much longer than Mr. Davis's 6.3 years of exposure during his time at Camp Lejeune.
 - Per US EPA guidance for cancer risk assessment, it is the cumulative dose averaged over a lifetime that is critical for evaluating cancer risk. As shown in the equations in Section 3, estimated doses are averaged over a 70-year lifetime before calculating risks. Therefore, once averaged over a lifetime, it is possible to have a dose based on a higher exposure concentration for a shorter exposure duration (which is the case for some of the plaintiffs at Camp Lejeune) that would not exceed a dose based on a lower exposure concentration for a longer exposure duration (like ingesting water at the MCL every day for a lifetime). In both cases, risks would be considered acceptable under US EPA guidelines. Therefore, a simple comparison of drinking water concentrations to MCLs, without considering exposure duration, is not consistent with standard risk assessment practice and is misleading.
- Dr. Hoppe's report also refers to exposure information from several Camp Lejeune studies to support his conclusions. However, as discussed in Dr. Goodman's report (Goodman, 2025), there are methodological limitations in these studies (*e.g.*, high likelihood of exposure misclassification). In addition, with regard to the Camp Lejeune studies, Dr. Goodman states the following:

Overall, most analyses do not provide evidence of associations between either working or living at Camp Lejeune or TCE, PCE, benzene, or vinyl chloride exposures at Camp Lejeune and NHL overall or any NHL subtype. Almost all risk estimates were less than or close to 1. The few reported statistically significant risk estimates were not consistently reported across analyses of the Camp Lejeune population, and all were <1. (Goodman, 2025)

- In addition, as discussed in Section 5, based on a comprehensive review of the best available and most current epidemiology and animal studies for TCE, PCE, benzene, and vinyl chloride exposures and NHL, Dr. Goodman (2025) concludes that the scientific evidence does not support a causal association between TCE, PCE, benzene, vinyl chloride, or 1,2-tDCE exposure and NHL.

As discussed in my report (Section 6), applying standard risk assessment methodology (*i.e.*, considering exposure concentrations in addition to exposure frequency and duration for the plaintiff), and considering reasonable mess hall exposure assumptions, the excess lifetime cancer risks estimated for Mr. Davis's exposures do not exceed US EPA's acceptable cancer risk range.

Therefore, Dr. Reynolds' and Dr. Hoppe's expert reports do not change my opinions, as discussed in my report and summarized in Section 10, regarding Mr. Davis's claim that exposures from Camp Lejeune are the cause of his NHL.

10 Conclusion and Summary of Opinions

Based on the conservative regulatory risk calculations discussed in Section 6, the MoE calculations discussed in Section 7, and consideration of the epidemiology and animal studies discussed in Section 8, it is my opinion, to a reasonable degree of scientific certainty, that there is insufficient evidence to conclude that Mr. Davis's exposures to TCE, PCE, benzene, vinyl chloride, and 1,2-tDCE from tap water during the 6.3 years that he was employed at Camp Lejeune were causally associated with his NHL.

References

Agency for Toxic Substances and Disease Registry (ATSDR). 2007a. "Toxicological Profile for Benzene." 438p., August.

Agency for Toxic Substances and Disease Registry (ATSDR). 2007b. "Analyses of Groundwater Flow, Contaminant Fate and Transport, and Distribution of Drinking Water at Tarawa Terrace and Vicinity, U.S. Marine Corps Base Camp Lejeune, North Carolina: Historical Reconstruction and Present-Day Conditions: Chapter A." July.

Agency for Toxic Substances and Disease Registry (ATSDR). 2013a. "Chapter A - Supplement 8: Field Tests, Data Analyses, and Simulation of the Distribution of Drinking Water with Emphasis on Intermittent Transfers of Drinking Water Between the Hadnot Point and Holcomb Boulevard Water-Distribution Systems." In "Analyses and Historical Reconstruction of Groundwater Flow, Contaminant Fate and Transport, and Distribution of Drinking Water Within the Service Areas of the Hadnot Point and Holcomb Boulevard Water Treatment Plants and Vicinities, U.S. Marine Corps Base Camp Lejeune, North Carolina." 212p., March. Accessed at https://www.atsdr.cdc.gov/sites/lejeune/docs/Chapter_A_Supplement_8.pdf.

Agency for Toxic Substances and Disease Registry (ATSDR). 2013b. "Analyses and Historical Reconstruction of Groundwater Flow, Contaminant Fate and Transport, and Distribution of Drinking Water Within the Service Areas of the Hadnot Point and Holcomb Boulevard Water Treatment Plants and Vicinities, U.S. Marine Corps Base Camp Lejeune, North Carolina: Chapter A." May.

Agency for Toxic Substances and Disease Registry (ATSDR). 2015. "Addendum to the Toxicological Profile for Benzene." 59p., June.

Agency for Toxic Substances and Disease Registry (ATSDR). 2017a. "Public Health Assessment for Camp Lejeune Drinking Water, U.S. Marine Corps Base Camp Lejeune, North Carolina." 202p., January 20.

Agency for Toxic Substances and Disease Registry (ATSDR). 2017b. "ATSDR Assessment of the Evidence for the Drinking Water Contaminants at Camp Lejeune and Specific Cancers and Other Diseases." 152p., January 13.

Agency for Toxic Substances and Disease Registry (ATSDR). 2018a. "Minimal Risk Levels (MRLs) for professionals: MRL information for the general public." June 21. Accessed at <https://www.atsdr.cdc.gov/mrls/index.html>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2018b. "Minimal Risk Levels (MRLs)." June 4. Accessed at <https://www.atsdr.cdc.gov/minimalrisklevels/index.html>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2019a. "Toxicological Profile for Trichloroethylene." 511p., June. Accessed at <https://www.atsdr.cdc.gov/ToxProfiles/tp19.pdf>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2019b. "Toxicological Profile for Tetrachloroethylene." 435p., June. Accessed at <https://www.atsdr.cdc.gov/ToxProfiles/tp18.pdf>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2023. "Toxicological Profile for 1,2-Dichloroethene (Draft for Public Comment)." 222p., August. Accessed at <https://www.atsdr.cdc.gov/toxprofiledocs/index.html>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2024a. "Shower and Household Water-use Exposure (SHOWER) Model v4.0." September 26. Accessed at <https://www.atsdr.cdc.gov/pha-guidance/toolbox/index.html>.

Agency for Toxic Substances and Disease Registry (ATSDR). 2024b. "Toxicological Profile for Vinyl Chloride (Final)." 312p., January. Accessed at <https://wwwn.cdc.gov/TSP/ToxProfiles/ToxProfiles.aspx?id=282&tid=51>.

Aleksunes, LM; Eaton, DL. 2019. "Principles of toxicology." In *Casarett and Doull's Toxicology: The Basic Science of Poisons (Ninth Edition)*. (Ed.: Klaassen, CD), McGraw-Hill Education, New York, NY. p25-64.

American Cancer Society (ACS). 2024. "Cancer Statistics Center." Accessed at <https://cancerstatisticscenter.cancer.org>.

Ames, BN; Gold, LS; Willett, WC. 1995. "The causes and prevention of cancer." *Proc. Natl. Acad. Sci. USA* 92:5258-5265.

Bassig, BA; Friesen, MC; Vermeulen, R; Shu, XO; Purdue, MP; Stewart, PA; Xiang, YB; Chow, WH; Zheng, T; Ji, BT; Yang, G; Linet, MS; Hu, W; Zhang, H; Zheng, W; Gao, YT; Rothman, N; Lan, Q. 2015. "Occupational exposure to benzene and non-Hodgkin lymphoma in a population-based cohort: The Shanghai Women's Health Study." *Environ. Health Perspect.* 123(10):971-977. doi: 10.1289/ehp.1408307.

Bove, FJ; Ruckart, PZ; Maslia, M; Larson, TC. 2014. "Evaluation of mortality among marines and navy personnel exposed to contaminated drinking water at USMC base camp Lejeune: A retrospective cohort study." *Environ. Health* 13:10. doi: 10.1186/1476-069X-13-10.

Calabrese, EJ. 2023. "Dose-response: A fundamental concept in toxicology." In *Hayes' Principles and Methods of Toxicology (Seventh Edition)*. (Eds.: Hayes, AW; Kobets, T), CRC Press, Boca Raton, FL. p95-141. doi: 10.1201/9781003390008-4.

Cardarelli, JJ II; Ulsh, BA. 2018. "It is time to move beyond the linear no-threshold theory for low-dose radiation protection." *Dose Response* 16(3):1559325818779651. doi: 10.1177/1559325818779651.

Centers for Disease Control and Prevention (CDC). 2019a. "NIOSH Pocket Guide to Chemical Hazards record for tetrachloroethylene (CAS No. 127-18-4)." October 30. Accessed at <https://www.cdc.gov/niosh/npg/npgd0599.html>

Centers for Disease Control and Prevention (CDC). 2019b. "NIOSH Pocket Guide to Chemical Hazards record for benzene (CAS No. 71-43-2)." October 30. Accessed at <https://www.cdc.gov/niosh/npg/npgd0049.html>.

Centers for Disease Control and Prevention (CDC). 2019c. "NIOSH Pocket Guide to Chemical Hazards record for vinyl chloride (CAS No. 75-01-4)." October 30. Accessed at <https://www.cdc.gov/niosh/npg/npgd0658.html>

Charbotel, B; Fevotte, J; Hours, M; Martin, JL; Bergeret, A. 2006. "Case-control study on renal cell cancer and occupational exposure to trichloroethylene. Part II: Epidemiological aspects." *Ann. Occup. Hyg.* 50(8):777-787. doi: 10.1093/annhyg/mel039.

Collins, JJ; Anteau, SE; Swaen, GM; Bodner, KM; Bodnar, CM. 2015. "Lymphatic and hematopoietic cancers among benzene-exposed workers." *J. Occup. Environ. Med.* 57(2):159-163. doi: 10.1097/JOM.0000000000000324.

Collins, JJ; Ireland, B; Buckley, CF; Shepperly, D. 2003. "Lymphohaematopoeitic cancer mortality among workers with benzene exposure." *Occup. Environ. Med.* 60(9):676-679. doi: 10.1136/oem.60.9.676.

Crump, KS; Allen, BC. [Science Research Systems, Inc.]. 1984. "Quantitative Estimates of Risk of Leukemia from Occupational Exposure to Benzene." Submitted to Occupational Safety and Health Administration (OSHA) Docket H-059B, Exhibit 152. 133p.

Davis, C. 2024. "Videotaped deposition and other relevant plaintiff-specific materials of Cometto Davis [re: Cometto Davis vs. United States of America]." Submitted to US District Court, Eastern District of North Carolina. No.: 7:23-cv-00043.

Feron, VJ; Hendriksen, CFM; Speek, AJ; Til, HP; Spit, BJ. 1981. "Lifespan oral toxicity study of vinyl chloride in rats." *Food Cosmet. Toxicol.* 19:317-333.

Glass, DC; Gray, CN; Jolley, DJ; Gibbons, C; Sim, MR; Fritschi, L; Adams, GG; Bisby, JA; Manuell, R. 2003. "Leukemia risk associated with low-level benzene exposure." *Epidemiology* 14(5):569-577. doi: 10.1097/01.ede.0000082001.05563.e0.

Golden, R; Bus, J; Calabrese, E. 2019. "An examination of the linear no-threshold hypothesis of cancer risk assessment: Introduction to a series of reviews documenting the lack of biological plausibility of LNT." *Chem. Biol. Interact.* 301:2-5. doi: 10.1016/j.cbi.2019.01.038.

Goodman, JE. [Gradient]. 2025. "Trichloroethylene, Perchloroethylene, Benzene, Vinyl Chloride, and trans-1,2-Dichloroethylene Exposure and NHL Risk." 434p., February 7.

Hennet, RJC. [S.S. Papadopoulos & Associates, Inc.]. 2024. "Expert Report of Remy J.-C. Hennet, In the United States District Court, Eastern District of North Carolina, No. 7:23-cv-897, In Re: Camp Lejeune Water Litigation." Report to US Dept. of Justice (US DOJ). 221p., December 9.

Hoppe, RT. [Stanford University]. 2025. "Specific Causation Expert Report of Richard T. Hoppe, MD, FACR, FASTRO, FARS, Cometto J. Davis v. United States of America, U.S. District Court for Eastern District of NC, Southern Division, Case No. 7:23-cv-00043." 81p., February 6.

International Agency for Research on Cancer (IARC). 2014. "Trichloroethylene." In "IARC Monographs on the Evaluation of Carcinogenic Risks to Humans: Volume 106: Trichloroethylene, Tetrachloroethylene, and Some Other Chlorinated Agents." IARC Monograph No. 106. International Agency for Research on Cancer (IARC), World Health Organization (WHO). p35-218. Accessed at <http://monographs.iarc.fr/ENG/Monographs/vol106/mono106-001.pdf>.

International Agency for Research on Cancer (IARC). 2018. "IARC Monographs on the Evaluation of Carcinogenic Risks to Humans Volume 120: Benzene." IARC Monograph No. 120. International Agency for Research on Cancer (IARC); World Health Organization (WHO). 307p.

Japan Industrial Safety Association (JISA). 1993. "Carcinogenicity Study of Tetrachloroethylene by Inhalation in Rats and Mice: Data No. 3-1." 53p., March 31.

LaKind, JS. [LaKind Associates, LLC]. 2025. "Expert Report of Judy S. LaKind, Ph.D. in the Matter of *Davis v. United States*." April 8.

Linnet, MS; Gilbert, ES; Vermeulen, R; Dores, GM; Yin, SN; Portengen, L; Hayes, RB; Ji, BT; Lan, Q; Li, GL; Rothman, N. 2020. "Benzene exposure-response and risk of lymphoid neoplasms in Chinese workers: A multicenter case-cohort study." *Am. J. Ind. Med.* 63(9):741-754. doi: 10.1002/ajim.23142.

Maltoni, C; Lefemine, G; Ciliberti, A; eds. 1984. *Experimental Research on Vinyl Chloride Carcinogenesis. Part I: Review of Available Data on General Pathology and Carcinogenicity*. Princeton Archives of Research on Industrial Carcinogenesis: Volume 2. Scientific Publishing, Co., Princeton, NJ. p1-35.

Maslia, ML; Aral, MM; Ruckart, PZ; Bove, FJ. 2016. "Reconstructing historical VOC concentrations in drinking water for epidemiological studies at a U.S. Military base: Summary of results." *Water* 8(10):449. doi: 10.3390/w8100449.

Mayo Clinic. 2024. "Cancer risk: What the numbers mean." March 29. Accessed at <https://www.mayoclinic.org/diseases-conditions/cancer/in-depth/cancer/art-20044092>.

McGowan, Hood, Felder, & Phillips, LLC. 2024. "Plaintiff's responses and objections to defendant United States of America's second set of requests for admission [re: *Cometto Davis v. United States*]." Submitted to US District Court, Eastern District of North Carolina, Southern Division. Case No. 7:23-cv-00897. 4p., August 9.

Mundt, KA; Dell, LD; Crawford, L; Gallagher, AE. 2017. "Quantitative estimated exposure to vinyl chloride and risk of angiosarcoma of the liver and hepatocellular cancer in the US industry-wide vinyl chloride cohort: mortality update through 2013." *Occup. Environ. Med.* 74(10):709-716. doi: 10.1136/oemed-2016-104051.

National Research Council (NRC). 1983. "Risk Assessment in the Federal Government: Managing the Process." Committee on the Institutional Means for Assessment of Risks to Public Health, National Academy Press, Washington, DC. 191p. Accessed at <https://www.nap.edu/catalog/366/risk-assessment-in-the-federal-government-managing-the-process>.

National Research Council (NRC). 2009. "Toward a unified approach to dose-response assessment: The need for an improved dose-response framework." In *Science and Decisions: Advancing Risk Assessment*. Committee on Improving Risk Analysis Approaches Used by the US EPA. The National Academies Press, Washington, DC. p118-173.

Olsen, GW; Butenhoff, JL; Cook, RR. 2014. "Epidemiology for toxicologists." In *Hayes' Principles and Methods of Toxicology (Sixth Edition)*. (Eds.: Hayes, AW; Kruger, CL), CRC Press, Boca Raton, FL. p527-570.

Orsi, L; Monnereau, A; Dananche, B; Berthou, C; Fenaux, P; Marit, G; Soubeyran, P; Huguet, F; Milpied, N; Leporrier, M; Hemon, D; Troussard, X; Clavel, J. 2010. "Occupational exposure to organic solvents and lymphoid neoplasms in men: Results of a French case-control study." *Occup. Environ. Med.* 67(10):664-672.

Paustenbach, DJ; Price, PS; Ollison, W; Blank, C; Jernigan, JD; Bass, RD; Peterson, HD. 1992. "Reevaluation of benzene exposure for the Pliofilm (rubberworker) cohort (1936-1976)." *J. Toxicol. Environ. Health* 36(3):177-231.

Popper, H; Maltoni, C; Selikoff, IJ. 1981. "Vinyl chloride-induced hepatic lesions in man and rodents. A comparison." *Liver* 1:7-20.

Raaschou-Nielsen, O; Hansen, J; McLaughlin, JK; Kolstad, H; Christensen, JM; Tarone, RE; Olsen, JH. 2003. "Cancer risk among workers at Danish companies using trichloroethylene: A cohort study." *Am. J. Epidemiol.* 158(12):1182-1192.

Reynolds, KA. [University of Arizona, Mel and Enid Zuckerman College of Public Health]. 2025a. "Cumulative Exposure Expert Report, Kelly A Reynolds, MSPH, PhD." [PLG-EXPERT_REYNOLDS_0000000001-PLG-EXPERT_REYNOLDS_0000000027]. February 7.

Reynolds, KA. [University of Arizona, Mel and Enid Zuckerman College of Public Health]. 2025b. "Calculations Summary." 28p., March 28.

Rinsky, RA; Smith, AB; Hornung, R; Filloon, TG; Young, RJ; Okun, AH; Landrigan, PJ. 1987. "Benzene and leukemia: An epidemiologic risk assessment." *N. Engl. J. Med.* 316:1044-1050.

Rinsky, RA; Young, RJ; Smith, AB. 1981. "Leukemia in benzene workers." *Am. J. Ind. Med.* 2(3):217-245. doi: 10.1002/ajim.4700020305.

Rodricks, JV; Rieth, SH. 1998. "Toxicological risk assessment in the courtroom: Are available methodologies suitable for evaluating toxic tort and product liability claims?" *Regul. Toxicol. Pharmacol.* 27:21-31.

Rushton, L; Schnatter, AR; Tang, G; Glass, DC. 2014. "Acute myeloid and chronic lymphoid leukaemias and exposure to low-level benzene among petroleum workers." *Br. J. Cancer* 110(3):783-787.

Schnatter, AR; Glass, DC; Tang, G; Irons, RD; Rushton, L. 2012. "Myelodysplastic syndrome and benzene exposure among petroleum workers: An international pooled analysis." *J. Natl. Cancer Inst.* 104(22):1724-1737. doi: 10.1093/jnci/djs411.

Seidler, A; Mohner, M; Berger, J; Mester, B; Deeg, E; Elsner, G; Nieters, A; Becker, N. 2007. "Solvent exposure and malignant lymphoma: a population-based case-control study in Germany." *J. Occup. Med. Toxicol.* 2:2.

Spiliotopoulos, A. [S.S. Papadopoulos & Associates, Inc.]. 2024. "Expert Report of Alexandros Spiliotopoulos, PhD, In the United States District Court for the Eastern District of North Carolina, No. 7:23-cv-897, In Re: Camp Lejeune Water Litigation." Report to US Dept. of Justice (US DOJ). 138p., December 9.

Stenehjem, JS; Kjaerheim, K; Bratveit, M; Samuelsen, SO; Barone-Adesi, F; Rothman, N; Lan, Q; Grimsrud, TK; UK Inflammatory Breast Cancer Working Group. 2015. "Benzene exposure and risk of lymphohaematopoietic cancers in 25 000 offshore oil industry workers." *Br. J. Cancer* 112(9):1603-1612. doi: 10.1038/bjc.2015.108.

Swenberg, JA; Lu, K; Moeller, BC; Gao, L; Upton, PB; Nakamura, J; Starr, TB. 2011. "Endogenous versus exogenous DNA adducts: Their role in carcinogenesis, epidemiology, and risk assessment." *Toxicol. Sci.* 120(Suppl. 1):S130-S145. doi: 10.1093/toxsci/kfq371.

Talibov, M; Auvinen, A; Weiderpass, E; Hansen, J; Martinsen, J-I; Kjaerheim, K; Tryggvadottir, L; Pukkala, E. 2017. "Occupational solvent exposure and adult chronic lymphocytic leukemia: No risk in a population-based case-control study in four Nordic countries." *Int. J. Cancer* 141:1140-1147. doi: 10.1002/ijc.30814.

US Congress. 1974. "Public Law 93-525: Safe Drinking Water Act of 1974." PL 93-525, 88 Stat 1660. December 16.

US EPA. 1989. "Risk Assessment Guidance for Superfund (RAGS). Volume I: Human Health Evaluation Manual (Part A) (Interim final)." Office of Emergency and Remedial Response. NTIS PB90-155581, EPA-540/1-89-002. 287p., December.

US EPA. 1990. "National Oil and Hazardous Substances Pollution Contingency Plan; Final rule." *Fed. Reg.* 55(46):8666-8865.

US EPA. 1991. "Role of the Baseline Risk Assessment in Superfund Remedy Selection Decisions." Office of Solid Waste and Emergency Response (OSWER). National Technical Information Service (NTIS). OSWER Directive 9355.0-30, NTIS PB91-92139, 10p., April 22.

US EPA. 1992. "Dermal Exposure Assessment: Principles and Applications (Interim)." Office of Health and Environmental Assessment, Exposure Assessment Group; Office of Research and Development, Center for Environmental Research Information. EPA-600/8-91-011B, January.

US EPA. 1993. "Reference Dose (RfD): Description and Use in Risk Assessments." IRIS Background Document 1A, March 15. Accessed at <https://www.epa.gov/iris/reference-dose-rfd-description-and-use-health-risk-assessments>.

US EPA. 1998. "Carcinogenic Effects of Benzene: An Update." National Center for Environmental Assessment (NCEA). PA/600/P-97/001F, 57p., April.

US EPA. 1999. "Extrapolation of the Benzene Inhalation Unit Risk Estimate to the Oral Route of Exposure." National Center for Environmental Assessment (NCEA). NCEA-W-0517, 21p., November.

US EPA. 2000. "Toxicological Review of Vinyl Chloride (CAS No. 75-01-4)." EPA/635/R-00/004. 197p., May.

US EPA. 2002. "A Review of the Reference Dose and Reference Concentration Processes (Final)." Risk Assessment Forum, Reference Dose/Reference Concentration (RfD/RfC) Technical Panel. EPA/630-P-02/002F, 192p., December.

US EPA. 2003a. "IRIS Chemical Assessment Summary for Benzene (CAS No. 71-43-2)." 43p., April 17. Accessed at <https://www.epa.gov/iris>.

US EPA. 2003b. "IRIS Chemical Assessment Summary for Vinyl Chloride (CAS No. 75-01-4)." 63p., October 28. Accessed at <https://www.epa.gov/iris>.

US EPA. 2004. "Risk Assessment Guidance for Superfund (RAGS). Volume I: Human Health Evaluation Manual (Part E, Supplemental Guidance for Dermal Risk Assessment) (Final)." Office of Superfund Remediation and Technology Innovation. EPA/540/R/99/005, OSWER 9285.7-02EP, PB99-963312, 156p., July.

US EPA. 2005. "Guidelines for Carcinogen Risk Assessment." Risk Assessment Forum. EPA/630/P-03/001F, 166p., March.

US EPA. 2010a. "IRIS Chemical Assessment Summary for trans-1,2-Dichloroethylene (CAS No. 156-60-5)." 21p., September 30. Accessed at <https://www.epa.gov/iris>.

US EPA. 2010b. "Toxicological Review of cis-1,2-Dichloroethylene and trans-1,2-Dichloroethylene (CAS Nos. cis: 156-59-2; trans: 156-60-5; mixture: 540-59-0) in Support of Summary Information on the Integrated Risk Information System (IRIS)." EPA/635/R-09/006F, 174p., September.

US EPA. 2011a. "Toxicological Review of Trichloroethylene (CAS No. 79-01-6) in Support of Summary Information on the Integrated Risk Information System (IRIS) (Final)." EPA/635/R-09/011F, 2469p., September.

US EPA. 2011b. "IRIS Chemical Assessment Summary for Trichloroethylene (CAS No. 79-01-6)." 65p., September 28. Accessed at <https://www.epa.gov/iris>.

US EPA. 2012a. "Benchmark Dose Technical Guidance." Risk Assessment Forum. EPA/100/R-12/001, 99p., June.

US EPA. 2012b. "Toxicological Review of Tetrachloroethylene (Perchloroethylene) (CAS No. 127-18-4) in Support of Summary Information on the Integrated Risk Information System (IRIS) (Final)." EPA/635/R-08/011F, 1077p., February.

US EPA. 2012c. "IRIS Chemical Assessment Summary for Tetrachloroethylene (Perchloroethylene) (CAS No. 127-18-4)." 38p., February 10. Accessed at <https://www.epa.gov/iris>.

US EPA. 2014. Memorandum from D. Stalcup to Superfund National Policy Managers, Regions 1-10 re: Human Health Evaluation Manual, Supplemental Guidance: Update of standard default exposure factors." Office of Solid Waste and Emergency Response (OSWER). OSWER Directive 9200.1-120, 7p., February 6.

US EPA. 2020a. "Risk Evaluation for Trichloroethylene (CASRN: 79-01-6) (Final)." EPA Document # 740R18008, 803p., November.

US EPA. 2020b. "Risk Evaluation for Perchloroethylene (Ethene, 1,1,2,2-Tetrachloro-) (CASRN: 127-18-4) (Final)." EPA Document # 740-R1-8011, 714p., December.

US EPA. 2021. "IRIS Glossary." March 11. Accessed at <https://www.epa.gov/iris/iris-glossary>.

US EPA. 2024a. "Trichloroethylene (TCE); Regulation under the Toxic Substances Control Act (TSCA) (Final rule)." *Fed. Reg.* 89(242):102568-102635. 40 CFR 751. December 17. Accessed at <https://www.govinfo.gov/content/pkg/FR-2024-12-17/pdf/2024-29274.pdf>

US EPA. 2024b. "National Primary Drinking Water Regulations." 40 CFR 141. 567p. Accessed at [https://www.ecfr.gov/current/title-40/chapter-I/subchapter-D/part-141#p-141.23\(i\)](https://www.ecfr.gov/current/title-40/chapter-I/subchapter-D/part-141#p-141.23(i))

Wong, O; Harris, F; Armstrong, TW; Hua, F. 2010. "A hospital-based case-control study of non-Hodgkin lymphoid neoplasms in Shanghai: Analysis of environmental and occupational risk factors by subtypes of the WHO classification." *Chem. Biol. Interact.* 184(1-2):129-146.

Appendix A

Curriculum Vitae Lisa A. Bailey, Ph.D.

Lisa Bailey, Ph.D.

Principal

Lisa.Bailey@gradientcorp.com

Areas of Expertise

Human health risk assessment, exposure assessment, toxicology, DNA repair, mutagenesis, carcinogenesis.

Education

Ph.D., Biochemistry, Massachusetts Institute of Technology, 1995

B.A., *cum laude*, Chemistry, Skidmore College, 1989

Professional Experience

2006 – Present GRADIENT, Boston, MA

Principal. Provides expertise in human exposure assessment and toxicology in support of human health risk assessment and toxic tort litigation projects. Evaluates chemical toxicology data and reviews specific environmental chemical exposures to assess potential human health risks. Special emphasis on exposure assessment, toxicology, mode of action, genotoxicity, and carcinogenesis.

1999 – 2006 MENZIE-CURA & ASSOCIATES, INC., Winchester, MA

Senior Scientist. Managed human health risk assessments under the Massachusetts Contingency Plan and the US Environmental Protection Agency Superfund Program.

1996 – 1999 HARVARD SCHOOL OF PUBLIC HEALTH, Boston, MA

Post-Doctoral Fellow, Department of Molecular and Cellular Toxicology. Investigated the contribution of spontaneously generated abasic site DNA damage to spontaneous mutagenesis in the yeast *Saccharomyces cerevisiae* system. Compiled data regarding the origin of spontaneous mutations to better understand their role in the carcinogenesis process.

1989 – 1995 MASSACHUSETTS INSTITUTE OF TECHNOLOGY, Cambridge, MA

Ph.D. Student, Department of Biochemistry and Division of Toxicology. Investigated the mutational specificity of aflatoxin B₁ (AFB₁), a potent mutagen and carcinogen, in *Escherichia coli* through the use of an M13 genome containing the AFB₁-N7-Gua adduct in a defined position. Compared the mutational specificity observed in *E. coli* to that found in human liver cancers believed to be caused by aflatoxin.

Professional Affiliations

Society of Toxicology (Full Member); Society for Risk Analysis

2/14/2025

Select Projects

Confidential Client: In support of toxic tort litigation, reviewed toxicology, epidemiology, mechanistic, and exposure information related to claims of causal associations between trichloroethylene and perchloroethylene inhalation exposures and health effects (e.g., pancreatic cancer and fetal heart malformation).

Confidential Client: In support of toxic tort litigation, reviewed toxicology, epidemiology, and exposure information related to claims of causal associations between exposures to chemicals associated with employment as an oil spill response worker and health effects (e.g., respiratory and dermal effects).

Confidential Client: In support of toxic tort litigation, conducted an in-depth review of toxicology, epidemiology, mechanistic, and biomonitoring data related to claims of a causal association between exposure to glyphosate-based herbicides and Non-Hodgkin's Lymphoma.

Industrial Client: Performed an evaluation of occupational exposure and toxicity information for trichloroethylene to provide support in responding to US EPA's request for information under the 2016 Toxic Substances Control Act (TSCA).

Confidential Client: In support of toxic tort litigation, reviewed toxicology, epidemiology, and exposure information related to claims of causal associations between exposure to diesel exhaust, diesel fuel, silica, asbestos, and cancer endpoints (e.g., lung cancer, colon cancer, and hematological cancers).

Consumer Product Company: Assessed toxicity and human health risk related to potential leaching of chemicals (i.e., nitrosamines) into a household appliance and into consumer tap water.

Consumer Product Company: Assessed toxicity and human health risk related to potential leaching of chemicals from a medical device.

Trade Association: Assessed the current state of the science on neurotoxicity from exposure to manganese in welding fumes and proposed a manganese occupational exposure limit for welders.

Consumer Product Company: Assessed toxicity and human health risk information related to exposure to mold and bacterial species identified in a children's toy product.

Trade Association: Performed in-depth evaluation of naphthalene toxicity and exposure data available in US EPA's ToxCast and ExpoCast programs in comparison to toxicity information from *in vivo* toxicity studies and ambient naphthalene exposure information.

Industrial Client: Performed an evaluation of occupational exposure and toxicity information for carbon tetrachloride, methylene chloride, and perchloroethylene to provide support in responding to US EPA's request for information under the 2016 Toxic Substances Control Act (TSCA).

Industrial Client: In support of toxic tort litigation, performed in-depth toxicological and risk evaluation for hexavalent chromium exposure for stainless steel welders.

Confidential Client: In support of toxic tort litigation, reviewed exposure information and medical records related to a claim of a causal association between inhalation exposure to naphthalene in mothballs and hemolytic anemia for the Plaintiffs.

Insurance Company: In support of toxic tort litigation, reviewed exposure information and medical records related to a claim of a causal association between formaldehyde inhalation exposure and acute myeloid leukemia.

Industrial Clients: In support of toxic tort litigation, assessed the current state of science on manganese neurotoxicity and human health, from exposure to manganese in air and soil, for workers and the general population.

Industrial Client: In support of toxic tort litigation, assessed the weight of epidemiological and toxicological evidence regarding the association between nitrosamine/amide inhalation and brain cancer.

Consumer Product Company: In support of toxic tort litigation, assessed the weight of epidemiological evidence regarding a causal association between inhalation exposures to trichloroethylene and perchloroethylene and cancer and non-cancer health effects.

Industrial Client: In support of toxic tort litigation, performed an extensive review of the mode-of-action data for asbestos and the epidemiology literature on vehicle brake repair and lung cancer and mesothelioma to assess whether there is a causal association.

Industrial Client: In support of toxic tort litigation, evaluated human health risk from exposure to chlorinated volatiles, including trichloroethylene and perchloroethylene, in groundwater *via* drinking water and showering.

Trade Association: Performed in-depth analysis of trichloroethylene and tetrachloroethylene toxicology and mechanistic data to evaluate whether the weight of the evidence supports the plausibility of trichloroethylene and tetrachloroethylene as a human renal carcinogen.

Trade Association: Performed in-depth analysis of methyl methacrylate toxicology and mechanistic data to evaluate the weight of evidence and propose an occupational exposure level.

Trade Association: Through Toxicology Excellence for Risk Assessment (TERA), participated in a peer review process of our proposed manganese reference concentration (RfC) (Bailey *et al.*, 2009), which resulted in the values being posted on the National Library of Medicine's National Institute of Health TOXNET compilation of databases as an ITER (International Toxicity Estimates for Risk Assessment) value for manganese dioxide.

Industrial Client(s): For several industrial clients, reviewed current status of manganese inhalation toxicity criteria (reference concentration [RfC], American Conference of Governmental Industrial Hygienists Threshold Limit Value [ACGIH TLV]), and current manganese inhalation toxicity literature, in support of regulatory comment/communication and public communication regarding potential health effects from both occupational and residential exposure to manganese in air.

Trade Association: Performed in-depth analysis of methanol toxicology and mechanistic data to evaluate whether the weight of evidence supports the plausibility that methanol exposure is associated with human lymphoma.

Trade Association: Performed in-depth analysis of naphthalene toxicology and mechanistic data to evaluate whether the weight of evidence supports the plausibility of naphthalene as a human carcinogen.

Trade Association: Performed in-depth analysis of formaldehyde toxicology and mechanistic data to evaluate whether the weight of the evidence supports the plausibility of formaldehyde as a human leukemogen.

Chemical Company: Provided comments on US EPA's 2009 trichloroethylene draft reassessment, focusing on the use of novel methods for reference concentration (RfC) and reference dose (RfD) determination, such as US EPA's use of physiologically based pharmacokinetic (PBPK) modeling.

Industrial Client: Reviewed toxicity data and various agency derivations of perchlorate toxicity criteria.

Pharmaceutical Company: Performed in-depth analysis of the toxicology data of a specific drug to determine whether the company could have anticipated potential adverse side effects in humans.

Confidential Client: Performed literature review of health effects from inhalation of mercury vapor, focusing on reversibility and latency of effects.

Medical Device Manufacturing Company: Participated in evaluation of potential for adverse side effects from residual contamination on medical implant device.

Industrial Company: Reviewed current status of US EPA's manganese inhalation toxicity value, and current manganese inhalation toxicity literature, in support of litigation regarding claims of elevated manganese air concentrations.

Industrial Client: Managed a Superfund risk assessment for US EPA Region I, including a number of chemicals and human exposure pathways for children and adults: direct contact with sediment and soil, direct contact with surface water and groundwater, ingestion of fish, inhalation of indoor air and trench vapor, and inhalation of asbestos in resuspended sediment and soil. This risk assessment required application of US EPA's "Supplemental Guidance for Assessing Susceptibility from Early-Life Exposure to Carcinogens" for carcinogenic polycyclic aromatic hydrocarbons (PAHs) in all media.

Industrial Client: Performed a human health Superfund risk assessment for residential exposure to chlorinated volatile organic compounds (VOCs) and metals in drinking water and indoor air, and from potential exposure to metals in sediment and surface water. Part of the project involved participating in public meetings to address concerned citizen groups.

Industrial Client: Performed a risk assessment for the state of Connecticut, for potential residential risk from lead in sediment and blue crab. The risk assessment involved use of the Integrated Exposure Uptake Biokinetic (IEUBK) Model for lead and the Adult Lead Model.

Municipal Facility: Helped design a sampling plan and performed a risk evaluation for an asbestos site that was developed into an urban park. This project was carried out in conjunction with the Massachusetts Department of Environmental Protection (MassDEP), and was used as a model for development of the Draft MassDEP Asbestos in Soil Regulations.

Awards and Honors

Best Overall Abstract Award, "Evaluation of US EPA's Proposed Rule for the Occupational use of Carbon Tetrachloride and Proposal for a Revised Occupational Exposure Value," Risk Assessment Specialty Section (RASS), Society of Toxicology (SOT) 64th Annual Meeting and ToxExpo, 2025

Best Abstract Award, "Hypothesis-Based Weight-of-Evidence Evaluation and Risk Assessment for Naphthalene Carcinogenesis," Risk Assessment Specialty Section (RASS), Society of Toxicology (SOT) 54th Annual Meeting and ToxExpo, 2015

One of the Top Ten Abstracts, "Health-Protective Manganese Guideline for Welding and Other Occupations," Risk Assessment Specialty Section (RASS), Society of Toxicology (SOT) 53rd Annual Meeting and ToxExpo, 2014

One of the Best Published Papers, "Hypothesis-Based Weight-of-evidence Evaluation of Methyl Methacrylate Olfactory Effects in Humans and Derivation of an Occupational Exposure Level," Risk Assessment Specialty Section (RASS), Society of Toxicology (SOT), 2013

One of the Top Ten Best Published Papers, "Hypothesis-Based Weight-of-Evidence Evaluation of Methanol as a Human Carcinogen," Risk Assessment Specialty Section (RASS), Society of Toxicology (SOT), 2012

DNA Damage and Repair NASA Conference Travel Award, Antalya, Turkey, 1997

Mutagenesis Gordon Conference Travel Award, Plymouth, NH, 1996.

Publications and Book Chapters

Bailey, L; Marchitti, S. 2024 (Spring). "Evolving chemical risk evaluation and management under the Toxic Substances Control Act: Trichloroethylene as an example." *Gradient Trends* 90.

Mayfield, DB; Bailey, LA; Cohen, JM; Beck, BD. 2022. "Properties and effects of metals." In *Principles of Toxicology: Environmental and Industrial Applications (Fourth Edition)*. (Eds.: Roberts, SM; James, RC; Williams, PL), John Wiley & Sons, Inc., Hoboken, NJ. p357-380.

Bailey LA, Boomhower SR. 2021. "Potential implications of new information concerning manganese Ohio community health effects studies." *Regul. Toxicol. Pharmacol.* doi: 10.1016/j.yrtph.2021.105069.

Langseth, D; Chien, J; Bailey, L. 2021 (Spring). "Opening the Malden River for recreational boating." *Gradient Trends - Risk Science & Application* 81:1-2.

Bailey, L. 2021 (Spring) "Collaborating to promote chemical safety and animal welfare." *Gradient Trends - Risk Science & Application* 81:6.

Bailey, L. 2020 (Fall). "Worker risk evaluations under TSCA: What we know so far." *Gradient Trends - Risk Science & Application* 79:3,7.

Bailey, LA; Rhomberg, LR. 2020. "Incorporating ToxCast™ data into naphthalene human health risk assessment." *Toxicol. In Vitro.* doi: 10.1016/j.tiv.2020.104913.

Bailey, LA; Zu, K; Beck, BD. 2018. "Comment on 'Impact of air manganese on child neurodevelopment in East Liverpool, Ohio' by Haynes *et al.* (2018)." *Neurotoxicology* 68:A1-A2. doi: 10.1016/j.neuro.2018.07.017.

Bailey, LA; Beck, BD. 2017. "Comment on 'Environmental exposure to manganese in air: Associations with tremor and motor function' by Bowler *et al.* (2016)." *Sci. Total Environ.* 595:839-841. doi: 10.1016/j.scitoenv.2017.03.277.

Bailey, LA; Kerper, LE; Goodman, JE. 2017. "Derivation of an occupational exposure level for manganese in welding fumes." *Neurotoxicology* 64:166-176. doi: 10.1016/j.neuro.2017.06.009.

Bailey, L; Nascarella, M; Kerper, L; Rhomberg, L. 2015. "Hypothesis-based weight-of-evidence evaluation and risk assessment for naphthalene carcinogenesis." *Crit. Rev. Toxicol.* 46(1):1-42. doi: 10.3109/10408444.2015.1061477.

Bailey, LA; Kerper, LE; Rhomberg, LR. [Gradient]. 2015. "Naphthalene." In *Hamilton and Hardy's Industrial Toxicology (Sixth Edition)*. (Eds.: Harbison, RD; Bourgeois, MM; Johnson, GT), John Wiley & Sons, Inc., Hoboken, NJ, p663-668.

Goodman, JE; Peterson, MK; Bailey, LA; Kerper, LE; Dodge, DG. 2014. "Electricians' chrysotile asbestos exposure from electrical products and risks of mesothelioma and lung cancer." *Regul. Toxicol. Pharmacol.* 68(1):8-15.

Pemberton, M; Bailey, LA; Rhomberg, LR. 2013. "Hypothesis-based weight-of-evidence evaluation of methyl methacrylate olfactory effects in humans and derivation of an occupational exposure level." *Regul. Toxicol. Pharmacol.* 66:217-233.

Goodman, JE; Prueitt, RL; Sax, SN; Bailey, LA; Rhomberg, LR. 2013. "Evaluation of the causal framework used for setting National Ambient Air Quality Standards." *Crit. Rev. Toxicol.* 43(10):829-849.

Rhomberg, LR; Goodman, JE; Bailey, LA; Prueitt, RL; Beck, NB; Bevan, C; Honeycutt, M; Kaminski, NE; Paoli, G; Pottenger, LH; Scherer, RW; Wise, KC; Becker, RA. 2013. "A survey of frameworks for best practices in weight-of-evidence analyses." *Crit. Rev. Toxicol.* 43(9):753-784.

Mayfield, DB; Lewis, AS; Bailey, LA; Beck, BD. 2015. "Properties and effects of metals." In *Principles of Toxicology: Environmental and Industrial Applications (Third Edition)*. (Eds.: Roberts, SM; James, RC; Williams, PL), John Wiley & Sons, Inc., Hoboken, NJ, p283-307.

Bailey, LA; Prueitt, RL; Rhomberg, LR. 2012. "Hypothesis-based weight-of-evidence evaluation of methanol as a human carcinogen." *Regul. Toxicol. Pharmacol.* 62:278-291.

Rhomberg, LR; Bailey, LA; Goodman, JE; Hamade, A; Mayfield, D. 2011. "Is exposure to formaldehyde in air causally associated with leukemia? - A hypothesis-based weight-of-evidence analysis." *Crit. Rev. Toxicol.* 41(7):555-621.

Prueitt, RL; Goodman, JE; Bailey, LA; Rhomberg, LR. 2011. "Hypothesis-based weight of evidence evaluation of the neurodevelopmental effects of chlorpyrifos." *Crit. Rev. Toxicol.* 42(10):822-903.

Rhomberg, LR; Bailey, LA; Goodman, JE. 2010. "Hypothesis-based weight of evidence – A tool for evaluating and communicating uncertainties and inconsistencies in the large body of evidence in proposing a carcinogenic mode of action – Naphthalene as an example." *Crit. Rev. Toxicol.* 40(8):671-696.

Goodman, JE; Dodge, DG; Bailey, LA. 2010. "A framework for assessing adverse effects in humans with a case study of sulfur dioxide." *Regul. Toxicol. Pharmacol.* 58:308-322.

Bailey, LA; Goodman, JE; Beck BD. 2009. "Proposal for a revised Reference Concentration (RfC) for manganese based on recent epidemiological studies." *Regul. Toxicol. Pharmacol.* 55:330-339.

Baird, SJS; Bailey, EA; Vorhees, DJ. 2007. "Evaluating human risk from exposure to alkylated polycyclic aromatic hydrocarbons in an aquatic system." *Hum. Ecol. Risk Assess.* 13:322-338.

Auerbach, P; Bennett, RAO; Bailey, EA; Krokan, HE; Demple, B. 2005. "Mutagenic specificity of endogenously generated abasic sites in *Saccharomyces cerevisiae* chromosomal DNA." *Proc. Natl. Acad. Sci. USA* 102:17711-17716.

Bailey, L. 2005. "Evaluating risk from asbestos in soil under the MCP." *LSP Assoc. Newsl.* 12(Oct.):7.

Smela, ME; Currier, SS; Bailey, EA; Essigmann, JM. 2001. "The chemistry and biology of aflatoxin B(1): From mutational spectrometry to carcinogenesis." *Carcinogenesis* 22(4):535-545.

Demple, B; Bailey, EA; Bennett, RAO; Masuda, Y; Wong, D; Xu, Y. 1998. *DNA Damage and Repair: Oxygen Radical Effects, Cellular Protection and Biological Consequences*. (Ed.: Dizdaroglu, M), Plenum Press, NY.

Bailey, EA; Iyer, RS; Stone, MP; Harris, TM; Essigmann, JM. 1996. "Mutational properties of the primary aflatoxin B1-DNA adduct." *Proc. Natl. Acad. Sci. USA* 93:1535-1539.

Bailey, EA; Iyer, RS; Harris, TM; Essigmann, JM. 1996. "A viral genome containing an unstable aflatoxin B1-N7 Gua adduct situated at a unique site." *Nucleic Acids Res.* 24:2821-2828.

Poster Presentations

Marchitti, SA; Bailey, LA. 2025. "Evaluation of US EPA's Proposed Rule for the Occupational Use of Carbon Tetrachloride and Proposal for a Revised Occupational Exposure Value." Abstract/Poster #4237/P751. Presented at the Society of Toxicology (SOT) 64th Annual Meeting and ToxExpo, Orlando, FL, March 16-20.

****Best Overall Abstract Award Winner, Risk Assessment Specialty Section**

Zu, K; Bailey, LA; Prueitt, RL; Beck, BD; Seeley, M. 2019. "Comparison of Lung Cancer Risks from Environmental Exposures to Arsenic and from Those Associated with Medical Monitoring Criteria for Smokers." Poster # 2776/P262. Presented at the Society of Toxicology (SOT) 58th Annual Meeting, Baltimore, MD, March 10-14.

Bailey, LA. 2019. "Evaluation of the Carcinogenic Mode of Action and Proposal for an Occupational Exposure Limit for Tetrachloroethylene." Poster # 1872/P255. Presented at the Society of Toxicology (SOT) 58th Annual Meeting, Baltimore, MD, March 10-14.

Bailey, LA; Rhomberg, LR. 2018. "Incorporating ToxCast Data into Naphthalene Human Health Risk Assessment." Poster # 2858/P381. Presented at the Society of Toxicology (SOT) 57th Annual Meeting, San Antonio, TX, March 11-15.

Bailey, LA; Lam, T; Peterson, MK; Beck, BD. 2017. "Does Hexavalent Chromium in Welding Fumes Cause Increased Lung Cancer Risk in Stainless Steel Welders?" Presented at the Society of Toxicology (SOT) 56th Annual Meeting, Baltimore, MD, March 12-16.

Bailey, L; Kerper, L; Goodman, J. 2016. "Occupational Exposure Level for Manganese in Welding Fumes Based on the Best Available Science." Presented at the Manganese 2016 Conference, New York, NY, September 25-28.

Bailey, L; Nascarella, M; Kerper, L; Rhomberg, L. 2015. "Hypothesis-based Weight-of-Evidence Evaluation and Risk Assessment for Naphthalene Carcinogenesis." Presented at the Society of Toxicology 54th Annual Meeting, San Diego, CA, March 22-26.

Bailey, L; Kerper, L; 2014. "Health-Protective Manganese Guideline for Welding and Other Occupations." Presented at the American Industrial Hygiene Association Fall Meeting, Washington, DC, October 20-21.

Bailey, L; Kerper, L; Beck, B. 2014. "Health-Protective Manganese Guideline for Welding and Other Occupations." Presented at the Society of Toxicology 53rd Annual Meeting, Phoenix, AZ, March 23-27.

Pemberton, M; Bailey, LA; Rhomberg, LR. 2013. "Weight-of-Evidence Evaluation of Methyl Methacrylate Olfactory Effects in Humans and Derivation of an Occupational Exposure Level." Presented at the Society of Toxicology 52nd Annual Meeting, San Antonio, TX. *Toxicologist* 132(1):473. Abstract No. 2216.

Prueitt, RL; Goodman, JE; Bailey, LA; Rhomberg, LR. 2012. "Hypothesis-Based Weight-of-Evidence Evaluation of the Neurodevelopmental Effects of Chlorpyrifos." Presented at the Society of Toxicology 51st Annual Meeting, San Francisco, CA. *Toxicologist* 126(1):309. Abstract No. 1430.

Bailey, LA; Goodman, JE; Beck, BD. 2012. "Revised Reference Concentration for Manganese Oxide Based on Recent Epidemiology and Pharmacokinetic Studies." Presented at the Society of Toxicology 51st Annual Meeting, San Francisco, CA, March. *Toxicologist* 126(1):213. Abstract No. 995.

Bailey, LA; Goodman, JE; Rhomberg, LR. 2011. "Hypothesis-based Weight-of-Evidence Evaluation of Naphthalene: Carcinogenic Hazard Assessment and Mode of Action." Presented at the Society of Environmental Toxicology and Chemistry (SETAC) North America 32nd Annual Meeting, Boston, MA, November 14, 1p.

Bailey, L; Hamade, AK; Rhomberg, LR. 2011. "Weight-of-Evidence Evaluation of a Plausible Mode of Action for Leukemogenesis from Inhalation Exposure to Formaldehyde." Presented at the Society of Toxicology 50th Annual Meeting, Washington, DC. *Toxicologist - Supplement to Toxicological Sciences* 120(Suppl. 2):417.

Peterson, MK; Bailey, L; Dodge, DG; Goodman, JE; Valberg, PA. 2011. "A weight-of-evidence evaluation of asbestos exposure and mesothelioma risk among electricians." *Toxicologist - Supplement to Toxicological Sciences* 120(Suppl. 2):414.

Hamade, AK; Bailey, L; Rhomberg, LR. 2011. "Does formaldehyde cause hematotoxicity? A weight-of-evidence evaluation of hematotoxicity studies in humans and animals in the context of leukemogenicity." *Toxicologist - Supplement to Toxicological Sciences* 120(Suppl. 2):417.

Goodman, JE; Mayfield, DB; Bailey, L; Rhomberg, LR. 2011. "Weight-of-evidence evaluation of formaldehyde exposure and leukemia risk." *Toxicologist - Supplement to Toxicological Sciences* 120(Suppl. 2):416.

Bailey, LA; Rhomberg, LR. 2009. "Hypothesis-Based Weight of Evidence (HBWoE) Evaluation of Naphthalene – Carcinogenic Hazard Assessment and Mode of Action." Presented at the 2009 Society for Risk Analysis Annual Meeting, Baltimore, MD, December 6-9.

Bailey, LA; Rhomberg, LR. 2009. "Hypothesis-Based Weight of Evidence – A Tool for Evaluating and Communicating Uncertainties and Apparent Contradictions in the Large Body of Evidence in Proposing a Potential Carcinogenic Mode of Action – Naphthalene as an Example." Presented at the 2009 Society of Toxicology Annual Meeting, Baltimore, MD, March 16-19.

Goodman, JE; Bailey, LA.; Beck, BD. 2008. "Recent Studies of the Health Effects of Manganese and the Implications for the Reference Concentration (RfC)." Presented at the 2008 Society of Toxicology Annual Meeting, Seattle, WA, March 16-20.

Bailey, L; Murray, D. 2006. "Comparison of EPA's Current Approach and a Proposed Approach to Evaluating Risk from Asbestos." Presented at the 2006 Brownfields Conference, Boston, MA, November 14.

Bailey, L; Murray, D. 2006. "Comparison of EPA's Current Approach and a Proposed Approach to Evaluating Risk from Asbestos." Presented at the 2006 University of Massachusetts at Amherst Conference on Soils, Sediments and Water, October 16-19.

Bailey, L; Lemay, J; Murray, D; Hunt, K. 2005. "Derivation of Soil Screening Values for the Vapor Intrusion Pathway – Is this a Valid Approach?" Presented at the 2005 University of Massachusetts at Amherst Conference on Soils, Sediments and Water, October 17-20.

Bailey, EA; Weil, M; Murray, D. 2004. "A Comparison of Risk Assessment Methods to Demonstrate Potential Risk from Exposure to Asbestos in Soil." Presented Poster at the 2004 University of Massachusetts at Amherst Conference on Soils, Sediments and Water, October 18-21.

Oral Public Comments, Presentations, and Testimony

Bailey, L. 2020. "Evaluation of Manganese Air Concentrations Related to the Ohio Manganese Research Program." Presented to US EPA, October 1.

Bailey, L. 2020. "Public Testimony Related to the Pennsylvania Department of Environmental Protection (PADEP) Proposed Rulemaking for 'Water Quality Standards for Manganese and Implementation.'" Pennsylvania Senate Environmental Resources & Energy Committee Hearing, September 9.

Bailey, L. 2020. "Public Testimony Related to the Pennsylvania Department of Environmental Protection (PADEP) Proposed Rulemaking for 'Water Quality Standards for Manganese and Implementation.'" PADEP Environmental Quality Board meeting, September 8.

Bailey, L. 2018. "Fenceline Air Monitoring: Interpretation and Risk Management." Presented at the Shale Insight Conference, October 23-25.

Bailey, L. 2018. "Review of Scientific Evidence Related to Potential Toxicity from Occupational Exposure to Manganese." Presented at the California Division of Occupation Safety and Health (DOSH) Health Advisory Committee (HEAC) Meeting, September 4.

Bailey, L. 2018. "Manganese Community Health Effects Studies: Interpretation and the Need to Consider Other Relevant Studies." Presented at the Air and Waste Management Association (A&WMA) Conference, Hartford, CT, June 28.

Bailey, L. 2017. Oral Comments Related to Potential Health Risks from Levels of Manganese, Benzene, Chromium, and Lead in Ambient Air in Lawrenceville, Pennsylvania. Presented at an Allegheny County Health Department (ACHD) Public Meeting, Lawrenceville, PA, December 4.

Bailey, L. 2017. Oral Comments Related to Potential Health Risks from Levels of Manganese in Ambient Air in East Liverpool, Ohio. Presented at an East Liverpool, Ohio, Public Meeting, October 24.

Bailey, L. 2017. "New Exposure Information Strategies for Chemical Risk Evaluation under the New TSCA." Presented as part of the Gradient Webinar Series, April 19.

Bailey, L. 2014. "Manganese Toxicity and Community Studies." Presented to the Manganese Interest Group Meeting, Washington, DC, October 16, 36p.

Bailey, L. 2014. Oral Public Comments Related to Naphthalene Toxicological Review at the US EPA Integrated Risk Information System (IRIS) Problem Formulation Meeting, September.

Bailey, L; Rhomberg, L. 2013. "Hypothesis-Based Weight of Evidence: An Approach to Assessing Causation and its Application to Regulatory Toxicology." Presented at the Society for Risk Analysis Annual Meeting, Arlington, VA, December 9.

Bailey, L. 2012. "Overview of Manganese Inhalation RfC and Oral RfD, and Implications for Interpretation of Community Studies." Presented to the Manganese Interest Group Meeting, Washington, DC, October 2, 41p.

Bailey, L. 2011. "Revised Manganese Reference Concentration – Implications for Interpretation of Recent Epidemiology Studies." Presented to the Manganese Interest Group Meeting, Washington, DC, June 15, 25p.

Appendix B

Testimony Experience of Lisa A. Bailey, Ph.D.

Lisa A. Bailey, Ph.D.

Last 4 Years of Expert Testimony Experience

Dr. Bailey has provided expert testimony as follows:

1. Steven Halvorsen *vs.* Union Pacific Railroad Company regarding a claim of causal association between occupational exposure to diesel exhaust, benzene, and herbicides and chronic lymphocytic leukemia. For defendant. Deposition on March 12, 2021.
2. Earl Neal *et al.* *vs.* Monsanto Company and Nathaniel Evans *vs.* Monsanto Company regarding claims of causal association between exposure to glyphosate-based herbicides and Non-Hodgkin Lymphoma. For defendant. Deposition on February 18, 2022.
3. Charles E. Adams, *et al.* *vs.* Adient US LLC regarding claims of exposure and health risks from TCE in indoor air and drinking water. For defendant. Deposition on September 10, 2024.
4. Charles A. Boggs *vs.* BP Exploration and Production, Inc. and BP America Production Company related to the Deepwater Horizon spill and claims of respiratory health effects from exposure to particulate matter and benzene in ambient air. For defendant. October 2, 2024.

Appendix C

Materials Considered

Appendix D

Plaintiff Risk Calculations

Table D.1 Risk Calculations for the Baseline Daily Drinking Water and Shower Exposures for Cometto Davis

Exposure Scenario	Exposure Point	Exposure Medium	Exposure Route	Analyte	Daily Exposure Dose (DED) or Concentration (DEC)		Lifetime Average Daily Dose (LADD) or Exposure (LADE) ^a		Toxicity Reference Value		Excess Lifetime Cancer Risk ^a	Point of Departure (POD)		Margin of Exposure ^b	Exposure Exceeds POD? (Y/N)
					Value	Units	Value	Units	Value	Units		Value	Units		
Central Tendency Exposure (CTE)															
CTE	Hadnot Point	Drinking water	Ingestion	Benzene	1.1E-04	mg/kg-day	9.8E-06	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	5.4E-07	5.5E-02	mg/kg-day	5.6E+03	N
				<i>trans</i> -1,2-Dichloroethylene	3.3E-03	mg/kg-day	2.9E-04	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	3.2E-04	mg/kg-day	2.9E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	6.0E-08	5.0E+01	mg/kg-day	1.8E+06	N
				Trichloroethylene	6.7E-03	mg/kg-day	6.0E-04	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	1.3E-05	4.6E-01	mg/kg-day	7.7E+02	N
				Vinyl Chloride	5.0E-04	mg/kg-day	4.5E-05	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	3.2E-05	1.3E-01	mg/kg-day	3.0E+03	N
Total for Hadnot Point Ingestion (CTE):											5E-05				
CTE	Hadnot Point	Shower water	Dermal	Benzene	1.1E-05	mg/kg-day	1.8E-07	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	1.0E-08	5.5E-02	mg/kg-day	3.0E+05	N
				<i>trans</i> -1,2-Dichloroethylene	2.9E-04	mg/kg-day	4.8E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	1.6E-04	mg/kg-day	2.7E-06	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	5.6E-09	5.0E+01	mg/kg-day	1.9E+07	N
				Trichloroethylene	8.2E-04	mg/kg-day	1.4E-05	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	2.9E-07	4.6E-01	mg/kg-day	3.4E+04	N
				Vinyl Chloride	2.6E-05	mg/kg-day	4.3E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	3.1E-07	1.3E-01	mg/kg-day	3.1E+05	N
Total for Hadnot Point Dermal (CTE):											6E-07				
CTE	Hadnot Point	Indoor air	Inhalation	Benzene	1.4E-01	µg/m ³	2.3E-03	µg/m ³	7.8E-06	(µg/m ³) ⁻¹	1.8E-08	3.8E+02	µg/m ³	1.6E+05	N
				<i>trans</i> -1,2-Dichloroethylene	4.7E+00	µg/m ³	7.8E-02	µg/m ³	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	4.5E-01	µg/m ³	7.5E-03	µg/m ³	2.6E-07	(µg/m ³) ⁻¹	1.9E-09	4.0E+05	µg/m ³	5.4E+07	N
				Trichloroethylene	1.5E+01	µg/m ³	2.5E-01	µg/m ³	2.0E-06	(µg/m ³) ⁻¹	5.0E-07	4.9E+03	µg/m ³	2.0E+04	N
				Vinyl Chloride	8.3E-01	µg/m ³	1.4E-02	µg/m ³	4.4E-06	(µg/m ³) ⁻¹	6.1E-08	2.3E+04	µg/m ³	1.6E+06	N
Total for Hadnot Point Inhalation (CTE):											6E-07				
CTE	Tarawa Terrace	Drinking water	Ingestion	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	1.9E-04	mg/kg-day	1.7E-05	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	1.5E-03	mg/kg-day	1.3E-04	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	2.8E-07	5.0E+01	mg/kg-day	3.7E+05	N
				Trichloroethylene	5.9E-05	mg/kg-day	5.3E-06	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	1.1E-07	4.6E-01	mg/kg-day	8.7E+04	N
				Vinyl Chloride	1.1E-04	mg/kg-day	9.8E-06	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	7.1E-06	1.3E-01	mg/kg-day	1.4E+04	N
Total for Tarawa Terrace Ingestion (CTE):											7E-06				
CTE	Tarawa Terrace	Shower water	Dermal	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	1.6E-05	mg/kg-day	1.2E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	6.1E-04	mg/kg-day	4.4E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	9.3E-08	5.0E+01	mg/kg-day	1.1E+06	N
				Trichloroethylene	6.2E-06	mg/kg-day	4.5E-07	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	9.7E-09	4.6E-01	mg/kg-day	1.0E+06	N
				Vinyl Chloride	5.3E-06	mg/kg-day	3.8E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	2.8E-07	1.3E-01	mg/kg-day	3.5E+05	N
Total for Tarawa Terrace Dermal (CTE):											4E-07				
CTE	Tarawa Terrace	Indoor air	Inhalation	Benzene	NA	µg/m ³	NA	µg/m ³	7.8E-06	(µg/m ³) ⁻¹	NA	3.8E+02	µg/m ³	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	2.2E+00	µg/m ³	1.6E-01	µg/m ³	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	1.4E+01	µg/m ³	1.0E+00	µg/m ³	2.6E-07	(µg/m ³) ⁻¹	2.6E-07	4.0E+05	µg/m ³	3.9E+05	N
				Trichloroethylene	7.7E-01	µg/m ³	5.6E-02	µg/m ³	2.0E-06	(µg/m ³) ⁻¹	1.1E-07	4.9E+03	µg/m ³	8.8E+04	N
				Vinyl Chloride	1.4E+00	µg/m ³	1.0E-01	µg/m ³	4.4E-06	(µg/m ³) ⁻¹	4.5E-07	2.3E+04	µg/m ³	2.2E+05	N
Total for Tarawa Terrace Inhalation (CTE):											8E-07				

Exposure Scenario	Exposure Point	Exposure Medium	Exposure Route	Analyte	Daily Exposure Dose (DED) or Concentration (DEC)		Lifetime Average Daily Dose (LADD) or Exposure (LADE) ^a		Toxicity Reference Value		Excess Lifetime Cancer Risk ^a	Point of Departure (POD)		Margin of Exposure ^b	Exposure Exceeds POD? (Y/N)
					Value	Units	Value	Units	Value	Units		Value	Units		
Reasonable Maximum Exposure (RME)															
RME	Hadnot Point	Drinking water	Ingestion	Benzene	2.7E-04	mg/kg-day	2.4E-05	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	1.3E-06	5.5E-02	mg/kg-day	2.3E+03	N
				<i>trans</i> -1,2-Dichloroethylene	8.1E-03	mg/kg-day	7.2E-04	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	7.9E-04	mg/kg-day	7.0E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	1.5E-07	5.0E+01	mg/kg-day	7.1E+05	N
				Trichloroethylene	1.7E-02	mg/kg-day	1.5E-03	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	3.3E-05	4.6E-01	mg/kg-day	3.0E+02	N
				Vinyl Chloride	1.2E-03	mg/kg-day	1.1E-04	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	7.7E-05	1.3E-01	mg/kg-day	1.2E+03	N
Total for Hadnot Point Ingestion (RME):											1E-04				
RME	Hadnot Point	Shower water	Dermal	Benzene	1.4E-05	mg/kg-day	2.3E-07	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	1.3E-08	5.5E-02	mg/kg-day	2.4E+05	N
				<i>trans</i> -1,2-Dichloroethylene	3.6E-04	mg/kg-day	6.0E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	1.9E-04	mg/kg-day	3.2E-06	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	6.6E-09	5.0E+01	mg/kg-day	1.6E+07	N
				Trichloroethylene	1.0E-03	mg/kg-day	1.7E-05	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	3.6E-07	4.6E-01	mg/kg-day	2.8E+04	N
				Vinyl Chloride	3.2E-05	mg/kg-day	5.3E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	3.8E-07	1.3E-01	mg/kg-day	2.5E+05	N
Total for Hadnot Point Dermal (RME):											8E-07				
RME	Hadnot Point	Indoor air	Inhalation	Benzene	3.2E-01	µg/m3	5.3E-03	µg/m3	7.8E-06	(µg/m ³) ⁻¹	4.1E-08	3.8E+02	µg/m ³	7.2E+04	N
				<i>trans</i> -1,2-Dichloroethylene	1.0E+01	µg/m3	1.7E-01	µg/m3	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	9.8E-01	µg/m3	1.6E-02	µg/m3	2.6E-07	(µg/m ³) ⁻¹	4.2E-09	4.0E+05	µg/m ³	2.5E+07	N
				Trichloroethylene	3.3E+01	µg/m3	5.5E-01	µg/m3	2.0E-06	(µg/m ³) ⁻¹	1.1E-06	4.9E+03	µg/m ³	8.9E+03	N
				Vinyl Chloride	1.8E+00	µg/m3	3.0E-02	µg/m3	4.4E-06	(µg/m ³) ⁻¹	1.3E-07	2.3E+04	µg/m ³	7.6E+05	N
Total for Hadnot Point Inhalation (RME):											1E-06				
RME	Tarawa Terrace	Drinking water	Ingestion	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	4.8E-04	mg/kg-day	4.3E-05	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	3.6E-03	mg/kg-day	3.2E-04	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	6.7E-07	5.0E+01	mg/kg-day	1.6E+05	N
				Trichloroethylene	1.5E-04	mg/kg-day	1.3E-05	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	2.9E-07	4.6E-01	mg/kg-day	3.4E+04	N
				Vinyl Chloride	2.6E-04	mg/kg-day	2.3E-05	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	1.7E-05	1.3E-01	mg/kg-day	5.7E+03	N
Total for Tarawa Terrace Ingestion (RME):											2E-05				
RME	Tarawa Terrace	Shower water	Dermal	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	2.6E-05	mg/kg-day	1.9E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	9.7E-04	mg/kg-day	7.0E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	1.5E-07	5.0E+01	mg/kg-day	7.1E+05	N
				Trichloroethylene	1.0E-05	mg/kg-day	7.3E-07	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	1.6E-08	4.6E-01	mg/kg-day	6.3E+05	N
				Vinyl Chloride	8.3E-06	mg/kg-day	6.0E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	4.3E-07	1.3E-01	mg/kg-day	2.2E+05	N
Total for Tarawa Terrace Dermal (RME):											6E-07				
RME	Tarawa Terrace	Indoor air	Inhalation	Benzene	NA	µg/m3	NA	µg/m3	7.8E-06	(µg/m ³) ⁻¹	NA	3.8E+02	µg/m ³	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	9.0E+00	µg/m3	6.5E-01	µg/m3	NA	NA	NA	NA	NA	NA	NA
				Tetrachloroethylene	6.2E+01	µg/m3	4.5E+00	µg/m3	2.6E-07	(µg/m ³) ⁻¹	1.2E-06	4.0E+05	µg/m ³	8.9E+04	N
				Trichloroethylene	3.5E+00	µg/m3	2.5E-01	µg/m3	2.0E-06	(µg/m ³) ⁻¹	5.1E-07	4.9E+03	µg/m ³	1.9E+04	N
				Vinyl Chloride	5.9E+00	µg/m3	4.3E-01	µg/m3	4.4E-06	(µg/m ³) ⁻¹	1.9E-06	2.3E+04	µg/m ³	5.3E+04	N
Total for Tarawa Terrace Inhalation (RME):											4E-06				

Exposure Scenario	Exposure Point	Exposure Medium	Exposure Route	Analyte	Daily Exposure Dose (DED) or Concentration (DEC)		Lifetime Average Daily Dose (LADD) or Exposure (LADE) ^a		Toxicity Reference Value		Excess Lifetime Cancer Risk ^a	Point of Departure (POD)		Margin of Exposure ^b	Exposure Exceeds POD? (Y/N)
					Value	Units	Value	Units	Value	Units		Value	Units		
Military High-End Exposure															
Military	Hadnot Point	Drinking water	Ingestion	Benzene	3.9E-04	mg/kg-day	3.5E-05	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	1.9E-06	5.5E-02	mg/kg-day	1.6E+03	N
				<i>trans</i> -1,2-Dichloroethylene	1.2E-02	mg/kg-day	1.1E-03	mg/kg-day	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	1.1E-03	mg/kg-day	9.8E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	2.1E-07	5.0E+01	mg/kg-day	5.1E+05	N
				Trichloroethylene	2.4E-02	mg/kg-day	2.1E-03	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	4.6E-05	4.6E-01	mg/kg-day	2.1E+02	N
				Vinyl Chloride	1.8E-03	mg/kg-day	1.6E-04	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	1.2E-04	1.3E-01	mg/kg-day	8.3E+02	N
Total for Hadnot Point Ingestion (Military):											2E-04				
Military	Hadnot Point	Shower water	Dermal	Benzene	1.4E-05	mg/kg-day	2.3E-07	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	1.3E-08	5.5E-02	mg/kg-day	2.4E+05	N
				<i>trans</i> -1,2-Dichloroethylene	3.6E-04	mg/kg-day	6.0E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	1.9E-04	mg/kg-day	3.2E-06	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	6.6E-09	5.0E+01	mg/kg-day	1.6E+07	N
				Trichloroethylene	1.0E-03	mg/kg-day	1.7E-05	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	3.6E-07	4.6E-01	mg/kg-day	2.8E+04	N
				Vinyl Chloride	3.2E-05	mg/kg-day	5.3E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	3.8E-07	1.3E-01	mg/kg-day	2.5E+05	N
Total for Hadnot Point Dermal (Military):											8E-07				
Military	Hadnot Point	Indoor air	Inhalation	Benzene	3.2E-01	µg/m3	5.3E-03	µg/m3	7.8E-06	(µg/m ³) ⁻¹	4.1E-08	3.8E+02	µg/m ³	7.2E+04	N
				<i>trans</i> -1,2-Dichloroethylene	1.0E+01	µg/m3	1.7E-01	µg/m3	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	9.8E-01	µg/m3	1.6E-02	µg/m3	2.6E-07	(µg/m ³) ⁻¹	4.2E-09	4.0E+05	µg/m ³	2.5E+07	N
				Trichloroethylene	3.3E+01	µg/m3	5.5E-01	µg/m3	2.0E-06	(µg/m ³) ⁻¹	1.1E-06	4.9E+03	µg/m ³	8.9E+03	N
				Vinyl Chloride	1.8E+00	µg/m3	3.0E-02	µg/m3	4.4E-06	(µg/m ³) ⁻¹	1.3E-07	2.3E+04	µg/m ³	7.6E+05	N
Total for Hadnot Point Inhalation (Military):											1E-06				
Military	Tarawa Terrace	Drinking water	Ingestion	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	6.9E-04	mg/kg-day	6.2E-05	mg/kg-day	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	5.2E-03	mg/kg-day	4.6E-04	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	9.7E-07	5.0E+01	mg/kg-day	1.1E+05	N
				Trichloroethylene	2.1E-04	mg/kg-day	1.9E-05	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	4.0E-07	4.6E-01	mg/kg-day	2.5E+04	N
				Vinyl Chloride	3.8E-04	mg/kg-day	3.4E-05	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	2.4E-05	1.3E-01	mg/kg-day	3.9E+03	N
Total for Tarawa Terrace Ingestion (Military):											3E-05				
Military	Tarawa Terrace	Shower water	Dermal	Benzene	NA	mg/kg-day	NA	mg/kg-day	5.5E-02	(mg/kg-day) ⁻¹	NA	5.5E-02	mg/kg-day	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	2.6E-05	mg/kg-day	1.9E-06	mg/kg-day	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	9.7E-04	mg/kg-day	7.0E-05	mg/kg-day	2.1E-03	(mg/kg-day) ⁻¹	1.5E-07	5.0E+01	mg/kg-day	7.1E+05	N
				Trichloroethylene	1.0E-05	mg/kg-day	7.3E-07	mg/kg-day	2.2E-02	(mg/kg-day) ⁻¹	1.6E-08	4.6E-01	mg/kg-day	6.3E+05	N
				Vinyl Chloride	8.3E-06	mg/kg-day	6.0E-07	mg/kg-day	7.2E-01	(mg/kg-day) ⁻¹	4.3E-07	1.3E-01	mg/kg-day	2.2E+05	N
Total for Tarawa Terrace Dermal (Military):											6E-07				
Military	Tarawa Terrace	Indoor air	Inhalation	Benzene	NA	µg/m3	NA	µg/m3	7.8E-06	(µg/m ³) ⁻¹	NA	3.8E+02	µg/m ³	NA	NA
				<i>trans</i> -1,2-Dichloroethylene	9.0E+00	µg/m3	6.5E-01	µg/m3	NA	NA	NA	NA	NA	NA	
				Tetrachloroethylene	6.2E+01	µg/m3	4.5E+00	µg/m3	2.6E-07	(µg/m ³) ⁻¹	1.2E-06	4.0E+05	µg/m ³	8.9E+04	N
				Trichloroethylene	3.5E+00	µg/m3	2.5E-01	µg/m3	2.0E-06	(µg/m ³) ⁻¹	5.1E-07	4.9E+03	µg/m ³	1.9E+04	N
				Vinyl Chloride	5.9E+00	µg/m3	4.3E-01	µg/m3	4.4E-06	(µg/m ³) ⁻¹	1.9E-06	2.3E+04	µg/m ³	5.3E+04	N
Total for Tarawa Terrace Inhalation (Military):											4E-06				

Notes:
 $\mu\text{g}/\text{m}^3$ = Micrograms per Cubic Meter; $(\mu\text{g}/\text{m}^3)^{-1}$ = Per Micrograms per Cubic Meter; $\text{mg}/\text{kg}\cdot\text{day}$ = Milligrams per Kilogram Body Weight per Day; $(\text{mg}/\text{kg}\cdot\text{day})^{-1}$ = Per Milligrams per Kilogram Body Weight per Day; N = No; NA = Not Applicable; POD = Point of Departure; Y = Yes.

(a) Lifetime average daily doses (LADDs), lifetime average daily exposures (LADEs), and excess lifetime cancer risks (ELCRs) are calculated using the following equations:

Ingestion:

$$\text{LADD} = \frac{\text{DED} \times \text{EF} \times \text{ED}_{\text{DW}}}{\text{AT}}$$

$$\text{ELCR} = \text{LADD} \times \text{CSF}$$

Dermal Contact:

$$\text{LADD} = \frac{\text{DED} \times \text{EF} \times \text{ED}_{\text{Shower}}}{\text{AT}}$$

$$\text{ELCR} = \text{LADD} \times \text{CSF}$$

Inhalation:

$$\text{LADE} = \frac{\text{DEC} \times \text{EF} \times \text{ED}_{\text{Shower}}}{\text{AT}}$$

$$\text{ELCR} = \text{LADE} \times \text{IUR}$$

where:

Variable	Definition	Units	Value	Source/Notes
LADD	Lifetime Average Daily Dose (Oral and Dermal)	mg/kg-day	Chemical specific	Calculated
LADE	Lifetime Average Daily Exposure (Inhalation)	$\mu\text{g}/\text{m}^3$	Chemical specific	Calculated
DED	Daily Exposure Dose	mg/kg-day	Chemical specific	LaKind (2025)
DEC	Daily Exposure Concentration	$\mu\text{g}/\text{m}^3$	Chemical specific	LaKind (2025)
EF	Exposure Frequency	days/year	365	Assumes daily exposure
ED_{DW}	Exposure Duration for Drinking Water Ingestion	years	6.3	Total time spent on base
$\text{ED}_{\text{Shower}}$	Exposure Duration for Shower Exposures	years	1.2 (Barracks - HP), 5.1 (Residential - TT)	Time spent living in barracks or residential housing
AT	Averaging Time	days	25,550	70-year lifetime \times 365 days/year
ELCR	Excess Lifetime Cancer Risk	unitless	Chemical specific	Calculated
CSF	Cancer Slope Factor	$(\text{mg}/\text{kg}\cdot\text{day})^{-1}$	Chemical specific	Section 5 of report
IUR	Inhalation Unit Risk	$(\mu\text{g}/\text{m}^3)^{-1}$	Chemical specific	Section 5 of report

(b) The margins of exposures (MoEs) are calculated by dividing the POD by the LADD or the LADE.

Table D.2 Risk Calculations for Mess Hall Exposures for Cometto Davis

Exposure Point	Analyte	Air Concentration in Dishwashing Area (AC _{dish}) ^a (µg/m ³)	Air Concentration in Pre-Rinse Area (AC _{rinse}) ^a (µg/m ³)	Air Concentration in Steam Table Area (AC _{steam}) ^a (µg/m ³)	Daily Exposure Concentration (DEC) ^a (µg/m ³)	Lifetime Average Daily Exposure (LADE) ^a (µg/m ³)	IUR ([µg/m ³] ⁻¹)	ELCR ^a	POD	MoE ^b	Exposure Exceeds POD? (Y/N)
Hadnot Point	Benzene	1.1E+02	1.4E+03	1.7E+00	5.1E+02	1.2E+00	7.8E-06	9.3E-06	3.8E+02	3.2E+02	N
	<i>trans</i> -1,2-Dichloroethylene	4.9E+03	6.1E+04	7.3E+01	2.2E+04	5.2E+01	NA	NA	NA	NA	NA
	Tetrachloroethylene	4.4E+02	5.5E+03	6.5E+00	2.0E+03	4.7E+00	2.6E-07	1.2E-06	4.0E+05	8.6E+04	N
	Trichloroethylene	8.8E+03	1.1E+05	1.3E+02	4.0E+04	9.3E+01	2.0E-06	1.9E-04	4.9E+03	5.2E+01	N
	Vinyl Chloride	7.5E+02	9.5E+03	1.1E+01	3.4E+03	8.0E+00	4.4E-06	3.5E-05	2.3E+04	2.8E+03	N
Total for Mess Hall Exposures – Hadnot Point:								2E-04			

Notes:

µg/m³ = Micrograms per Cubic Meter; (µg/m³)⁻¹ = Per Micrograms per Cubic Meter; IUR = Inhalation Unit Risk; N = No; NA = Not Applicable; POD = Point of Departure; Y = Yes.

(a) Daily exposure concentrations (DECs), lifetime average daily exposures (LADEs), and excess lifetime cancer risks (ELCRs) are calculated using the following equations:

$$DEC = \frac{(AC_{dish} \times ET_{dish}) + (AC_{rinse} \times ET_{rinse}) + (AC_{steam} \times ET_{steam})}{24 \text{ hours/day}}$$

$$LADE = \frac{DEC \times EF \times EV}{AT}$$

$$ELCR = LADE \times IUR$$

where:

Variable	Definition (Units)	Units	Value	Source/Notes
AC _{dish}	Air Concentration in Mess Hall - Dishwashing Area	µg/m ³	Chemical specific	LaKind (2025)
AC _{rinse}	Air Concentration in Mess Hall - Pre-Rinse Area	µg/m ³	Chemical specific	LaKind (2025)
AC _{steam}	Air Concentration in Mess Hall - Steam Table Area	µg/m ³	Chemical specific	LaKind (2025)
DEC	Daily Exposure Concentration	µg/m ³	Chemical specific	Calculated
LADE	Lifetime Average Daily Exposure	µg/m ³	Chemical specific	Calculated
ET _{dish}	Exposure Time in Dishwashing Area	hours/day	8	Professional Judgment
ET _{rinse}	Exposure Time in Pre-Rinse Area	hours/day	8	Professional Judgment
ET _{steam}	Exposure Time in Steam Table Area	hours/day	0	Professional Judgment
EF	Exposure Frequency	days/event	1	Professional Judgment
EV	Events During Exposure Duration	number of events	60	Professional Judgment
AT	Averaging Time	days	25,550	70-year lifetime × 365 days/year
ELCR	Excess Lifetime Cancer Risk	unitless	Chemical specific	Calculated
IUR	Inhalation Unit Risk	(µg/m ³) ⁻¹	Chemical specific	Section 5 of report

(b) The margins of exposures (MoEs) are calculated by dividing the POD by the LADE.

Table D.3 Summary of Risks By Exposure Pathway (Baseline + Additional) for Cometto Davis

Exposure Scenario	Exposure Point	Analyte	Baseline Exposure Pathways								Additional Pathways		Total ELCR		
			Ingestion (Drinking Water)		Dermal (Shower at HP Barracks)		Dermal (Shower at TT)		Inhalation (Shower at HP Barracks)		Inhalation (Shower at TT)			Inhalation (Mess Hall Duty)	
			ELCR	%	ELCR	%	ELCR	%	ELCR	%	ELCR	%		ELCR	%
Central Tendency Exposure (CTE)															
CTE	Hadnot Point: Drinking Water, Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Benzene	5.4E-07	1%	1.0E-08	2%	NA	--	1.8E-08	3%	NA	--	9.3E-06	4%	1E-05
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	6.0E-08	0.1%	5.6E-09	0.9%	9.3E-08	24%	1.9E-09	0.3%	2.6E-07	32%	1.2E-06	0.5%	2E-06
		Trichloroethylene	1.3E-05	28%	2.9E-07	47%	9.7E-09	3%	5.0E-07	86%	1.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	3.2E-05	70%	3.1E-07	50%	2.8E-07	73%	6.1E-08	10%	4.5E-07	54%	3.5E-05	15%	7E-05
	Tarawa Terrace: Dermal and Inhalation from Showering (Residential)	Pathway-Specific Total:	5E-05		6E-07		4E-07		6E-07		8E-07		2E-04		3E-04
CTE	Tarawa Terrace: Drinking Water, Dermal and Inhalation from Showering (Residential)	Benzene	NA	--	1.0E-08	2%	NA	--	1.8E-08	3%	NA	--	9.3E-06	4%	9E-06
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	2.8E-07	4%	5.6E-09	0.9%	9.3E-08	24%	1.9E-09	0.3%	2.6E-07	32%	1.2E-06	0.5%	2E-06
		Trichloroethylene	1.1E-07	2%	2.9E-07	47%	9.7E-09	3%	5.0E-07	86%	1.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	7.1E-06	95%	3.1E-07	50%	2.8E-07	73%	6.1E-08	10%	4.5E-07	54%	3.5E-05	15%	4E-05
	Hadnot Point: Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Pathway-Specific Total:	7E-06		6E-07		4E-07		6E-07		8E-07		2E-04		2E-04
Reasonable Maximum Exposure (RME)															
RME	Hadnot Point: Drinking Water, Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Benzene	1.3E-06	1%	1.3E-08	2%	NA	--	4.1E-08	3%	NA	--	9.3E-06	4%	1E-05
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	1.5E-07	0.1%	6.6E-09	0.9%	1.5E-07	25%	4.2E-09	0.3%	1.2E-06	33%	1.2E-06	0.5%	3E-06
		Trichloroethylene	3.3E-05	29%	3.6E-07	47%	1.6E-08	3%	1.1E-06	86%	5.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	7.7E-05	69%	3.8E-07	50%	4.3E-07	73%	1.3E-07	10%	1.9E-06	53%	3.5E-05	15%	1E-04
	Tarawa Terrace: Dermal and Inhalation from Showering (Residential)	Pathway-Specific Total:	1E-04		8E-07		6E-07		1E-06		4E-06		2E-04		4E-04
RME	Tarawa Terrace: Drinking Water, Dermal and Inhalation from Showering (Residential)	Benzene	NA	--	1.3E-08	2%	NA	--	4.1E-08	3%	NA	--	9.3E-06	4%	9E-06
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	6.7E-07	4%	6.6E-09	0.9%	1.5E-07	25%	4.2E-09	0.3%	1.2E-06	33%	1.2E-06	0.5%	3E-06
		Trichloroethylene	2.9E-07	2%	3.6E-07	47%	1.6E-08	3%	1.1E-06	86%	5.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	1.7E-05	95%	3.8E-07	50%	4.3E-07	73%	1.3E-07	10%	1.9E-06	53%	3.5E-05	15%	5E-05
	Hadnot Point: Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Pathway-Specific Total:	2E-05		8E-07		6E-07		1E-06		4E-06		2E-04		3E-04
Military High-End Exposure															
Military	Hadnot Point: Drinking Water, Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Benzene	1.9E-06	1%	1.3E-08	2%	NA	--	4.1E-08	3%	NA	--	9.3E-06	4%	1E-05
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	2.1E-07	0.1%	6.6E-09	0.9%	1.5E-07	25%	4.2E-09	0.3%	1.2E-06	33%	1.2E-06	0.5%	3E-06
		Trichloroethylene	4.6E-05	28%	3.6E-07	47%	1.6E-08	3%	1.1E-06	86%	5.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	1.2E-04	71%	3.8E-07	50%	4.3E-07	73%	1.3E-07	10%	1.9E-06	53%	3.5E-05	15%	2E-04
	Tarawa Terrace: Dermal and Inhalation from Showering (Residential)	Pathway-Specific Total:	2E-04		8E-07		6E-07		1E-06		4E-06		2E-04		4E-04
Military	Tarawa Terrace: Drinking Water, Dermal and Inhalation from Showering (Residential)	Benzene	NA	--	1.3E-08	2%	NA	--	4.1E-08	3%	NA	--	9.3E-06	4%	9E-06
		trans -1,2-Dichloroethylene	NA	--	NA	--	NA	--	NA	--	NA	--	NA	--	NA
		Tetrachloroethylene	9.7E-07	4%	6.6E-09	0.9%	1.5E-07	25%	4.2E-09	0.3%	1.2E-06	33%	1.2E-06	0.5%	4E-06
		Trichloroethylene	4.0E-07	2%	3.6E-07	47%	1.6E-08	3%	1.1E-06	86%	5.1E-07	14%	1.9E-04	80%	2E-04
		Vinyl Chloride	2.4E-05	95%	3.8E-07	50%	4.3E-07	73%	1.3E-07	10%	1.9E-06	53%	3.5E-05	15%	6E-05
	Hadnot Point: Dermal and Inhalation from Showering (Barracks), Inhalation from Mess Hall Duty	Pathway-Specific Total:	3E-05		8E-07		6E-07		1E-06		4E-06		2E-04		3E-04

Notes:
ELCR = Excess Lifetime Cancer Risk; HP = Hadnot Point; NA = Not Applicable; TT = Tarawa Terrace.

Appendix E

Point of Departure (POD) Derivations for Trichloroethylene (TCE) and Vinyl Chloride

Because the United States Environmental Protection Agency (US EPA) does not present points of departure (PODs) for trichloroethylene (TCE) or vinyl chloride for several endpoints and exposure pathways for which toxicity criteria are available, as described in this appendix, I have estimated the PODs based on the oral and inhalation toxicity criteria for these chemicals and pathways. These PODs are used in the margin of exposure (MoE) calculations discussed in Section 7.

E.1 Trichloroethylene (TCE)

PODs can be estimated from cancer toxicity criteria based on the fact that the cancer slope factor (CSF) or inhalation unit risk (IUR) values are expressed in terms of a specific risk per milligrams per kilogram body weight per day (*i.e.*, $[\text{mg/kg-day}]^{-1}$) or per micrograms per cubic meter (*i.e.*, $[\mu\text{g/m}^3]^{-1}$), respectively.

For TCE, the PODs that US EPA provides for some of the CSFs and IURs, and that are used to extrapolate to other cancer toxicity criteria, are based on a cancer risk of 1% (*i.e.*, the lower confidence limit of the exposure dose or concentration at an extra risk level of 1% [LED_{01} or LEC_{01}]) (US EPA, 2011a). Assuming that the TCE CSFs and IURs for which PODs were not provided would also be equivalent to a 1% cancer risk, the following equations can be used to calculate PODs from those CSFs and IURs.

To estimate PODs (LED_{01} values) from CSFs:

$$\text{POD (mg/kg-day)} = 1\% \div \text{CSF } ([\text{mg/kg-day}]^{-1})$$

To estimate PODs (LEC_{01} values) from IURs:

$$\text{POD } (\mu\text{g/m}^3) = 1\% \div \text{IUR } ([\mu\text{g/m}^3]^{-1})$$

Tables E.1 and E.2 summarize the PODs for TCE.

Table E.1 US EPA TCE Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs]) and Points of Departure (PODs)

Chemical	Oral CSF ^a ($[\text{mg/kg-day}]^{-1}$)	POD ^a (mg/kg-day)	Cancer Type	Sources
TCE	4.6×10^{-2}	$\text{LED}_{01} = 0.21$	Renal cell carcinoma, NHL, and liver cancer	US EPA (2011a,b)
	9.33×10^{-3}	$\text{LED}_{01} = 1.07^b$	Renal cell carcinoma	
	2.16×10^{-2}	$\text{LED}_{01} = 0.46^b$	NHL	
	1.55×10^{-2}	$\text{LED}_{01} = 0.65^b$	Liver cancer	

Notes:

LED_{01} = Lower Confidence Limit of the Exposure Dose at an Extra Risk Level of 1%; mg/kg-day = Milligrams per Kilogram Body Weight per Day; $(\text{mg/kg-day})^{-1}$ = Per Milligrams per Kilogram Body Weight per Day; NHL = Non-Hodgkin's Lymphoma; TCE = Trichloroethylene; US EPA = United States Environmental Protection Agency.

(a) US EPA (2011b) calculated the oral CSFs for renal cell carcinoma, NHL, and liver cancer individually and the LED_{01} for the three cancers combined as described in Section 5 and Table 5.1.

(b) PODs (LED_{01} values) for renal cell carcinoma, NHL, and liver cancer are calculated based on the equation described above. For example, for the renal cell carcinoma LED_{01} , the calculation is as follows: $1\% \div 0.00933 (\text{mg/kg-day})^{-1} = 1.07 \text{ mg/kg-day}$.

Table E.2 US EPA TCE Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs]) and Points of Departure (PODs)

Chemical	IUR ^a [($\mu\text{g}/\text{m}^3$) ⁻¹ ; [ppm] ⁻¹]	POD ^a ($\mu\text{g}/\text{m}^3$ [ppb])	Cancer Type	Sources
TCE	4.1×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 2.2×10^{-2} (ppm) ⁻¹	LEC ₀₁ = 2,445 (455)	Renal cell carcinoma, NHL, and liver cancer	Charbotel <i>et al.</i> (2006); Raaschou-Nielsen <i>et al.</i> (2003); US EPA (2011a,b)
	1.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 5.5×10^{-3} (ppm) ⁻¹	LEC ₀₁ = 9,781 (1,820)	Renal cell carcinoma	
	2.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 1.1×10^{-2} (ppm) ⁻¹	LEC ₀₁ = 4,890 ^b (910)	NHL	
	1.0×10^{-6} ($\mu\text{g}/\text{m}^3$) ⁻¹ ; 5.5×10^{-3} (ppm) ⁻¹	LEC ₀₁ = 9,781 ^b (1,820)	Liver cancer	

Notes:

$\mu\text{g}/\text{m}^3$ = Microgram per Cubic Meter; ($\mu\text{g}/\text{m}^3$)⁻¹ = Per Microgram per Cubic Meter; LEC₀₁ = Lower Confidence Limit of the Exposure Concentration at an Extra Risk Level of 1%; ppb = Parts per Billion; ppm = Parts per Million; (ppm)⁻¹ = Per Parts per Million; NHL = Non-Hodgkin's Lymphoma; TCE = Trichloroethylene; US EPA = United States Environmental Protection Agency.

(a) US EPA (2011b) calculated the individual IURs and the LEC₀₁ values for renal cell carcinoma, NHL, and liver cancer combined and renal cell carcinoma individually as described in Section 5 and Table 5.2.

(b) PODs (LEC₀₁ values) for NHL and liver cancer are calculated based on the equation described above. For example, for the NHL LEC₀₁, the calculation is as follows: $1\% \div 0.000002 (\mu\text{g}/\text{m}^3)^{-1} = 4,890 \mu\text{g}/\text{m}^3$. Note that rounding the IURs changes the PODs slightly.

E.2 Vinyl Chloride

Similar calculations were conducted for vinyl chloride. As described by US EPA (2003), one set of oral and inhalation cancer toxicity criteria for vinyl chloride (that are essentially identical to the other set of toxicity criteria calculated by the agency) are based on a cancer risk of 10% (*i.e.*, the lower confidence limit of the exposure dose or concentration at an extra risk level of 10% [LED₁₀ or LEC₁₀]). Therefore, the following equations can be used to calculate PODs from these CSFs and IURs.

To estimate PODs (LED₁₀ values) from CSFs:

$$\text{POD (mg/kg-day)} = 10\% \div \text{CSF } ([\text{mg/kg-day}]^{-1})$$

To estimate PODs (LEC₁₀ values) from IURs:

$$\text{POD } (\mu\text{g}/\text{m}^3) = 10\% \div \text{IUR } ([\mu\text{g}/\text{m}^3]^{-1})$$

Tables E.3 and E.4 summarize the PODs for vinyl chloride.

Table E.3 US EPA Vinyl Chloride Oral Cancer Toxicity Values (Cancer Slope Factors [CSFs]) and Points of Departure (PODs)

Chemical	Oral CSF ^a ([mg/kg-day] ⁻¹)	POD ^b (mg/kg-day)	Cancer Type (Sex/Species)	Sources
Vinyl Chloride	Continuous Lifetime Exposure During Adulthood			
	7.2 × 10 ⁻¹ ; 7.5 × 10 ⁻¹	LED ₁₀ = 0.133	Liver angiosarcomas, hepatocellular carcinomas, and neoplastic liver nodules (female rat)	Feron <i>et al.</i> (1981); US EPA (2000, 2003)
	Continuous Lifetime Exposure from Birth			
	1.4; 1.5	LED ₁₀ = 0.067	Liver angiosarcomas, hepatocellular carcinomas, and neoplastic liver nodules (female rat)	Feron <i>et al.</i> (1981); US EPA (2000, 2003)

Notes:

LED₁₀ = Lower Confidence Limit of the Exposure Dose at an Extra Risk Level of 10%; mg/kg-day = Milligrams per Kilogram Body Weight per Day; (mg/kg-day)⁻¹ = Per Milligrams per Kilogram Body Weight per Day; US EPA = United States Environmental Protection Agency.

(a) US EPA (2003) calculated the individual oral CSFs as described in Section 5 and Table 5.10.

(b) PODs (LED₁₀ values) are calculated based on the equation described above. For example, for the continuous lifetime exposure during adulthood LED₁₀, the calculation is as follows: 10% ÷ 0.75 (mg/kg-day)⁻¹ = 0.133 mg/kg-day.

Table E.4 US EPA Vinyl Chloride Inhalation Cancer Toxicity Values (Inhalation Unit Risks [IURs]) and Points of Departure (PODs)

Chemical	IUR ^a ([μg/m ³] ⁻¹)	POD ^b (μg/m ³ [ppb])	Cancer Type (Sex/Species)	Sources
Vinyl Chloride	Continuous Lifetime Exposure During Adulthood			
	4.4 × 10 ⁻⁶	LEC ₁₀ = 22,727 (8,900)	Liver angiosarcomas, angiomas, hepatomas, and neoplastic liver nodules (female rat)	Popper <i>et al.</i> (1981); Maltoni <i>et al.</i> (1984); US EPA (2000, 2003)
	Continuous Lifetime Exposure from Birth			
	8.8 × 10 ⁻⁶	LEC ₁₀ = 11,364 (4,445)	Liver angiosarcomas, angiomas, hepatomas, and neoplastic liver nodules (female rat)	Popper <i>et al.</i> (1981); Maltoni <i>et al.</i> (1984); US EPA (2000, 2003)

Notes:

μg/m³ = Micrograms per Cubic Meter; (μg/m³)⁻¹ = Per Microgram per Cubic Meter; LEC₁₀ = Lower Confidence Limit of the Exposure Concentration at an Extra Risk Level of 10%; ppb = Parts per Billion; US EPA = United States Environmental Protection Agency.

(a) US EPA (2003) calculated the individual IURs as described in Section 5 and Table 5.11.

(b) PODs (LEC₁₀ values) are calculated based on the equation described above. For example, for the continuous lifetime exposure during adulthood LEC₁₀, the calculation is as follows: 10% ÷ 0.0000044 (μg/m³)⁻¹ = 22,727 μg/m³.

References

Charbotel, B; Fevotte, J; Hours, M; Martin, JL; Bergeret, A. 2006. "Case-control study on renal cell cancer and occupational exposure to trichloroethylene. Part II: Epidemiological aspects." *Ann. Occup. Hyg.* 50(8):777-787. doi: 10.1093/annhyg/mel039.

Feron, VJ; Hendriksen, CFM; Speek, AJ; Til, HP; Spit, BJ. 1981. "Lifespan oral toxicity study of vinyl chloride in rats." *Food Cosmet. Toxicol.* 19:317-333.

Maltoni, C; Lefemine, G; Ciliberti, A; eds. 1984. *Experimental Research on Vinyl Chloride Carcinogenesis. Part I: Review of Available Data on General Pathology and Carcinogenicity*. Princeton Archives of Research on Industrial Carcinogenesis: Volume 2. Scientific Publishing, Co., Princeton, NJ. p1-35.

Popper, H; Maltoni, C; Selikoff, IJ. 1981. "Vinyl chloride-induced hepatic lesions in man and rodents. A comparison." *Liver* 1:7-20.

Raaschou-Nielsen, O; Hansen, J; McLaughlin, JK; Kolstad, H; Christensen, JM; Tarone, RE; Olsen, JH. 2003. "Cancer risk among workers at Danish companies using trichloroethylene: A cohort study." *Am. J. Epidemiol.* 158(12):1182-1192.

US EPA. 2000. "Toxicological Review of Vinyl Chloride (CAS No. 75-01-4)." EPA/635/R-00/004. 197p., May.

US EPA. 2003. "IRIS Chemical Assessment Summary for Vinyl Chloride (CAS No. 75-01-4)." 63p., October 28. Accessed at <https://www.epa.gov/iris>.

US EPA. 2011a. "IRIS Chemical Assessment Summary for Trichloroethylene (CAS No. 79-01-6)." 65p., September 28. Accessed at <https://www.epa.gov/iris>.

US EPA. 2011b. "Toxicological Review of Trichloroethylene (CAS No. 79-01-6) in Support of Summary Information on the Integrated Risk Information System (IRIS) (Final)." EPA/635/R-09/011F, 2469p., September.